
Mind's Response to the Body's Betrayal: Gestalt/Existential Therapy for Clients with Chronic or Life-Threatening Illnesses

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In the literature on chronic or life-threatening illness, there is an overriding emphasis on clients' psychological coping styles and how they relate to psychological functioning. By contrast, in our approach, we look at the subjective mind/body experiences that clients have of their illness and how their lives are impacted by their illness. As psychotherapists, we address their existential distress, pain, body experience, thoughts, and feelings, as well as their efforts to cope or find meaning in their illness. We summarize Gestalt/Existential therapy for chronic illness, illustrate the approach with three case-vignettes, and stress the importance of attending to each client's unique responses to illness. © 2002 Wiley Periodicals, Inc. *J Clin Psychol/In Session* 58: 1361–1373, 2002.

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In this article, we present our Gestalt/Existential therapy for chronic and life-threatening illnesses and illustrate our approach with three cases of women struggling with different illnesses and issues. Being psychotherapists for clients with chronic and/or life-threatening illnesses has been humbling. Discerning a good course to follow at a given moment in therapy is difficult, and there are no easy answers. Our clients continue to teach us.

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Thumbnail Sketch of Gestalt/Existential Therapy

Gestalt therapy is not about recipes or techniques. Rather, it is an approach based on certain views about people's alienation from themselves and others and about what can help them become more aware, integrated, and contactful with themselves, with others, and with their environment.

A hallmark of Gestalt therapy is awareness of feelings, thoughts, actions, perceptions, and beliefs. We keep in mind the ways in which people block or cloud awareness through the defenses of projection, retroflexion, confluence, and introjection. We keep in mind the concept of figure and ground and the extent to which a person is able to move fluidly from one figure to another. We watch for polarities and how the person may be at odds with her or himself, possibly stuck in an impasse because two parts of the personality have been unable to join hands. We believe that unfinished business hangs around in one form or another until we find a way to work through the situation, either in symbolic enactment or in real life. We use the framework of the contact/withdrawal cycle of experience to see where people habitually get stuck in their processes. We focus on the breathing and the body and the voice to detect how a person habitually restricts energy to deaden full aliveness and authenticity. We believe that growth takes place when there is immediacy to one's experience and when we bring all of ourselves—mind/body/sensation/emotion—into congruent, authentic expression in the present.

In existential psychotherapy, the therapist attends carefully to how clients construe what happens to them, what meanings they assign to events in their lives, and how they relate to their disease and to the possibility of death.

How does this translate into actual work with our chronically ill clients? Principally, we think the therapy must be individualized to the client's subjective experiences. People with illness are not all alike; thus, therapy cannot be formulaic. A person's responses to illness may be affected variously by the severity of the illness, family background and history, relationships (intimate, family, social), cultural context, and financial situation. There is considerable research indicating the importance of these variables in adjustment to illness (Engelhardt, 1982; Kausar & Akram, 1998; Kestenbaum, 1982; Moos & Tsu, 1977; Pellegrino, 1982; Rawlinson, 1982).

Case Illustrations

Client Descriptions/ Presenting Problems

The two clients who are still living, Joan and Pat, responded in writing to a questionnaire that was adapted from a questionnaire on the experience of betrayal of the body. The third client, Leslie, died a few years ago, and therefore we have used notes and memory to describe her.

Joan and Pat have given us permission to use the material they have written without attempting to obscure their identity, so none of the demographic or historical details of their lives have been changed. We have changed their names. We have also changed Leslie's name and several other identifying details.

JOAN. Joan is a 52-year-old African-American single woman who grew up in Ohio with her parents, twin sister, brother, and within a broader context of many relatives and "adopted relatives." Her father, though physically and emotionally abusive toward Joan, her siblings, and her mother, consistently held a job to support his family and to send all his children to college. Her mother, a kind and nurturing parent, gave her children love,

acceptance, and encouragement, but little protection. Both parents highly valued and drilled into their children the supreme importance of hard work as *the* way to ensure their place on the planet and to avoid the dreaded existence of some neighbors and relatives who were on drugs and welfare. This theme of working to earn a living figures prominently in Joan's response to physical limitations, which we elaborate upon later.

Joan is extremely likeable, intelligent, and enterprising. While navigating graduate school (she's A.B.D. in clinical psychology), it was not unusual for her to hold down two or three jobs. She is greatly loved and respected by many people and is attractive, though overweight. Joan's initial presenting problems prior to her life-threatening illness were: depression; lack of self-love; childhood abuse; negative body image; a tendency to exhaust herself and her health with hard work; and living with hypertension. During the course of therapy, she also dealt with grief over the deaths of her beloved twin sister and her mother, and financial and emotional betrayal in several relationships with men. Hard fortune seems to have followed her unmercifully. Joan is more loved by others than she is by herself. She often internalizes her father's criticism of her body.

Six months after returning to Atlanta from her psychology internship in another state, where she had faced heart disease, cancer, and other life-threatening medical problems, Joan re-entered weekly therapy in July, 1999, to deal with depression and anxiety related to her illness. The Wellbutrin she had been taking since 1997 did not seem to be helping, so I recommended she see a psychiatrist for a medical consult. However, it was not until May, 2001, that she saw the psychiatrist, who gradually took her off the Wellbutrin and prescribed a combination of Klonopin, Luvox, and Neurontin. She says she cannot tell if these medications are helping, although she feels a bit better recently and believes this may be attributed to learning that a mass in her chest was not cancer. She is interested in joining a heart-disease support group, but has not as yet had the energy to do so.

PAT. Pat, a 59-year-old Caucasian woman, lost her biological father at the age of one. She and her older brother were mostly reared by their alcoholic stepfather and needy mother. Pat became a caretaker at an early age.

Pat is warm, affable, creative, and insightful, and in close contact with family and friends. She is divorced with two married daughters and lives alone with her two dogs. She is financially comfortable and has medical insurance through her job. She works as a media specialist at the Centers for Disease Control. She gardens, has an active social life with friends, and is active in her church.

When she entered weekly therapy in July, 1998, Pat's initial presenting problems were: discomfort with weight gain; lack of motivation to exercise; grief over the death of her aunt, her mother, and a beloved dog in the previous year; anger at herself for not writing a book and newsletter for which she had ideas, along with having a touch of the impostor phenomenon (Clance & Imes, 1978); and ambivalence about professional and personal directions. She had not yet developed her chronic illness, rheumatoid arthritis, at the time, though she began to have symptoms shortly thereafter.

She has addressed and resolved most of her initial issues and now remains in therapy for growth and sustenance. She has not taken any psychotropic medications or had any additional or alternative therapies.

LESLIE. Leslie was 42 when she entered therapy. She grew up in a Midwestern working-class farm family. Her father was a man who worked very hard to support his family. He was kind, and Leslie liked him, but he was rarely at home and was very sparse with his interactions. Her mother was somewhat depressed and alternated between emotional reactivity and withdrawal. Leslie did not think she could bother either of her parents with any of her problems or concerns. She liked her sisters and brothers but did not feel close to them.

Leslie's initial presenting problems were depression, difficulty with intimacy, childhood issues, and job dissatisfaction. She had great difficulty feeling pleasure and aliveness.

She was in individual therapy before and during a first diagnosis of cancer and its remission and then again after reoccurrence of the cancer. The second course of therapy lasted two and one-half years, with a session scheduled almost every week with some breaks when either of us traveled. Leslie had chemotherapy and radiation treatments and also received pain medication when needed. She occasionally attended a cancer support group, but she did not receive any other alternative therapies.

In all of the cases being discussed, the clients developed their life-threatening or chronic illnesses during therapy (Joan and Pat) or during a break in therapy (Leslie). As a part of our case formulation and therapy work, we consider the context of the clients' lives before onset of the illness as important background to understanding their mind/body reactions to the changes wrought in their existence. In all cases, the clients had made progress with their presenting problems and had fairly positive and hopeful outlooks on life at the time of the onset of their illnesses.

Subjective Themes of Therapy and Illness

The following section will relate the unfolding circumstances and processes for each of the three clients in three transitions of therapy: (a) context prior to onset of chronic illness; (b) occurrence of illness, subjective mind/body reactions, and impacting factors; and (c) ongoing subjective themes.

JOAN. During the course of her therapy, Joan's self-esteem improved, which she attributes to therapy, the death of her father who had abused her, and being appointed to an executive position in the state prison system. She had even revised the appellation of her body to "Rubenesque," and began to take pleasure in it.

Even developing cancer in one breast, having a mastectomy and reconstructive surgery, and accruing more debt due to lack of medical insurance did not totally quell her enthusiasm and hope for her future. She was armed with assurance from her surgeon that she was unlikely to develop cancer in her other breast and with the belief that she would soon get her Ph.D. and get a well-paying job. Joan was not devastated by having cancer and was coping well. She made the difficult but exciting move to Colorado for her internship, away from a well-developed support system of friends.

While on her internship, Joan was diagnosed with three life-threatening illnesses—Conn's disease (potassium wasting due to a tumor on her adrenal gland), congestive heart failure, and cancer in her other breast. Because of her heart condition, simultaneous surgeries to remove her adrenal gland (for the potassium problem) and her left breast were in and of themselves life-threatening. She survived these surgeries, only again to come close to death another time from a potassium overdose when her cardiologist failed to adjust her potassium intake after adrenal surgery. She was hospitalized with pneumonia several times. And finally, she had to undergo a total hysterectomy in 2000, because of a prolapsed uterus, as well as a biopsy for an enlarged lymph node, found to be negative for cancer.

Joan's initial reaction to learning that she had three life-threatening illnesses was shock. She describes it as a "cosmic boom." She remembers, "It was as though a mammoth hole had been made in my reality, forever changing how I think of myself, move through the world, and relate to my family and friends."

The toll of so many invasive medical procedures, financial ruin, inability to work, constant fatigue, lack of self-reliance, a body ravaged by scars in every sector, loss of feelings of femininity, having to go on disability, and generally losing control of her life

have been very traumatic for Joan. Cautious hope has turned into seemingly unending despair. Sleepless nights are interrupted with night sweats and nightmares, and troubled days are plagued with obsessions about survival and about what might be the next illness to prevent her from forging anything like the life she had expected and for which she had hoped.

Joan does not feel her body betrayed her. Instead, she has an internal sense of having betrayed her body by running out of coping resources—"I felt unprepared to deal with the enormity and severity of my medical problems. And I often think I *should* have been prepared to deal with this in my life." Such "shoulds" are often a theme in Joan's therapy.

Her major sense of betrayal is seated outside herself, in the medical establishment. She is still angry with the doctor who told her there was little risk of getting breast cancer in her remaining breast, at the cardiologist who forgot to lower her potassium, and at her primary care doctor for failing to diagnose the potassium wasting before it became life threatening. Joan has also felt gratitude to those in the medical field who saved her life more than once. In therapy it is important for her to tell the stories about such events and for me to listen with care and understanding. I see her betrayal feelings and the aftermath of many invasive procedures the same way I would any other form of post-traumatic stress.

Joan's experience of her illnesses has been wrought with shame. For example, soon after developing congestive heart failure, she was willing to jeopardize her life by climbing four sets of stairs without her oxygen tank to get to a job interview. In this realm of "jobness" that had always so defined her self-worth, her shame was almost unbearable. She explains, "I loath to be seen as a person with a physical handicap, or worse, with a terminal illness." She still feels ashamed of her physical self. She discloses, "My feelings of unattractiveness have effectively kept me from attempting to date anyone since I was diagnosed. I just don't know how to tell a new person in my life how ill I have been, or face their reaction to the information and their reaction to my distorted body."

Joan's illness has put a strain on her relationship with her brother. Sharing the family ethic of hard work, he was disappointed when Joan went on disability because he expected her to finish her doctorate and get a job. Joan protects him by minimizing her health problems and sounding positive about work plans for the future.

Joan has had an extraordinary support system of friends throughout her illness to whom she is immensely grateful. She also fears they will tire of her long illness and accompanying depression and leave her if she does not "put on a good face" much of the time. Therefore, she sometimes isolates herself so that she doesn't have to act better than she feels.

Although depression and the limitations of energy are currently figural for Joan, I can see her indomitable spirit working very hard to keep her alive and living as well as possible. She persisted in gathering all the materials she needed to get disability—twice—since she was turned down the first time. She continues to pursue job possibilities. She still has hopes of writing a dissertation. She has moved twice since returning to Atlanta in attempts to make a home that feels comfortable to her. She stays in touch with friends here and in other states and visits them whenever possible. These are only a few of the things she has done in an attempt to normalize her life, even while believing that "living with a debilitating chronic illness is a lot harder than dying from that same illness."

PAT. Pat believes that the cumulative effect of losses in her life somehow triggered her rheumatoid arthritis. She does not, as Joan does, attribute to past relationship history her feelings about herself since her illness. Rather, she believes more that the stress of caring for dying relatives, the nature of her relationships, and her reactions to loss of important others have compromised the health of her body.

First, Pat's aunt died—the only link to her paternal biological family line. Then, Pat's mother died unexpectedly, and Pat didn't have a chance to say good-bye. She describes the loss as "a terrible assault," exacerbated by many unresolved issues with her mother. She felt guilty that tears eluded her. The third loss released her tears—that of her beloved golden retriever, whom she counted on for unconditional love. By the summer of 1998, Pat thought she was "over" the deaths of loved ones. She had started a new job, had a new puppy, and "life was pretty good." Soon after Pat was feeling a renewed sense of well-being, she woke up one morning with excruciating pain in one shoulder and arm. Then the pain appeared in her knees, and moving from place to place became very difficult. Because the symptoms were gradual and intermittent, she didn't realize she was adapting to something abnormal—her own form of denial.

The pain worsened, and ibuprofen prescribed by her internist for presumed osteoarthritis did not help. With the pain pervading her life, she realized she would have to make major changes in her life, including selling her home of 30 years and moving to a one-story house.

Pat's self-image was shaken. Except for being overweight, she thought of herself as sturdy, vigorous, and healthy and assumed she'd stay that way until she "dropped dead at 90." She writes, "So, yes, the physical changes very much felt like a betrayal. I think my reaction was, 'Wait a minute! *This* wasn't part of my plan!'" She moved and felt like an old woman, "scuttling" about, watching her step, shifting her weight constantly to sit comfortably, waking in the night in pain. She adds:

None of this matched my image of myself as an independent, active, engaged woman. I had to learn to slow down, measure my energy. The worst part was thinking that this existence or worse was all that lay ahead for me.

After several mishaps with the medical system, she found her way to a gentle and kind holistically inclined rheumatologist who helped transform her gloom into hope. When she and her doctor found the right combination of medications, Pat began to feel better much of the time, with variable amounts of pain and fatigue. She even tapered off some of the medications one fine day when she was feeling great and thought she might be in remission. But the pain and fatigue returned, and so did the meds.

Pat's illness does not dominate her life. She does see herself "as a person with a chronic condition, one that requires self-monitoring and self-care, as well as good medical attention." She reported in her questionnaire that she is neither in despair nor does she see herself as a victim. She hastened to tell me in a recent therapy session that she would say the opposite on a day when pain recurs, and also that she is keenly aware of the loneliness of not having a mate at those times. As her therapist, I try to stay tuned in to those times when she is optimistic and those when she is not.

Pat felt betrayed by her body—a body that she had counted on to stay strong and healthy into old age. Her feeling of betrayal took the form of outrage. "How could my body *do* this to me!" she remembers screaming inside herself. She wonders now if what she thought was just a positive attitude about good health might have been "a form of magic that would protect me from ever being affected by poor health. Having RA brought me up short." Like Joan, Pat also discussed feeling betrayed by her primary-care physician, who misdiagnosed her illness and referred her to inappropriate physicians.

Unlike Joan, Pat does not recall having felt shame or embarrassment about her rheumatoid arthritis, "perhaps because I work in public health, and specifically in the field of chronic disease prevention."

During the course of her therapy, Pat has developed an increased awareness of her body and has started weight training, Pilates exercises, and daily walking. However, she

is not always certain of the best balance between exercise and rest. She wonders, "If I don't feel like exercising one day, does that mean I'm responding sensibly to a flare, or does it mean that I'm reverting to my sedentary ways?"

LESLIE. Two years into her first therapy with Pauline, Leslie developed cancer, had surgery, and seemed to have recovered. She was eating better, running often, and working on her relationship in couples therapy. However, it was my impression that her cancer left her feeling very vulnerable. She shut down again emotionally and made less progress in her quest for self-development. Her trust in herself and in life diminished. Our work in therapy did not seem to shift a helplessness she felt about obtaining a good and satisfying life. After a time she ended individual therapy and decided to go into couples therapy to concentrate on her relationship.

Seven years after her first diagnosis of cancer, Leslie called for an appointment with me. She told me that her cancer had recurred and that the prognosis was very bad; she was not expected to live long. When she said this, a silence settled in the room, and her tears began to fall slowly. We cried together for a long while.

In addition to sadness, Leslie's main feelings were hurt and disappointment that her body was failing her. Before her first episode with cancer, she had always been strong and athletic; after her surgery she had worked hard to make her body even stronger. Now her body was a source of pain, fear, and threat.

In her mind, a critical theme became, "Why me?" She was relatively young (49), and yet she was dying. Her self-doubt and self-questioning were great. This was exacerbated by having a couples therapist who held the philosophical perspective that "We create our own reality." She asked Leslie, "Why are you choosing to die?" I was appalled by the judgmentalness and the lack of scientific grounding of this therapist. Targ (1998, p. 12), a well-known researcher in the area of spirituality and chronic illness, agrees, "Such New Age guilt, even when delivered by well-intentioned healthcare providers as a 'spiritual perspective,' is both inappropriate and destructive."

Leslie herself felt terrible when asked this question, and she and her spouse discontinued couples therapy. Leslie, however, spent several of the next sessions questioning if she had been self-destructive or wanted to die. I listened with empathy and concern as she went through her self-questioning until she could eventually answer from her being that she had not wanted to die but that she wanted to live. Ironically, as she faced death, Leslie made a conscious decision to live more vibrantly, meaningfully, and contactfully than she ever had before.

After dealing with feelings of anger, sadness, and shame, Leslie came to a quiet acceptance that she was dying. Even though she was physically sick after chemotherapy treatments, she made therapy a priority. Sometimes she was very sad about her loss of energy and angry about the cancer and her pain, but in many other sessions she expressed her gratitude toward her friends, co-workers, family, and spouse for their willingness to be with her and to show their love and kindness. She had not spent much time with her family of origin in recent years, and her illness seemed to bring them together. She was much more willing to receive love and care and to believe in their genuineness than she had in the past.

For almost two years, Leslie was able to continue. Her energy was very low at times, but her cancer did not get worse, and she was able to work and to connect. She loved movies, travel, and video. She made time for these loves and let herself have them. She and her spouse became much more intimate and connected better. Their arguments and differences receded into the background, and their love became figural.

During her therapy, Leslie did not deny that she was facing death. She talked with the hospice workers and planned her funeral. She did not want to die in a hospital, and her

spouse and sisters agreed to care for her at her home. She was very grateful. I agreed to continue her therapy at home when she could no longer come to the office.

When her remission ended, Leslie quickly became much sicker. She could no longer drive, and her pain became intense. She became weak and had to be in bed much of the time. She refused heavy medication because she wanted to remain awake and conscious. I came to her bedside for our therapy work. Sometimes we sat in silence; other times we cried together. She often told me her dreams or shared her concern that she was too much of a burden for others.

Leslie asked for a session with each of her sisters. In these sessions, she expressed her appreciation and regrets, and each of them expressed their sorrow that it had taken her illness to bring them close again. They also expressed their love in a very verbal way, which had been hard for them before.

When Leslie lost the use of her hands and could not sit up, she told me, "It's time. I'm going to start taking the pain medicine as often as possible." She was very aware that she would die soon. We said goodbye. She fell asleep, and I sat at her bedside for another 30 minutes. Her family told me she slept all afternoon but woke in the early evening, talked, and was very present with them. She died that night.

Course of Therapy

In the above case illustrations, we illustrate the individual mind/body reactions to the illnesses of three clients. We believe the subjective experiences and awareness of each client to be of paramount importance. Bugental (1987, p. 7) defines subjectivity as "that inner, private realm in which we lie most genuinely." As psychotherapists, we respond to whatever is figural for the client in each session. We also pay attention to what is figural for us—a tone of voice, a body posture, a recurrent theme, and even an intuition or unusual body sensation within ourselves.

We do keep in mind typical themes documented in the research literature and observed in clinical work but do not expect *all* clients to manifest those themes. For example, Joan and Leslie felt shame related to their illnesses; Pat did not. Pat and Leslie felt betrayed by their bodies; Joan did not. Pat's financial situation is very stressful; Joan's and Leslie's were not. Some aspect of being ill dominates Joan's therapy sessions, whereas Pat's illness is not her major reason for remaining in therapy. Leslie was dealing with the imminence of death. The theme of death comes up sometimes for Joan, but rarely for Pat. We deal with some of these themes in the ways described later in the article.

Psychotherapy from Clients' Points of View

We asked Joan and Pat to tell us what had been helpful in therapy and what had not been helpful.

Helpful Experiences. Joan emphasized that "the most curative experiences I've had in psychotherapy have been when clinicians recognized that I needed healing, not treatment." She sees treatment as something that is "done to" the client and ignores the "huge existential issues and the spiritual self," whereas healing occurs when the clinician interacts with the client on a deeper level, "the grittiness—the frustrations with the medical system, the fears, the profound questions of life and death. It is important that my therapist has not muted the realness of the experience."

Joan has also appreciated the willingness of each of her therapists to see her without charge, to come to her hospital bed if she was hospitalized, and to be present with her in her most despairing times. At times when she feels overwhelmed and befuddled, practical

advice about what to do next has been relieving. She has felt that my experience with multiple back-surgeries and chronic back-pain has enabled me to understand better what it is like to live with a chronic condition.

Pat says that simply being listened to and having her anxieties and fears acknowledged in therapy has been helpful. She has found it valuable to discuss, from more philosophical and spiritual points of view, the polarities of life "that have put in perspective that pain and sorrow are all part of life, the shadow side that also allows joy."

Like Joan, from time to time Pat has appreciated advice. She has gotten relief from pain on several occasions when I used hands-on healing touch techniques on her sore finger and hand. Encouragement to pursue and continue physical activity has also been useful to her.

Pat's advice to clinicians is to learn more about chronic conditions, find out about resources (Internet, support groups) to recommend, and get continuing education in the field of coping with chronic diseases.

Unhelpful Experiences. Despite my assurances that I truly wanted to learn and that my feelings would not be hurt, information about unhelpful experiences in therapy were harder to come by. Pat still couldn't remember anything that had been unhelpful. Joan noted that her Colorado therapist's failure to complete paper work had prevented the approval of her Social Security Disability claim. She then admitted sheepishly, "Well, about that meaning thing . . ." She was referring to times when, out of my own anxiety about her despair, I had occasionally wondered aloud if she might find some meaning in her situation, something that might give her comfort if not hope. I know that a spiritual perspective is often life-sustaining in dealing with illness; I, nonetheless, wish that I had been more sensitive to the fact that Joan was too busy just surviving to think about meaning.

Psychotherapy from Therapists' Points of View

We will discuss a few of the elements of therapy which have been particularly important with our chronically ill clients.

Empathy and Validation. We have found that the expression of understanding of the client's internal experience is the most healing thing we can do. That means we often have to put in the background our own anxiety or need to "help" or wish for the client to "feel better," and validate the realness of the pain, fear, anger, limitations, life changes, etc., that the client is experiencing.

Following are transcriptions of parts of a recent session that demonstrate validation and understanding of Joan's pain:

JOAN: I used to love camping. I've prematurely lost a lot of things in my life without voluntarily giving them up.

THERAPIST: You've lost control of what you can do.

JOAN: Yes. It's grossly unfair.

THERAPIST: Yes, it *is*.

JOAN: I'm so ashamed of my depression. I don't feel engaging.

THERAPIST: You think you *should* be able to be different.

JOAN: Yes, I managed the first year better; I was more feisty. I was overwhelmed, but in denial, and assumed I could restore my life as if it hadn't happened. Realizing I can't have my life the way it was is very depressing (tears), and so I relate to people in a less optimistic fashion, more fatalistic than before. I think I'm a drag to be around, so I think I would chase most of my friends away if I were around them more.

THERAPIST: You seem to have two choices—using energy to appear to feel better than you do or risk chasing them away.

JOAN: Yes.

Listening to the Story. In his book, *A Population of Selves*, Polster (1995) emphasizes the importance of the storyline in therapy. He elaborates, "Tuning in to the person just as he is, without requiring change, is part of the Gestalt paradoxical theory of change. Getting over fear, anger, confusion, inferiority, degradation, and so forth is said to happen when the patient experiences these states freshly" (p. 78). He notes further, "The story, well told and palpably experienced, is an essential therapeutic tool for countering the emptiness of experience . . . Therapy, therefore, is the process of getting out the vote for oneself or another by restoring the events of the person's life story" (pp. 110–111). By listening to complex and interwoven stories, the therapist can help bring to light a multiplicity of selves who are all contributing to the person's life.

Joan indeed has a *despondent self* who is currently a major player in her life. However, she also has called into action what I call her *scholar self*. She tells about how, after being diagnosed with multiple illnesses, she shored up her defenses by reading everything she could about each of her medical disorders and exploring all the treatment options with her doctors. Her *scholar self* provides a counterbalance to her *despondent self*. Her *relational self* has also been a saving part of her during this time. She tells many stories about how she has reached out to friends who have housed, fed, and listened to her and given her financial support. Her *isolationist self* (apparent in the transcript above) sometimes sabotages her *relational self*. Her stories make it clear that, although Joan is deeply despondent, she also possesses a strong spirit for living as well as possible.

Attention to the Body. From the beginnings of Gestalt therapy we have paid attention and drawn attention to how the body can express and feel and want what the conscious mind may not yet know. Many of us do not think of the body, the mind, the emotions, and the spirit as operating separately, and yet our language has no single word to encompass the idea of mind/body as an integrated unit. In Gestalt therapy we believe owning, or integrating, disowned parts of the self is key to healing. Kepner (1987) points out how disease or painful medical treatment can support disownership of bodily aspects of the self.

We find useful Kepner's analysis of several non-holistic, or "person-as-parts" approaches that presume a *causal* relationship between body and mind—monism, dualism, and parallelism. The first treats the body alone, as if it were totally responsible for the problem—such as in the use of psychotropic medications. In the dualistic approach, the body and mind are seen as entirely separate, each requiring treatment in their own right. In the parallelism model, the body and mind are seen as linked, one causing problems in the other and requiring alternating treatments.

We have found that using any one of these models alone in therapy can create more distress than the person is already experiencing. The first two concepts can lead the client to be convinced, "There is something *wrong* with me"—either their body or their mind. The third can lead to a feeling of shame, as in, "I caused my illness, and if I caused it, I should be able to cure it," as happened with Leslie.

Kepner suggests an integrated approach in which we look at any (conflicts, life themes, physical symptoms), "as part of a larger whole, which *includes* somatic and the psychological aspects" (p. 39). The organism as a whole creates the field within which we employ traditional and not so traditional Gestalt approaches to working with the body with our chronically ill clients. Traditional approaches include dialoguing between dif-

ferent parts of the body, working with restricted breathing, and bringing to the client's attention habitual bodily tensions.

An example of dialoguing occurred in a recent session with Joan:

JOAN: I still feel depressed. My glass is empty, not even half full. My mind realizes my heart living circumstances are better, but the rest of me (pointing to her heart) doesn't feel pleasure in anything.

THERAPIST: Are your head and heart on speaking terms?

JOAN: (laughs) No, not really.

THERAPIST: If they *did* speak, what would your head want from your heart, and what would your heart want from your head?

JOAN: My head wants my heart to have some peace, some connection to something larger in the universe, some spiritual connection. It's harder to know what my heart wants from my head. (Pauses) I think it would be good rational thinking and clarity about goals and purpose.

We also integrate direct, hands-on approaches, with a mix of techniques from Feldenkrais, Trager, healing touch, and bioenergetics. As stated in our edited book, *Touch in Psychotherapy: Theory, Research, and Practice* (Smith, Clance, & Imes, 1998), we recommend extensive training in body therapies as well as attention to related ethical considerations for therapists using touch. Pat specifically mentioned touch as being helpful. It is not unusual in my work with Joan for me to hold her as she sobs through reliving experiences of painful, humiliating, and invasive medical procedures.

Advice. We were actually surprised to find that both Joan and Pat mentioned occasional direct advice as having been helpful aspects of therapy. How often we have "preached" to members of our therapy groups that people are rarely seeking advice when they reveal the painful or stuck places in their lives! There are clearly exceptions. But when do we give advice, and when do we hold our tongues? Here are some guidelines we use: When in doubt, be silent. If an idea keeps tugging and won't recede into the background, take a risk. To find out if timing for advice is appropriate, ask the client, "Would you like some advice?"

Humor. If a client with a chronic illness can find humor in their situation, it is a blessing—and we believe, curative. Dillon, Minchoff, and Baker (1985–86) found that the levels of common-cold-fighting antibodies were raised in subjects who watched a video of comedian Richard Pryor. But the therapeutic relationship must be very solid and again, the timing very good, to support the use of humor by the therapist, lest it be interpreted as taking a very serious subject too lightly.

Existential Meaning. As psychotherapists, we look at how our clients cope with illness, how they see their illness, and the existential themes that the clients face. Do they create meaning or think there is no meaning to their illness? An existential approach is one that looks at the unique subjective experience of the client to illness and works with their internal experience as it evolves. Joan has had difficulty finding meaning in her illness. Dominant in her existential experience are depression, anger, and frustration. After learning that *encouraging* her to find meaning was not helpful, the therapist stayed more present with these feelings moment to moment, and only then did she spend more time in therapy centering on the meaning in her experience of illness. Pat has always enjoyed good health and assumed that would continue. In therapy, when she explored her reactions to her illness, she realized that she had had a sense of entitlement about this and that she was not immune to bad things happening in her life. "I don't know what's going to happen tomorrow," she states, "so I see what meaning I can

bring to my life today." Leslie came to therapy to be able to live a more meaningful, satisfying life even as she faced death. She dealt very well with decreasing death anxiety while focusing on increasing the meaningfulness of life each day. Leslie decided that she could not change her illness and death, but that she could choose to make her life more meaningful in response to her impending death.

Non-investment in Outcome. One of the hardest things to sit with as a therapist may be our helplessness to help, at least in the way we might at times distort "help." This issue is poignantly captured by Lazarus and Folkman (1984, p. 368):

The dominant form of help presently offered to those who face serious illness and loss is problem-focused, directed mainly at teaching ways to manage the side-effects of chemotherapy, swallowing a stomach tube, etc. These interventions are worthwhile, but they tend to ignore other kinds of existential distress that are part of the plight of people whose illnesses have profound implications for the quality of their lives and well-being. The lack of attention given to distress of this sort in interventions that are problem-focused is compounded by the societal and professional tendency to downplay negative and encourage positive thoughts and feelings. Lazarus (in press) has referred to this as the trivialization of distress. It is as if victims of tragedy are told that they have no right to feel bad about their plight; people who react with distress are described as having failed to cope adequately. In a sense, these people are victims, not only of illness, but also of the judgments of those who set themselves up as wanting help.

It is difficult to allow the process of clients to unfold without the need to "change" them when they are gripped by relentless pain, anxiety, depression, etc. And yet, we believe this is *the* most important therapeutic task with clients suffering chronic illnesses. We cannot change the reality of their existential situations. Their plights are real, and, as our mentor, Sonia Nevis, reminded us, "You can't lose what you don't own" (personal conversation, May, 1990). We have found that we need to remind ourselves of our own belief about what actually "helps" in therapy, and that is a non-judgmental, validating, and empathic stance—and a sincere stance of not knowing what the client should or should not be feeling, thinking, doing, wanting, or needing. All these are inside the client, and our job is to assist in the emergence and working through process. Our own distress about our clients' pain needs to go with us to either supervision, consultation with a colleague, yoga class, running, therapy, or however we deal with our own unfinished business.

Clinical Issues and Summary

Principally, we believe that therapy for those with chronic illness must be centered on the unique subjective mind/body experiences of the client. People with chronic illness are not all alike. In the background we keep the knowledge that a person's responses to chronic or life-threatening illness may be affected by the severity of the illness, family background and history, relationships, cultural context, financial situation, and so on. We also keep in mind that a person's issues may (or may not) include denial and shock, a sense of betrayal, pervasiveness, shame, relationships, self-image, etc.

We should mention that we do not have empirical data on the effectiveness of our therapy work with these clients. Although they each reported that the therapy was important and effective for them in coping with their illness, we did not have randomized assignment of clients to treatments nor control subjects. We recommend that a systematic research study be conducted with a Gestalt/Existential approach on different groups of clients with life-threatening or chronic illness. We surmise that our approach works best

with people who are interested in their own psychological processes and who are willing to be curious about their mind/body reactions to their illness.

Overall, we believe the most important healing presence we can provide for our clients is one of caring, support, empathy, non-judgment, careful listening, seeing and hearing, a selective sense of humor, attention to meaning, and a lack of expectation about outcome.

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