Finite-Horizon Discernment Before Contact

Panagiotis Kalomoirakis
Independent Researcher, Synkyria Project

December 2025

Abstract

Clinical and phenomenological traditions often interpret non-engagement as avoidance, resistance, or deficit. This paper advances a different reading: that certain forms of non-contact operate as viability-preserving responses under conditions of finite capacity and finite temporal horizons.

Drawing on the Synkyrian viability framework [Kalomoirakis, 2025c], we articulate a pre-contact discernment layer that distinguishes viability-preserving holding from avoidance, shutdown, or collapse without introducing diagnostic categories or therapeutic techniques. The contribution is structural rather than prescriptive. It provides a conceptual language for recognising when contact would function as overload, and when clinical restraint is required to preserve the possibility of future integration.

1 Motivating Problem: When Contact Is No Longer Free

Across phenomenological and Gestalt traditions, contact is treated as a primary site of meaning and transformation: it is where experience becomes figure, where novelty can be assimilated, and where change can occur [Perls et al., 1951, Yontef, 1993, Francesetti et al., 2013]. Yet clinical practice repeatedly encounters situations in which contact, if pursued prematurely, becomes coercive rather than liberating.

Such moments are often interpreted as resistance, avoidance, or lack of cooperation. However, that interpretation already presupposes that contact remains structurally available—that the ground can carry figure formation, dialogue, and the risks of change. Gestalt field theory has long insisted that contact is not a mere act of will, but an event supported (or not) by a wider field configuration, including the organism–environment boundary, the available ground, and the costs of mobilization [Wheeler, 1991].

Trauma-oriented Gestalt work sharpens this point: when the ground is unstable, the most "contactful" intervention can function as an intrusion. What looks like refusal may be a protective holding action that preserves minimal coherence; what looks like "engagement" may be compliance purchased at the price of collapse. In such conditions, stabilising ground is not a preparatory nicety but a precondition for contact to be non-coercive [Taylor, 2014, Wheeler, 1991].

The present paper therefore starts from a simple question: *what must already hold for contact to remain a free, non-coercive possibility at all?* We do *not* answer this by proposing a new diagnostic category or by naming a clinical "type." Instead, we treat the issue as a structural one: there are regimes in which the field cannot sustainably support the energetic and informational demands of contact. In Synkyrian terms, contact can fail to be "free" because the system has entered a finite-horizon viability regime in which stabilising actions are prioritised over exploratory assimilation [Kalomoirakis, 2025c,b].

This motivates a viability-first lens for clinical and therapeutic contexts. Before interpreting non-contact as deficit, we propose to assess whether the field is near collapse horizons and whether the organism–environment system still has sufficient capacity to bear contact without coercion. The goal is a minimal, practical pre-contact diagnostic orientation that distinguishes: (i) pre-contact holding that preserves viability, (ii) avoidance as a learned strategy within an otherwise viable field, and (iii) shutdown as a collapse regime requiring restoration of ground before any contact demand can be ethical or effective.

2 Finite-Horizon Viability as a Prior Condition

The Synkyrian framework shifts emphasis from asymptotic notions of stability toward finite-horizon survival under load [Kalomoirakis, 2025c]. Rather than asking whether a system converges in the long run, it asks whether the system can remain admissible over a bounded temporal horizon given its current capacities, constraints, and environmental pressures.

For a system state x and a finite horizon T, let $q_T(x)$ denote the probability that the system crosses a collapse or failure set before time T. This probability does not describe subjective experience; it characterizes structural risk. A canonical viability gauge is given by the log-hazard transform

$$H_{\mathrm{rig}}(x;T) = -\frac{1}{T}\log q_T(x),$$

which measures the persistence of admissibility over the specified horizon. Higher values of H_{rig} indicate that the system can sustain its current mode of operation without imminent collapse, while lower values signal proximity to critical thresholds.

2.1 Viability versus stability

This finite-horizon framing marks a decisive conceptual shift. Classical stability notions presuppose that systems should be evaluated with respect to equilibrium or long-term convergence. Clinical and phenomenological contexts rarely satisfy this assumption. Human systems operate under fluctuating load, incomplete information, and bounded processing capacity. What matters is not asymptotic optimality, but whether the system can *hold* long enough for meaningful contact, assimilation, or change to remain possible.

Gestalt field theory already gestures toward this priority by insisting that contact depends on support and ground, not on will or intention alone [Perls et al., 1951, Wheeler, 1991]. Viability

theory makes this dependence explicit: when load exceeds capacity, the question is no longer how contact unfolds, but whether it can occur without accelerating collapse.

2.2 Admissibility as a pre-contact condition

The relevance of H_{rig} for clinical translation lies in its role as a pre-contact condition. Contact presupposes admissibility: the system must be able to bear the energetic, informational, and relational demands of engagement without losing coherence. When admissibility is compromised, contact ceases to be a free event and becomes coercive, regardless of therapeutic intention.

This clarifies why certain clinical impasses cannot be resolved through interpretation, insight, or relational intensity. In such moments, further engagement functions as additional load. The system responds not by integrating experience, but by narrowing, fragmenting, or shutting down. From a viability perspective, this response is not pathological; it is protective.

Trauma-oriented Gestalt work articulates this insight experientially by emphasizing stabilization and restoration of ground prior to exploratory or narrative work [Taylor, 2014]. Viability theory provides the structural rationale for this ordering. Stabilization is not merely helpful; it is necessary whenever $q_T(x)$ approaches critical levels.

2.3 From mathematical gauge to clinical discernment

The introduction of H_{rig} does not imply that clinicians should estimate probabilities or compute hazard rates. The function serves as a conceptual anchor that disciplines interpretation. It formalizes the idea that certain configurations demand restraint rather than activation.

Clinically, this translates into a shift of priority: before asking what an experience means, one must ask whether the field can sustain the work of meaning-making at all. Viability, in this sense, is not an additional diagnostic variable. It is the condition under which diagnosis, phenomenological interpretation, and therapeutic technique remain legitimate.

The remainder of this paper develops this claim by articulating concrete distinctions at the pre-contact level—most notably between holding that preserves viability, avoidance within a viable field, and shutdown as a collapse regime—without introducing new clinical categories or taxonomies.

3 Pre-Contact Holding Versus Avoidance: A Structural Discriminator

Clinical language frequently collapses distinct non-engagement regimes under a single interpretive label: avoidance, resistance, withdrawal, or deficit. While phenomenological traditions—and Gestalt therapy in particular—have long resisted purely intrapsychic explanations, the dominant discriminator remains experiential: how contact is interrupted or distorted once engagement is underway [Perls et al., 1951, Yontef, 1993].

The present distinction operates at a prior layer. It does not ask how contact unfolds, but whether contact remains structurally admissible at all.

3.1 Why behavioural descriptions are insufficient

From a finite-horizon viability perspective, behavioural similarity does not imply structural equivalence. Two systems may exhibit identical surface behaviour (non-engagement, hesitation, silence) while occupying radically different viability regimes.

Avoidance, in a structural sense, is characterised by progressive loss of responsiveness, narrowing of temporal openness, and reduced capacity to re-enter contact even when field conditions improve. Shutdown marks a more severe regime: collapse of admissibility itself, where future contact is no longer possible without external support or field reconstitution.

By contrast, pre-contact holding preserves responsiveness while suspending engagement. The system remains sensitive to changes in field conditions, capable of temporal extension, and able to re-enter contact without coercion. The difference is not motivational but structural.

This distinction cannot be resolved by behavioural observation alone, nor by appeals to intention or moral posture. It requires a criterion anchored in viability rather than in experience-description.

3.2 Finite-horizon viability as discriminator

Let $q_T(x)$ denote the probability that a system starting at state x crosses a collapse or failure set within a finite horizon T [Kalomoirakis, 2025c]. The associated log-hazard gauge $H_{\mathrm{rig}}(x;T)$ captures whether admissibility is preserved over that horizon.

From this perspective, the discriminator is simple but decisive. The viability effect of non-engagement thus becomes the decisive criterion.

- In avoidance or shutdown regimes, non-engagement coincides with increasing $q_T(x)$: the system moves closer to collapse as engagement is withheld.
- In pre-contact holding regimes, non-engagement stabilises or reduces $q_T(x)$: the suspension of contact preserves future admissibility.

The same outward behaviour—not engaging—thus has opposite structural meaning depending on its effect on finite-horizon viability.

This framing explains a recurring clinical intuition: that forcing contact in certain moments does not lead to integration, but to overload and breakdown. In viability terms, forced engagement increases effective load, accelerating horizon crossing rather than supporting assimilation [Kalomoirakis, 2025a].

3.3 Pre-contact holding is not moral restraint

A common misinterpretation treats restraint from engagement as either defensive avoidance or virtuous self-control. Both readings are misleading.

Pre-contact holding is not a moral achievement, nor a behavioural technique. It is a viability operation that preserves the possibility of contact under bounded capacity and finite resources. When load exceeds processing capacity, refusal or suspension is not optional; it is a structural requirement for persistence [Kalomoirakis, 2025a,d].

This also clarifies why pre-contact holding must be sharply distinguished from shutdown. Shutdown reflects loss of admissibility; holding reflects its protection. Confusing the two risks pathologising precisely those moments in which clinical restraint is most needed.

3.4 Clinical relevance without protocolisation

The purpose of this distinction is not to introduce a diagnostic rule or intervention algorithm. It provides a structural lens that justifies clinical hesitation where contact would become coercive rather than liberating.

Gestalt therapy remains the primary phenomenology of contact [Perls et al., 1951]. The viability layer articulated here does not replace that phenomenology. It names the condition that must be preserved so that contact can remain free rather than forced.

3.5 Relation to Gestalt Diagnostic Maps

Gestalt therapy has long resisted diagnostic classification in favour of field-oriented process discernment. Dreitzel's diagnostic maps are explicitly framed as a *field guide* rather than a nosological taxonomy, aiming to orient the therapist within the unfolding contact process rather than to assign fixed categories [Dreitzel, 2010].

Within this framework, disturbances are described across multiple levels of the contacting process, including a distinct layer associated with the pre-contact phase. At this level, Dreitzel locates energetic weaknesses and contact interruptions that affect the system's readiness for engagement prior to full contact.

This contribution is decisive. It recognises that difficulties may arise *before* contact itself, and that not all non-engagement is to be interpreted within the dynamics of full contact or post-contact integration. However, the Gestalt diagnostic framework remains phenomenological in scope. It describes how contact is impeded, but it does not specify when contact itself ceases to be structurally admissible.

The Synkyrian viability framework does not contradict this diagnostic approach. Rather, it introduces a prior discriminator. While Gestalt diagnosis maps disturbances *within* the contacting process, finite-horizon viability clarifies when the process itself is at risk of collapse under load.

This distinction matters clinically. Without a viability criterion, pre-contact restraint risks being misread as disturbance, resistance, or deficit. With such a criterion, restraint can be recognised as a viability-preserving operation that maintains the possibility of future contact rather than undermining it.

In this sense, the viability layer does not replace Gestalt diagnostic maps. It specifies the condition under which those maps remain valid. When admissibility is preserved, phenomenological

diagnosis can proceed. When it is not, diagnostic interpretation itself must be suspended in favour of holding.

4 Clinical Discernment Without Forcing Contact

The contribution of this paper is not a protocol but a restraint: it articulates when *not* to intervene. Clinical discernment, on this view, includes recognising moments in which contact would function as additional load rather than as a medium of integration. In such moments, therapeutic insistence risks transforming contact from a free event into a compelled one.

This perspective does not replace Gestalt practice. It supplies a viability grammar beneath it, clarifying when contact remains possible as an expression of freedom and when it has become structurally compelled. Gestalt therapy has long emphasised that contact cannot be forced without distortion, and that support must precede mobilization [Perls et al., 1951, Yontef, 1993]. The viability layer formalises this intuition by specifying the conditions under which contact itself ceases to be admissible.

4.1 Restraint as clinical competence

Within a viability-first frame, restraint is not passivity and not a failure of therapeutic engagement. It is an active form of clinical competence grounded in the recognition of bounded capacity and finite resources. When effective load exceeds what the field can support, attempts to deepen contact, intensify affect, or accelerate insight add pressure rather than meaning.

Trauma-oriented Gestalt work repeatedly underscores this ordering: safety and ground must be restored before exploration can become productive [Taylor, 2014]. Viability theory explains why this ordering is not merely pragmatic but structural. Stabilisation preserves admissibility; premature activation erodes it.

4.2 Why forcing contact undermines integration

From the perspective developed here, forcing contact undermines integration because it accelerates horizon crossing. When engagement is demanded in a low-viability regime, the system must divert resources to basic persistence. Under such conditions, experience cannot be assimilated; it is either fragmented or endured.

This dynamic clarifies a recurrent clinical observation, noted across Gestalt and trauma-oriented work: interventions that are theoretically sound and relationally well-intentioned can nonetheless produce deterioration when applied in the absence of sufficient ground [Francesetti et al., 2013, Wheeler, 1991, Taylor, 2014]. The failure lies not in technique but in timing. Without sufficient viability, even empathic contact functions as overload. In Synkyrian terms, forced engagement increases effective load and raises the probability of collapse within the relevant horizon [Kalomoirakis, 2025c,a].

4.3 Holding the condition for future contact

Clinical discernment without forcing contact thus aims at preserving the conditions under which future contact can become possible again. This does not entail withdrawal from relationship, nor does it imply clinical neutrality. It involves maintaining presence while suspending demands for engagement, interpretation, or change.

Such holding aligns with Gestalt understandings of support and ground while extending them structurally. The clinician's task, at this level, is not to resolve experience but to prevent further loss of admissibility. When viability is preserved, phenomenological work can resume; when it is not, interpretation itself must be postponed.

In this sense, restraint is not opposed to therapeutic action. It is the action required to keep contact free rather than coerced, and to ensure that when contact does occur, it remains a genuine event rather than an act of survival.

5 Clinical Misreadings and the Risk of Forced Contact

Clinical practice routinely operates under pressure to act. Silence, hesitation, and non-engagement are easily interpreted as signals that intervention is required. Within such contexts, contact is implicitly treated as a universal good, and its absence as a deficit to be remedied.

From a viability perspective, this assumption is dangerous.

5.1 When contact becomes coercive

When system load approaches or exceeds processing capacity, engagement ceases to be freely chosen. Under such conditions, attempts to initiate or intensify contact function as external load, further reducing admissibility.

Clinically, this is often experienced as paradoxical deterioration: the more the therapist invites engagement, the more the client contracts, dissociates, or destabilises. Without a viability lens, such reactions are easily misread as resistance or lack of motivation. With such a lens, they appear as predictable responses to overload [Kalomoirakis, 2025a].

The risk is not merely therapeutic inefficacy, but structural harm. Forced contact accelerates horizon crossing, reducing the likelihood that future engagement will remain possible.

5.2 Misdiagnosis through premature interpretation

Gestalt-informed diagnosis relies on phenomenological interpretation within the contacting process [Dreitzel, 2010]. However, when admissibility itself is compromised, interpretation becomes unreliable.

In such moments, meaning-making does not clarify experience; it overwhelms it. Interpretive activity presupposes a minimum level of stability and temporal openness. Absent these conditions, diagnostic insight risks functioning as intrusion rather than support.

This clarifies a frequent clinical confusion: the belief that better interpretation can compensate for insufficient holding. The viability framework reverses this order. Holding is the precondition for interpretation, not its outcome.

5.3 Ethical restraint as structural necessity

The restraint advocated here is not ethical minimalism or therapeutic passivity. It is an acknowledgment of finite capacity.

Where viability is threatened, the ethical act is not to press for expression, insight, or contact, but to preserve the conditions under which these may later re-emerge. This reframes clinical responsibility: from facilitating immediate engagement to safeguarding future possibility.

Seen in this light, pre-contact holding is not a retreat from clinical work. It is work at the level of structural care.

6 Why Viability Is Not Diagnosis (and Not Trauma Theory)

Given its clinical implications, the viability framework introduced here risks being misread as a diagnostic proposal or as a contribution to trauma theory. Both interpretations miss its level of operation.

Viability is not a category of psychopathology, nor a descriptive account of suffering. It names a prior structural condition: whether a system can sustain contact, interpretation, or intervention without crossing a collapse horizon.

6.1 Viability versus diagnosis

Diagnosis, even when phenomenologically informed, operates within the field of experience. It presupposes that experience can be articulated, interpreted, and integrated within an ongoing contact process [Dreitzel, 2010, Francesetti et al., 2013].

Viability precedes this field. It concerns the admissibility of the process itself. When admissibility is compromised, diagnostic distinctions lose traction: not because suffering is absent, but because interpretive engagement becomes structurally destabilising.

For this reason, viability cannot be added as another diagnostic lens. It does not refine classification; it determines whether classification remains meaningful at all.

6.2 Relation to trauma-oriented frameworks

Contemporary trauma theory has made decisive contributions by emphasising stabilization, regulation, and the restoration of bodily and relational ground prior to narrative or interpretive work [Taylor, 2014]. These approaches correctly insist that contact and meaning-making cannot be forced under conditions of overwhelm.

The present framework does not extend trauma theory, nor does it offer another account of traumatic experience. Instead, it articulates the structural reason such clinical wisdom is necessary. Under finite capacity and finite temporal horizons, stabilization is not a technique but a requirement for persistence.

In this sense, trauma-informed practice appears as a special case of a more general viability principle. The latter applies wherever load exceeds processing capacity, regardless of whether the source is traumatic, relational, organizational, or systemic.

6.3 Ground, structure, and admissibility

Gestalt theory has increasingly foregrounded the role of structured ground in shaping contact and resistance [Wheeler, 1991]. This shift clarifies how enduring relational and historical conditions organize experience.

Viability theory complements this insight by introducing a threshold concept. Structured ground may exist, yet fail to remain viable under current load. In such cases, attention to ground alone is insufficient; the decisive question becomes whether the ground can sustain further contact without collapse.

This threshold is not phenomenological but structural. It cannot be directly observed as experience, only inferred from the system's capacity to remain open to future contact.

6.4 Clinical consequence

Recognizing viability as distinct from diagnosis reframes clinical responsibility. The clinician is not asked to decide what a client *is*, but to discern what the field can presently sustain.

Where viability is preserved, phenomenological diagnosis and therapeutic engagement may proceed. Where it is not, restraint is not a failure of treatment but an act of structural care.

This distinction preserves the integrity of both clinical phenomenology and trauma-informed practice by situating them within their proper domain of validity.

7 Discussion: Where Phenomenology Must Pause

A central implication of the present work concerns the limits of phenomenological interpretation. Phenomenology presupposes contact that can be sustained without threatening the integrity of the field. Where this presupposition fails, interpretation does not merely lose explanatory power; it becomes structurally intrusive.

From a viability perspective, phenomenology must pause when the work of meaning-making itself functions as load. This does not indicate a failure of understanding, but a violation of admissibility. In such conditions, asking what an experience means risks accelerating collapse rather than supporting integration.

What takes the place of phenomenological interpretation is not a rival theory of meaning, but a prior form of discernment. Viability discernment does not ask what is experienced, but whether

the field can currently bear experience without forfeiting future contact. This reorders clinical responsibility: before interpreting content, one must assess admissibility.

Within this frame, clinical restraint is not an absence of action but a structural intervention. By suspending demands for contact, interpretation, or change, restraint preserves the possibility that contact may later re-emerge as a free event rather than as a compelled response to pressure.

This perspective reframes a long-standing clinical tension. Rather than treating non-engagement as a deficit to be overcome, the viability lens allows non-contact to be recognised, in certain regimes, as a viability-preserving operation. Phenomenological work resumes not when content is resolved, but when admissibility is restored.

The contribution of the present framework is thus not to delimit the scope of phenomenology in general, but to specify the conditions under which it remains ethically and structurally appropriate.

The present framework identifies conditions under which phenomenological interpretation must pause in order to preserve viability. This pause should not be misunderstood as a denial of ambiguity, silence, or non-knowledge. It marks a structural boundary rather than an experiential one: a point at which interpretation becomes coercive because the field cannot yet bear the work of meaning-making.

What remains beyond this boundary is not theoretical emptiness but a different mode of holding. Ambiguity, silence, and uncertainty persist, not as objects of interpretation, but as conditions to be sustained. Their experiential articulation belongs to a different register than the one developed here. The present paper delineates when interpretive work must be suspended; it does not exhaust what it means to inhabit that suspension.

8 Limitations and Scope

This paper does not propose diagnostic criteria, therapeutic techniques, or outcome measures. It introduces a structural language whose role is protective rather than prescriptive. The viability concepts articulated here are not intended to classify individuals, predict clinical outcomes, or replace phenomenological diagnosis.

The scope of the argument is deliberately limited. The finite-horizon viability framework is offered as a prior condition for clinical discernment, not as an explanatory theory of psychopathology and not as a substitute for established therapeutic traditions. Its function is to clarify when interpretive, relational, or experiential work remains legitimate, and when such work risks becoming coercive under conditions of reduced admissibility.

No claim is made that viability can be directly measured in clinical practice. The mathematical formalism serves as a conceptual anchor, disciplining interpretation rather than guiding intervention. Any attempt to operationalise these ideas into protocols, metrics, or decision rules would exceed the intent of this contribution and risk misuse.

Finally, the framework advanced here is not value-neutral. It carries an implicit ethical commitment: that preserving the possibility of future contact takes precedence over forcing present

engagement. This priority places limits on therapeutic ambition and underscores the importance of clinical restraint under conditions of finite capacity.

9 Conclusion

Pre-contact viability names a condition that must be preserved if contact is to remain meaningful rather than compelled. By foregrounding admissibility as a prior concern, the paper reframes non-engagement not as a failure of motivation or relation, but as a potential operation of holding under load.

Recognising this condition allows clinical practice to distinguish pre-contact holding from avoidance or shutdown without collapsing discernment into moral judgement. It supports hesitation where contact would function as overload, and restraint where intervention would accelerate collapse rather than integration.

The contribution of this work is thus modest and structural. It does not tell clinicians what to do. It clarifies when doing more may do harm, and when preserving ground is the most responsible form of care. In this sense, viability-first discernment does not compete with Gestalt phenomenology or trauma-informed practice; it specifies the condition under which their insights can remain effective and ethically grounded.

References

Hans Peter Dreitzel. *Gestalt and Process: Clinical Diagnosis in Gestalt Therapy: A Field Guide*. EHP (Edition Humanistische Psychologie), Bergisch Gladbach, 2010. ISBN 9783897970670.

Gianni Francesetti, Michela Gecele, and Jan Roubal, editors. *Gestalt Therapy in Clinical Practice: From Psychopathology to the Aesthetics of Contact*. FrancoAngeli, Milan, 2013. ISBN 9788820420727.

Panagiotis Kalomoirakis. The thermodynamic right to refusal: Finite negentropy supply and bounded capacity. Preprint, 2025a. URL `https://synkyria.github.io/papers/right-to-refusal/`. Synkyria Project.

Panagiotis Kalomoirakis. The self before contact, 2025b. URL `https://synkyria.github.io/papers/self-before-contact/`.

Panagiotis Kalomoirakis. Synkyrian stability as an architectural framework. Preprint, 2025c. URL `https://doi.org/10.5281/zenodo.17741656`. Synkyria Project.

Panagiotis Kalomoirakis. Tropic information theory. Preprint, 2025d. URL `https://synkyria.github.io/papers/tropic-information-theory/`. Synkyria Project.

Frederick S. Perls, Ralph Hefferline, and Paul Goodman. *Gestalt Therapy: Excitement and Growth in the Human Personality*. Julian Press, New York, 1951.

Miriam S. Taylor. *Trauma Therapy and Clinical Practice: Neuroscience, Gestalt and the Body*. Open University Press, 2014. ISBN 9780335263097.

Gordon Wheeler. *Gestalt Reconsidered: A New Approach to Contact and Resistance*. Gestalt Institute of Cleveland Press, 1991. ISBN 089876159X. Distributed by Gardner Press.

Gary Yontef. *Awareness, Dialogue and Process: Essays on Gestalt Therapy*. Gestalt Journal Press, Highland, NY, 1993.