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The power of *Presence*: Exploring experiences of therapy with a client suffering from a chronic neurological condition

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Abstract: This article explores the applicability and effectiveness of the Gestalt paradigm in therapy involving clients with chronic and/or progressive physiological illnesses, a common occurrence in therapy. It presents a case study involving one particular client, Gary (pseudonym), as developed through an innovative process of collaboration between therapist and client. Gary's three-year therapeutic journey following the diagnosis of his progressive neurological condition is captured via a methodology that incorporates features of Narrative Inquiry. After therapy ends, therapist and client join forces to re-explore the experience via discussions, meetings, journal writing and reflexivity. This joint endeavour then becomes the basis for the author's exploration of the relevance and benefits of the Gestalt paradigm, her own favoured theoretical stance. Here, she argues, the focus of therapy is on staying in steadfast contact with the client in the here, rather than seeking to eradicate the problematic facets of chronic illness. On the basis of her work with Gary, who emerges with greater ability to manage his experiences, the author concludes that beneficial therapy is rooted in the resolute contact and the soulful presence of the 'I and Thou' relationship (Buber, 1958) and that the psychotherapeutic interventions that characterized her work with Gary have relevance for other clients confronting chronic physiological conditions.

Keywords: presence, neurological condition, gestalt interventions, contact, reflexive journal writing, narrative inquiry

Truth is not born,
nor is it to be found
inside the head of an individual person,
it is born between people
collectively searching for truth,
in the process of their dialogic interaction.
(Bakhtin, 1984)

Clients suffering from some form of chronic and/or progressive physiological illness are a common occurrence in therapy. Such conditions may elude cure and can manifest in complex, multi-faceted ways, often with intense and pervasive symptoms. It falls to the therapist to gauge the impact, often far-reaching, on the day-to-day functioning of clients undergoing such difficulties, and to offer a therapeutic presence geared not so much to eliminating problematic aspects of the illness as to helping clients manage their situation better.

My awareness of the debilitating effects of such conditions has been enriched by personal experience. Some years ago, I suffered an illness which struck suddenly and from which it took me a year to fully recover. A close family member has a

progressive neurological condition, and some of my clients experience chronic physiological and/or progressive conditions. In my own country of Malta, I have given a number of talks to patients with multiple sclerosis and their relatives. All this has helped me gain a deeper understanding of the impact of therapy, and specifically the Gestalt modality, on clients with chronic and/or progressive neurological conditions.

In this article, I offer a case study: that of a patient of mine called Gary (not his real name). The case study was developed through collaborative discussions with Gary after therapy had finished. I decided to approach Gary a few months after the end of our work together because his narrative and process continued to intrigue me; they highlighted the need to go deeper into the experience of patients suffering from progressive neurological conditions. This case study encompasses Gary's thoughts, experiences and perceptions of the therapeutic process as they emerged from our discussions, together with my own reflexive process, which involved the application of the Gestalt paradigm lens to our therapeutic and research journey.

The conceptual framework for this article is that of Narrative Inquiry and the notion of "justifications", a term which encompasses personal, practical and social forms of justification (Clandinin, 2013). In what follows, I refer to all three forms: firstly, the personal justifications for the study emerging from my reflexive engagement with my own life experience; secondly, practical justifications, including therapeutic practices within the Gestalt field of study; and thirdly, social justifications relating to the possibility of change in practice or action through the therapeutic intervention.

Narrative Inquiry permeates the process and writing of this case study. In what is essentially a reflexive process, consideration is given to interventions from the Gestalt paradigm and their impact, both during and after therapy. During the case study process, Gary was still undergoing an existential repositioning in his life due to the impact of his chronic illness on his personal and professional life.

Introducing Gary

Gary was 45 when he first came to therapy. He was experiencing significant stress after being diagnosed with a rare progressive neurological autoimmune condition where focal areas of multiple motor nerves are attacked by the patient's own immune system and muscles can also be affected. The condition progresses slowly and has no known cure. In Gary's case, he experiences weakness in various muscles and limbs, deterioration in some muscles and nerve endings, tiredness, occasional twitching, and reduced dexterity.

Gary combines working for a private company with running his own small company. When he began therapy, he described his life as highly stressful, largely because of the significant financial, legal, and professional issues he was experiencing with the private company he was employed by. He was also having relational difficulties in his marriage, in part stemming from his lack of free time and the constant flow of problems at work. The little time he had at home was devoted to his two young children. The health problems he was experiencing, which required regular treatment, had only made his work situation worse.

Gary was an active person who loved to play tennis twice a week and enjoyed restoring old cars. He started attending therapy at the suggestion of a family friend, who had noticed Gary's psychological deterioration: at times he became a very reactive, angry person, while at other times he seemed to withdraw from all those around him.

Gary attended regular therapy for three years, after which we agreed to terminate the sessions. However, he continues to schedule occasional sessions with me, usually when he feels he needs to touch bases following a downturn in his condition or a particularly difficult life experience.

Our intention was that Gary's case study would emerge out of conversations and discussions, rather than from the researcher's own analysis of therapeutic sessions. To this end, Gary and I conducted four research meetings, between which we shared written thoughts and reflexive annotations emerging from the sessions. The work in progress was mediated by my own reflections on our therapeutic journey.

The final text was discussed with Gary. All possible identifiers were changed so that Gary's identity would remain hidden, and he endorsed the final version of the study.

Methodology: Narrative Inquiry

Throughout, the research process was informed by Narrative Inquiry methodology, which seeks to enable the researcher to enter participants' lives. Central to this methodology is the ongoing engagement between researcher and research participant, and a commitment on the part of the researcher to engage in a process of co-construction.

Narrative Inquiry is rooted in the view that humans live storied lives and that our world is a storied one (Gergen & Gergen,

1986). On the basis of the co-lived narrative, I (the therapist and practitioner-researcher) also become transformed through the reality-constructing and meaning-making processes (Holstein & Gubrium, 1995). Evocative writing of personal experiences enables the researcher to enter the lives of others; it displaces the detached 'mask' of the 'invisible researcher' that may be assumed in formal scholarship (Kawalilak & Dudley, 2002).

In narrative inquiry, the self becomes interwoven with the narrative fabric of the other, so that a new fabric is woven for both client and therapist. Every client I encounter transforms my life to a greater or lesser extent. Gary impacted my life at both the personal and the professional level throughout our therapeutic journey and in our subsequent research work together.

Seeking to 'write from the inside' (Ellis, 1995) in order to understand the meaning of the lived experience of the therapy and research processes. I adopted Behar's (1996) stance of 'words that sing'. Phrases that struck me with particular force were noted down and then reflected upon with the client/research participant, resulting in a process of collaborative reflexivity. I read and re-read the transcripts, my journal, and the communications Gary and I shared between research meetings.

Throughout, I was aware of the ethical responsibilities that come with research informed by Narrative Inquiry. Clandinin (2013) highlights the need to be aware of the ways in which participants can be affected by research. To avoid any occurrence of harm to Gary, I sought his endorsement of all content before finalising the text, and he was invited to edit and comment on any content as he deemed fit. As suggested by Riessman (2008), the shared primary data was carefully documented and the whole process was guided by ethical considerations. The validity of the research is enhanced by the fact that the development process was recorded both by Gary (in his journal) and by my own field notes.

As Narrative Inquiry involves a continuous process of reflexivity (Clandinin, 2013), I analysed my own therapeutic interventions and contributions during the discussions with Gary and conducted a critical evaluation of my work.

Research Process Involving the Client

A stance of "respectful curiosity" (Foucault Live Interviews, 1989) was adopted in the course of co-creating a collaborative venture of meaning-making with Gary. Foucault argues that curiosity evokes concern, care in relation to what exists and could exist, relentlessness to break up our familiarities and fervor to grasp what is happening. I adopted this stance in the collaborative understanding of the process with my client.

Given the rarity of the condition Gary suffers from, it was clear that I needed to build a deep collaborative reflexive process with him so as to capture his experience and emerging meanings.

A literature search on Gestalt practices with clients suffering from chronic physiological conditions revealed few instances of research in this area. However, research focusing on Multiple Sclerosis and psychosomatic illnesses provided useful insights, Kleinmann (1988) explores how the experience of chronic illness is lived and reacted to by diverse people, and how individuals try to organise or regulate their experience of illness in order to make it livable and meaningful. They then find ways to communicate these meanings to others.

The discursive practice with Gary was a relational activity and a collaborative practice of meaning-making (Riessman, 1993). Gary also tried to find agency through participating in our discursive process; he was both agent and witness to his own narrative (now existing in the realm of research).

Reflexivity

Interspersed with the client's narratives, I added my reflexive annotations. Here, I reflected on the therapeutic journey from my standpoint as both therapist and researcher. Etherington (2004) states that "reflexivity implies a difference in how we view the self: as a real entity to be 'discovered' and 'actualized' or as a constantly changing sense of our selves within the context of our changing world" (p. 30).

Reflexivity also opens up an opportunity for a "dynamic process of interaction within and between ourselves and our participants" (Etherington, 2004, p. 36). My understanding was enriched through this collaborative reflexivity. More questions arose, my thoughts and beliefs were challenged or confirmed, and useful insights were generated (McLeod, 2001).

Ethical Considerations

McLeod (2003) states that "It is necessary to give careful consideration to ethical issues at all stages of the research process: planning, implementation and dissemination of results" (p. 167).

This research was conducted with attention to five ethical research principles: *beneficence* (commitment to promoting

the participant's well-being); *non-maleficence* (avoidance of doing harm); *autonomy* (respecting the participant's right to be self-governing; *justice* (impartiality and fair treatment); and *fidelity* (honoring the trust placed in the researcher (Beauchamp & Childress, 2001; Kitchener, 1984; Bond, 1993).

Three ethical dimensions were adhered to throughout this research: procedural ethics, situational ethics, and relational ethics (Tracy, 2010). ***Procedural ethics*** involved providing Gary with written information on the objectives of the study, along with an explanation of what his role as research participant would entail. I then obtained a signed consent form from Gary.

Situational ethics helped me to be aware of any moments that could have caused Gary emotional discomfort during our four research meetings, along with the discussion sessions we organised to clarify which details Gary might want to leave out. All excerpts from the interviews, discussions and written annotations between the research sessions were discussed with Gary.

I made a point of discussing with Gary how best to mask his identity, and whether or not to include certain sensitive information about his situation. We discussed whether to use a pseudonym for Gary or change particular aspects within the narrative. I considered clarity with the research participant to be more ethically respectful than simply using a pseudonym, since a client can be easily recognised by circumstantial details and connections. As a result, it was decided that in addition to using a pseudonym particular details would be changed so that Gary's identity became even more difficult to decipher. As a further precaution, Gary requested the omission of the name of his specific medical condition, a rare one through which he could be identified on Malta, the island where I practice.

Relational ethics (Bond, 2006) pertain to the interplay of the foreground relationship with the participant with contextual factors. This is especially relevant in such an intertwined milieu as that of Malta. Given that I had first known Gary as a client, the relational change to 'research participant' was discussed in detail to understand the impact this might have on our past therapeutic relationship and to see if Gary needed any future sessions. In retrospect, I realize that, for both of us, our therapeutic reflexive processes were enhanced through the research. Gary, too, observed that "becoming a research participant consolidated further my therapeutic process with you. Even though reconnecting and remembering some episodes was difficult, I reflected further where I was and who I became throughout the therapy process".

Bond (1999) asserts that virtue ethics accentuate the importance of personal qualities in being ethical. This cannot be adequately characterised as impersonal reasoning solely informed by principles. One of the virtue ethics that was considered for this research was trust. The latter was crucial in my relationship with the client, before, during and after the research. Through the quality of the trust established, I ensured that the relationship with Gary that had been fostered in therapy was enhanced by the research process. In addition, 'an ethic of trust' accentuates the value of dialogue as a way of resolving any ethical issues that might arise (Bond, 2006).
My positioning as a researcher further supported my critical reflexivity of the therapeutic process. Critical evaluation was conducted every step of the way, and I was constantly mindful that the beneficence experienced in therapy would enhance the research process.

Qualitative Validity and Reliability in Research

In order to engage the issue of trustworthiness of a research study, reference is made to Lincoln and Guba's (1985) four evaluative, namely, credibility, transferability, dependability, and confirmability.

Credibility

Lincoln and Guba (1985) suggest that keeping a reflexive journal is one way of ensuring credibility. I collected my thoughts, observations, feelings and process in a journal as this practice supported my critical self-awareness (Riessman, 2008). Credibility is further enhanced by encouraging participants to be honest in their answers (Creswell & Creswell, 2018). Gary needed no prompting in this regard, as both our therapeutic relationship and our research relationship were based on directness and genuine interaction.

Transferability

Riessman (2008) also recommends "transparency" (p. 195), which enables others to gain a detailed picture of the research and perhaps follow a similar research path. I produced descriptions of my interpretations within the Gestalt framework, and where appropriate, I referred to the primary data gathered from discussions with Gary.

The provision of such information enables 'transferability', whereby readers can decide if the present study can be adapted to other situations and also whether the findings can be justifiably applied and adapted to other settings (Shenton, 2004). The latter was one of my main research objectives. I hoped that readers with other neurological conditions might find their own experiences reflected in Gary's story. I also hoped that practitioners might find our therapeutic process a possible modality for their own work with clients with chronic/progressive conditions.

Dependability

Another vital facet of a trustworthy study is reliability: what Lincoln and Guba (1985) refer to as 'dependability' or 'consistency'. Merriam (2009) asserts that in qualitative research an imperative question is "whether the results are consistent with the data collected" (p. 221). In order to address the issue of dependability, I engaged in dialogue with Gary throughout the research process. I recorded our sessions and used a reflexive journal, as suggested by Riessman (2008), for my reflections.

Confirmability

Finally, trustworthiness is also supported by taking steps that ensure confirmability. Throughout this study, I was explicitly clear about my choice of therapy interventions, basically arising from Gary's own process, and about the decision to adopt Gestalt approaches. I also made clear my personal justifications, as well as the practical and social justifications for this research. Additionally, as the researcher I have an obligation to ensure that findings portray the participant's own narratives and are presented in an honest and objective manner. I made a point of discussing both the positive and negative aspects of therapy with Gary, using appropriately unbiased language.

The Therapeutic Process

Initial Sessions

My first impression of Gary was of a man with observant eyes. In his casual but smart clothes, he gave the impression of having strong boundaries; his demeanor was somewhat distant.

Gary had come to therapy after experiencing problems with his wife, who had said that he had become so distant that it was not worth living together anymore. His initial declaration was: 'What is she expecting? Do you think I'm in a mind to offer anything to anyone at this moment in my life?'

Gary said he did not know why he had come for therapy, as talking would not change his situation. However, a good friend of his, whom he trusts and who is also a therapist, had suggested going to therapy. He emphasized that he did not want to be patronized, nor did he wish to be a burden on anybody. He was quite sparing with his comments, although his answers were direct. His withdrawnness and skepticism regarding therapy were evident: two silent presences.
After a while he explained that his life was not making sense. His marriage was falling apart; his servicing company was in severe financial and legal difficulties; and he had been diagnosed with a chronic and progressive neurological illness.

While weekly sessions were agreed upon, Gary stated that he would decide on a week-by-week basis if he was up to the next session.

In our initial sessions, Gary did not want to talk about his condition but rather about his work and family situations. He also recounted that even though there were other people around him, he felt he was living all these experiences alone.

In the third session, after Gary had recounted how he was feeling, I asked him what other effects he was experiencing due to the issues he was going through. This was the first time Gary opened up about his health issues. 'My body betrayed me when I needed it most,' he declared. 'I feel my head is separated from my body…I cannot connect to my body anymore except through the negative symptoms I am feeling'.

Slowly, Gary began to open up. He spoke of the initial trauma of being diagnosed with his illness, noting that this was the first time he had discussed this issue and that he was doubtful whether it was going to be beneficial:

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> I woke up one day with excruciating pain in my hand, forearm and foot. A huge spasm had taken over and I couldn't control my left foot and right hand. After a couple of hours, I just felt tingling and then numbness. This happened several times over a period of 6 months. How can I explain? These bodily reactions happened intermittently and gradually. I did not notice that I was adapting to something atypical!!

Describing his reaction to these bodily sensations as 'utter denial', Gary continued:

> I simply did not want to believe that something was not right, I was blaming tennis playing and my being in my mid-forties for these spasms and numbness. However, one day I was playing with a doctor friend of mine and a spasm occurred in front of him. My friend was concerned and told me to go to a neurologist for tests. I took him lightly at the time and joked about him being afraid of me winning the game. But I was concerned as this friend is not one to make a fuss about trivialities! I chose to visit a neurologist who is known within my then circle of friends. I was recommended a number of tests. But what I immediately noticed was that the neurologist was not taking this as a passing condition. One day, when I went for my test results, I received my devastating neurological diagnosis. I was dumbstruck and numb…as if the world around me and time suddenly stood still. Immediately afterwards, I felt a sense of uncertainty: thoughts that life would never be quite the same. One erratic feeling after another: shock, bitterness, anger, sadness, mind intrusive questions, a whirlwind of feelings, thoughts and emotions…. as if I was going crazy. I just wanted to fight and scream or run away, but at the same time I felt frozen.

This was an intense session and a breakthrough: it was the first time Gary had stayed in contact with me and his feelings long enough for him to acknowledge the deep pain and sadness he felt in the process of discovering his illness.

In subsequent sessions, we processed diverse aspects of his condition. My focus here is on the ones that Gary himself chose as the main phases that supported and helped him during our therapeutic journey:

Gary said that something which helped him was **having a name for the symptoms** he was experiencing, and being able to share that with me:

> I felt devastated but at the same time relieved that I am not imaging the symptoms or going crazy as now these could be attributed to a specific condition with a label, not an unknown entity created in my mind.

Gary also expressed **concern for his family members and friends,** who had also been suddenly thrust into emotional chaos as a result of his diagnosis:

> My family and friends did not understand the erratic manifestations of my condition and neither did I, for that matter. I felt that no one was recognizing me anymore; I had become totally absorbed with the condition and it took me over completely, leaving no space for any contact with myself and others around me.

In view of this, we agreed that Gary should also come for a few therapy sessions with his wife. These sessions helped tremendously; subsequently husband and wife were able to sit down with their children and discuss the changes that were happening.

Gary felt that he could no longer capture **who he had become.** In therapy**,** we constantly processed the shifts in his identity, interests, contact with family and friends, choices, work, hobbies, appearance, values and beliefs, and social life. Even his timeframe seemed to be changing: 'It's like I am living in a different time to those around me…time now revolves around my hospital treatment and to how I am feeling on the day'. Gary asserted that his **life was not worth living**:

> My wife will be better off without me as she will not need to take my burden. I am just existing for my children and elderly parents, who would be unbearably affected if I chose to end it all.

Gary also mentioned that he had once read an article which stated that suicide is a permanent solution to a temporary problem. The temporary problem is often the loss of purpose and meaning, and the loss or change in relationships. Gary said that this statement had initially made him livid, as for him his condition was not a temporary problem but a rather progressive one. In contrast, he had found my response to his talk of suicide helpful:

> You did not make a fuss when I told you I wanted to end it and that I knew exactly how, if that decision had to be taken. You could take it and stay with me in my darkness, but no one out there could. You gave me the space to process what was strongly churning in me.

During one of his hospital check-ups, Gary was prescribed a low dose of antidepressants and anxiolytics. However, he was very resistant, telling the psychiatrist that taking them would only be a short-term solution for him.

Gary desperately needed to find **meaning in his life**. When I tried to process this meaning with him, he became angry and stayed that way for some time:

> I do not want to force meaning into what is meaningless. I have barked up too many wrong trees in my life, worked too many hours, led a life of too much stress, tried to overachieve, and failed to take enough care of many other areas in my life, such as friendships, hobbies and family.

Therapy sessions with Gary were long drawn out, with many shifts in feeling and emotion. Slowly, Gary started to connect with the cumulative losses his medical condition had triggered.

These losses left him bereft of the meaning he had previously gained from work. They reduced the control he had over his life, along with his independence, strength and energy.

However, he also started to realize that the life he had led before falling ill also carried its own set of cumulative effects. In this former life, Gary had been alienated from himself, those close to him and the environment around him. The realization that the illness had at least facilitated this awareness caused a shift in Gary's meanings. This change was expressed in a very powerful statement:

> I decided to live despite being pulled towards death. At least, this situation gave me the space to reflect on where I want to channel more effectively the limited energy I have.

Having to go for **regular treatment** once every four weeks left Gary feeling that his life was being controlled by his medical condition. Accustomed to being in control of his life, he found this new dependency hard to cope with. He felt angry that he had now to be partially dependent and was likely to be increasingly so as the condition progressed.

Reality-checking his expectations, limitations and the implications of symptoms and treatment was another difficult pill for Gary to swallow. We looked at potentially unhelpful patterns, including occasional self-defeating moments of optimism regarding the possibility of recovery. A more nuanced approach, geared to validating Gary's feelings rather than entertaining false hopes (which could place Gary under further strain, to the detriment of his health), proved helpful. Talking about the treatment he was receiving and what he was experiencing during and after his hospital visits helped bring about some shifts in Gary's attitude:

> Treatment makes us homogenous. Looking around me in hospital, seeing older and younger men and women from all walks of life… illness makes us equal! Every time I go for treatment, it brings me to my senses… I reconnect with what and who is important in my life rather than always dealing with the urgent.

Gary mentioned that during treatment he spent time reaching out to others and his environment. He texted old friends, connected with other patients, and took note of what was going on around him. He also did some reading. As he once put it, 'Well, when you are stuck to the equipment, you do not have much choice but to experience the here-and-now you tell me about'.

Since the onset of the **physical symptoms of the condition,** Gary said, his head and his body seemed to be detached from each other. His mind wanted one thing, but his body did not respond. What helped him in therapy was to stay with his changing psychological, emotional and physical symptoms, irrespective of the pain involved:

> I have slowly come to terms with some of my physical symptoms but the mood changes, the anxiety, depression, anger and abruptness I feel, still occasionally take me off guard.

Gary also observed that no two people suffering from a neurological condition were the same. Even apart from each individual's subjective experiences, the same condition impacts each patient in a unique way. The therapeutic process was strengthened by our ability to stay together, to share the difficult experience of the range of facets presented by the condition. We processed the ways in which the varied nature of the chronicity and progression of the condition impacts the sense of self. We explored what Gary was then able to do (or not), all the while acknowledging his constant fear about where the condition was taking him.

The Therapeutic Process from a Gestalt Perspective

In the therapeutic process, much of the work was conducted on the basis of the Gestalt paradigm. In this section I discuss some of the main therapeutic interventions that supported this long process. I also consider my uncertainties about the choice of interventions along the way.

Relational Gestalt therapy focuses on presence and contact, along with the trust and safety needed for a beneficial relationship with the client. The quality of contact between therapist and client is given utmost importance in the here-and-now experience of therapy, which may reflect or express what is happening in the client's day-to-day life.

Through my reflections on the process, I identify **mindfulness** and **presence** (Yontef, 1993) as the key elements in the intricate therapy process Gary and I engaged in. Gary attributed the fact that he had gained some respite through therapy to his therapist being firmly present as a witness to his experience:

> What helped was that we stayed with what was actually happening in me and my life. We discussed my darkness, sometimes false hopes, pain, stress, fear, difficulties, huge waves of feelings, my cynicism…I trusted you and that does not come easily to me.

A relational approach develops out of contact with another; through relational contact, a person grows and forms his or her own identity. Developing a contactful relationship with Gary was not easy at the start, given his doubts about whether

therapy would be of any help. Relationships may suffer in the process of the shifts in manifestations due to medical issues, medication and treatments. I was very attentive to grounding my contact with Gary in an authentic therapeutic relationship, so that any shifts he experienced could be processed within the safety of that bond.

Relational Gestalt therapy brings awareness to contact with the self, the other and the environment. It gives wider inferences in terms of one's values and philosophy of life as expressed through what one says, perceives, and feels, together with one's actions and non-actions. Throughout therapy with Gary, I reminded myself to be aware of what was happening to me as I processed Gary's reactions and responses, and also outside issues that helped or hindered this process.

In Gestalt therapy, the self is not thought of as a fixed agent but as a continuous process of **figure/ground formation** (Bloom, 2003). In the sessions with Gary, we did not talk about his life situations in an abstract way. Instead, we brought in the here-and-now: Gary's immediate experience of what was occurring within him, around him and in his contact with others. Sessions did not always run smoothly; there were numerous pauses and periods of silence; intense emotions were expressed and, sometimes, despair.

Sometimes such moments led me to question my interventions. What kept me grounded was my determination to maintain awareness, to stay with the here-and-now contact and process. Here I was helped by my twenty years in therapeutic practice and my experience as a supervisor to other therapists. I recognize that a therapist in the early years of practice may find it more difficult to stay within a process, where often there is little light amid the darkness and the heaviness is tangible.

Gestalt therapy is grounded in the **here-and-now** (Perls, 1947). The focus is on the moment-by-moment process of the relationship and the authentic meeting in-between (Clarkson & Cavicchia, 2014); a collaborative field, defined as a network of interactions where all phenomena are linked (Latner, 2000). The Gestalt approach contends that dwelling on the past or trying to overthink the future hinders one from experiencing and living in the present by diverting the energy necessary for this.

In Gary's case, keeping the focus on the here-and-now was challenging. During our first sessions, he found it very difficult to face the here-and-now because of his reluctance to accept his medical condition. Instead, he focused his energy on the past and the future; he pined for what he had lost while nursing fears about what might become of him, particularly the fear that he would become a burden on his loved ones. Looking back, Gary acknowledged the importance of his eventual shift of perspective:

> Bringing my focus to the present was the fulcrum of my accepting the condition. I wanted to escape the here-and-now many, many times, but gently bringing me back to awareness of my experience thoroughly helped. I did not and still don't happily accept my illness but am co-living with this as a state of fact and working through who I am and am becoming, even though if I had a choice I would not have chosen in my wildest imagination to experience this condition.

At times I questioned the pace of our sessions. I wondered if I was leaving enough space for silence or giving Gary sufficient space when he (frequently) shifted his attention to philosophical or social discussions. I was also concerned that I might be prematurely challenging Gary to situate our session in the here-and-now. Here, I was helped by staying present to the needs of the moment, perhaps gently asking Gary what he was feeling, thinking or experiencing while remaining grounded and fully aware of Gary's reactions and responses.

In Gestalt therapy, "the **phenomenological** attitude is to recognize and put in parentheses preconceived ideas about what is important" (Yontef, 1998, p. 218). Through Gestalt phenomenological positioning, one methodically refines awareness and thus enhances the exploration, understanding and insight of the situation being processed (Yontef, 1993).

I sought to understand Gary's own perception of the reality he was living, noting what was emerging as figural as well as the possibilities presented by his situation. I stayed present to the bond between Gary and his experience of the world, and also the bond between him and others, rather than attempting to explain or analyze them (Merleau-Ponty, 1964). In the initial sessions, staying with Gary's emerging pain was difficult and I processed these sessions in supervision a number of times. My supervisor is keenly aware of progressive conditions and her insight also supported me in the process.

I noticed that Gary usually responded positively to my staying with his intense outbursts and strong feelings. During our subsequent research discussions, he had this to say:

> I felt that the space I was given to express myself, no matter how angry, frustrated or broken I was, gave me the liberty to become more aware of my state of mind, accept my experiences and all the intense inner turmoil I was going through. I still use this same skill, especially when I feel my condition is further deteriorating. I give myself the space and time to stop and become aware of my feelings, thoughts and behaviors, then connect again to my deteriorating body.

The phenomenological basis of our therapy helped Gary to own his feelings and perception of the reality he was living. It kept the focus on what was becoming figural in the here-and-now and on the possibilities that were emerging.

Every person goes through diverse life experiences, some of which, because of their intensity or lack of effective processing, remain open and unfinished. This can lead to a loss of positive energy and to self-defeating behavior. Closure of such **unfinished business** by addressing these experiences allows one to be more present to the here-and-now. It opens the way to clearer perception, since life is no longer perceived through past narratives. Such closure occurs when one closes an experience and moves on to another. By focusing on the unfinished business, attention is given to where one's energy is blocked, as one can only be open to new possibilities and choices when the preoccupation with what is not resolved is processed and resolved.

For Gary, too, the unfinished business of past experiences needed attention. Unexpressed feelings and unprocessed thoughts, together with intense memories of the past, became entangled in Gary's present, to the detriment of contact with himself and others.

Most of Gary's unfinished experiences related to his work domain, where interactions with certain colleagues had resulted in multiple problems:

> I felt thoroughly betrayed by some people I worked closely with. One of them in particular was supposed to be a friend I met regularly. He lied about me and brought me to the point of despair. Legally and financially, I experienced severe repercussions. I cannot reconcile myself with this experience.

His anger and disappointment led Gary to recoil from contact, even with people he trusted:

> I coiled up within my own shell, even stayed emotionally and sometimes physically away from family and close friends. I could not come out of these barriers I created and did not want to for quite some time. All the experience hurt too much, I was angry, hurting, feeling beaten to the core -- huge disbelief that some people could be so heartless, and for what?

Gary needed to recount his experiences many times during the course of therapy, especially when some new aspects of these work difficulties and/or resolutions of some challenges emerged. Working through this unfinished business was long, slow and painful. At times there seemed to be a lot of repetition. However, processing the same experiences in the here-and-now helped the emergence of different perspectives and feelings, as well as new realizations. Gary gradually assumed greater ownership of these experiences and became more aware of his reactions. Special attention was paid to where Gary's energy was blocked, the reduced energy he felt, and resistances that were being created.

Gary believed that his declining health was the result of all the work difficulties he had been enduring:

> It is like my body gave up on me and I stopped being able to function in the present…too much harshness was there. It was like journeying slowly through a trauma scene that was happening to me. It was surreal…yet very real.

Spagnuolo Lobb (2012) asserts that each domain of contact encompasses the capacity for being fully present at the **contact boundary**. As a result of his adverse work experiences and medical symptoms (especially after his diagnoses), Gary retreated from contact with himself and those around him. Oaklander (2001) and Clarkson (2004) argue that psychological health is marked by beneficial contact with oneself and others. Healthy living can be deemed as a creative adjustment to meet the individual's changing needs. Disease or organismic disturbance transpires when the contact cycle is habitually interrupted (Clarkson, 2004).

Gary had diverse **resistances to contact.** During therapy, our focus was on the following: **projection** (where Gary disowned his feelings and assigned them to those around him, especially those closest to him); **retroflective behavior** (as, for example, when Gary lashed out at himself because he was fearful of directing his anger towards those closest to him); **desensitization** (Gary's efforts to 'feel nothing' as a way of avoiding painful or adverse health manifestations or work difficulties); and **deflection** (where Gary's difficulty in sustaining contact was expressed by evasive behavior such as changing the subject or deflecting a serious situation through sarcasm). All these resistances were defenses Gary had developed to prevent him from experiencing the painful and traumatic present.

In response, therapy focused on processing these situations through the diverse examples that Gary brought to therapy. I also explored with Gary situations where stuckness was being experienced. **Impasses and fixed polarities** were very evident in Gary's stressful situations and they needed significant time to process. According to Yontef (1993), an impasse occurs when external support is not enough, when clients believe they are incapable of supporting themselves because their strength is being sapped by the contending forces of impulse and resistance. I processed several polarities with Gary: fight-hopeless, inactive-overactive, and retract-overreact. Here I needed to be mindful and attuned so that fluid movement from one figure to another could emerge.

Tacit **experiments** were also undertaken. These included internal dialogue, exercises, staying with the feeling, guided fantasy, dream work and other experiential tools. However, Gary resisted more explicit therapeutic techniques such as the empty chair. As a therapist, his resistance gave me a more refined understanding of when and how to use experiments.

I found **creativity** to be very important in this therapeutic process. This was especially the case when Gary struggled to describe his changing bodily symptoms and the associated fatigue, thoughts and emotions. For Zinker (1977), the aesthetic dimension and creative process in Gestalt therapy serve as a chance for growth and exploration. They facilitate spontaneity and the emergence of novel ideas, and they support creative adjustment. Spagnuolo Lobb & Amendt-Lyon (2003) argue that creativity involves individually designed experiments tailored to the uniqueness of the client. Artistic creation enhances the process of becoming, of developing new self-awareness (Perls, 1989). Examples include the use of art, music, writing, and metaphor.

The metaphors that Gary created were helpful. They also became a running joke between us: Gary would tell me that this particular week he had been such and such a car, describing its specific color, location, ailment, and sound. The fact that Gary's metaphors were accompanied by very vivid descriptions helped me understand his feelings better. What he seemed unable to put into words started to be communicated through images and metaphors.

The final element to consider is Gary's **embodied experience** of disconnection and isolation due to his worsening health condition. The restriction of energy stifled Gary's experience of being alive in an authentic way; addressing this proved to be a crucial factor in his therapeutic journey. Through his desensitization and disembodied sense of self, Gary's sense of self and of the world around him had diminished. He had become 'absent' (Kennedy, 2005) in his interactions, robotically going through the motions but present neither to his own feelings and process nor to his interaction with others. There were many times when he tried to silence his body. However, gradually Gary became more in touch with how his body was speaking

Kepner (2003) defines the concept of 'field' as:

> the contextual, interactive, energetic and interpersonal environment that supports a particular way of interacting (p. 8) … to be deeply embodied is to have access to one's body experience as self-experience. It requires sensitivity to one's own body sensation and having contact with one's visceral 'insides' as much as with one's thoughtfulness and intuition; and the capacity to experience an integral continuity between body experience and other aspects of one's being. (p. 12)

Embodiment is the sensate experience of one's body as oneself in relation to another and the world. As a Gestalt therapist, in my work with Gary I sought to center myself on the immediate embodiment, both within me and through Gary's experience. As a result, a deeper dialogic resonance to what was being experienced became possible. Co-created meanings emerged from the shared embodied experience in the field. Embodiment was experienced through the quality of presence in the here-and-now in the relational field of therapy. We worked through embodiment, understood not only in the way Gary experienced himself but also in how I experienced myself in the presence of what was being processed. We did this through awareness of Gary's economy of movement in sessions: the moments when he was very rigid and still; his breathing; the feeling in his hands, legs, and feet (his most problematic bodily areas); his back-to-the-chair posture (he tended to sit either on the edge of his chair or slumped backwards); his eye movements and sensing; and the meaning given to these feelings in the here-and-now.

In addition to awareness, what supported the embodiment process was staying open to what the body was saying and being curious when desensitization was experienced again. The mutual experiencing of these moments in the therapeutic field became a collaborative and meaningful attunement to what Gary experienced in the relational field and to how I in turn experienced this embodiment experience in relation to his process.

We were also able to relate this to Gary's outside relationships by processing how others experienced and perceived him. Gary stated that his relative lack of contact with himself and the world around him was momentarily useful, given that 'the emotional and physical pain was too much'. We explored this relative absence as a creative adjustment. Once Gary became more attuned to himself and was able to stay with what was emerging within him, he was better able to reach outwards:

> When I look at my effected body areas, it still hurts. However, I am somewhat embracing my body better and I remember to focus on what I still can do, rather than what I cannot and that gives me that energy to move another step. It is still not easy but through this I am still finding meaning and value in my life.

Conclusion

Therapy sessions with Gary have ended now, except for an occasional session whenever he feels the need to touch bases. Therapy is never formulaic, rigid or pre-set. Discerning a good course to follow at any given moment in therapy is difficult, and there are no set answers: therapy is a lived experience

with the particular client. One individual's experience of a progressive chronic medical conditions is like no one else's. A person's physical, emotional and psychological response depends on multiple variants: the severity of the illness, the response to it, support systems, financial situations, changes to one's lifestyle and forms of treatment. All these (and other) aspects need to be carefully embraced in the course of therapy.

From my own perspective, my work with Gary affirmed the potency of relationally attending to the client. It underlined the need to respect the unpredictable nature of the condition through the steadfast contact of the 'I and Thou' relationship (Buber, 1923, 1958). It emphasized the value of offering Gary a solid, soulful therapist presence, even in the abyss both of us sometimes experienced until some form of meaning emerged from our work together in the relational, collaborative therapeutic field.

Along the way, tools from the Gestalt paradigm – a non-judgmental stance, for example, along with validating interventions, resolute staying, careful listening, and avoiding expectations about outcomes – helped Gary to reposition his life. He is now handling his experiences more effectively and feels sufficiently empowered to actively participate in the management of his life. He is in greater holistic contact with himself, others and the environment. For my part, I have received a fresh affirmation of the therapist's need to be a soulful relational presence, fully attentive to the here-and-now co-creation in the relational dialogue and process. These, after all, are based on mutual embodied awareness geared to the possibility of change and growth.

In this article, my object has not been to prove or disprove any particular hypothesis. But while Gary's case involved a particularly rare chronic neuropathic autoimmune condition, I believe his therapy journey has much to tell us about the effectiveness of Gestalt psychotherapy and its relevance to other clients with testing physiological conditions.

I would like to end on a personal note. Every client I encounter has a major impact on my life. Many clients leave an indelible mark on my personal as well as professional life; it is enriching to be in such a field where, through the co-creation of therapy, my own growth is enabled alongside that of the client. Writing a reflexive journal, discussing issues and problems during supervision, and striving to 'write from the inside' (Ellis, 1995) all supported me in my therapeutic work with Gary. They also enhanced the emerging insights, meanings and understandings that, together, constitute the lived experience of therapy and research.

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