Chapter 10

Hospital Philosophy: An existential-phenomenological perspective

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Regardless of our orientation to therapeutic practice, few of us can avoid feeling troubled when we are not able to maintain some level of continuity with our clients - meeting at the same time, in the same place, for the same duration, with sessions at set intervals, offering a consistent kind of presence (often comprising at least relative anonymity of the therapist, abstinence of physical contact, etc.), in a confidential relationship, for the benefit of the person seeking our help. Continuity is the mainstay of the frame, versions of which range from the 'flexible frame' (Gray, 1994) to the rigidly defined 'secure frame' (Langs, 1998). In actuality, the frame is a theoretically derived, more or less rigorously applied, *set* of boundaries around the therapeutic setting and relationship. While boundaries can be *a la carte*, the frame, in any form, is closer to a '*set menu*', set by the theory prescribing it.

In the following chapter, I attempt to describe some dilemmas of frame therapy highlighted by psychotherapeutic practice in an acute general hospital setting. In order to do this, I will briefly describe the situation in hospitals, some of the needs of clients (patients or relatives), and the obstacles to adopting a frame-based orientation in this setting. Despite the inability to abide by a frame approach, deep therapeutic work is done

in hospitals. This raises questions about the necessity of frames, and since frames are the outcome of theory, it must also imply questions about the associated therapeutic theory. In response to my experience in hospitals, I find myself emphasizing a more philosophical attitude to therapy, implying different responses to frame issues. Delineating alternatives to orthodox frame therapy could prove attractive to those therapists who would like to practice in settings where their usual understanding of psychotherapy is not sustaining.

The Hospital

The world of psychotherapy is quite rarefied compared to the glimpsed tragedies and sensory onslaught of daily hospital life. Arriving in hospital itself can generate considerable vulnerability, uncertainty, boredom, in addition to conforming to the routine of a large institution and the subsequent loss of individual choice and privacy. Hospitals are strange and often lonely places, bringing people into contact with the suffering and dying of others, sometimes evoking previous bereavements. As well as issues arising from the environment, patients and families request counselling support for stressors related to physical diagnosis and treatment, such as: anxiety regarding invasive procedures, sudden paralysis or loss of a limb, chronic illness, critical or terminal diagnoses, and the inevitable social consequences of having a disease (for other examples, see Spiegel, 1999,1993,1994) - all significant crises for which counselling is not routinely provided[i]

If therapy is to be available to anyone requesting it, practice must be flexible enough to accommodate the physical environment, unplanned procedures, the patient's medical condition, unexpected discharge or death, as well as delayed discharge (when an end to therapy has been planned to coincide with a patient's discharge which is then delayed). Clients who are patients may be at any stage of medical treatment; recovering from a successful operation and looking forward to going home, living with uncertain diagnosis or prognosis, slipping in and out of unconsciousness, or in the terminal stages of illness and deciding where they would like to die. The hospital environment is very unpredictable so working there is *unavoidably* as messy as life gets. Listed below are common deviations from frame considerations inherent in working as a psychotherapist in this setting.

1. Inconsistency of place. Since many patients are physically unable to leave the ward, sessions might be conducted in patient's rooms, ward manager's offices, day rooms, any available space and often not the same place twice. For patients who are totally immobile, their sessions take place at their bedsides, sometimes on acute intensive care or high dependency units, and often on busy old-fashioned open wards with just a curtain pulled around the bed.

2. Inconsistency of session timings. Understandably, the medical ethos prevails in hospitals, so even if you have a regular time allocated for a client, there can often be intrusions. For example, if a long-awaited scan can finally occur at the hour your session is about to start, the scan almost always takes precedence, usually

both from the point of view of the medical staff and the patient/client. If the scan is missed it could mean waiting another week, and thereby prolonging the anxiety of an unconfirmed diagnosis. The therapist soon learns when to avoid scheduling sessions in order to miss busy times (for example ward rounds) thus minimizing this specific collision between therapy practice and medical environment.

3. Inconsistency of frequency/interval. The client (patient or relative) can be seen once a week, daily during acute periods of distress, or intermittently upon request. For example, if a family member requests daily contact while the patient is in a critical state, it would be difficult to invoke a frame-based rationale for not agreeing to this, knowing that by the next regular session time the patient may be dead and the family member gone. It would mean in effect that therapy could not occur. After discharge, clients (whether patients or relatives) can return for follow-up sessions at the hospital. Due to travelling distances, this is not always practical and those clients wishing to continue in counselling are routinely offered referrals to local agencies or their GP surgery counsellors.

4. Inconsistency of contract durations. Therapists find themselves embarking on a contract without always knowing the kind of contract being agreed to. In a sense each session is best viewed as a discreet therapeutic contract since the situation can spontaneously and inadvertently change between short-term, longer-term, crisis work, and not infrequently therapy is terminated abruptly due to unexpected hospital transfer, discharge, or death.

5. Inconsistency of session duration. The patient's physical condition can lead to requests for shorter sessions. Likewise, a relative in distress may request that the therapist remain longer than the normal fifty-minute session, for example, until a family member arrives.

6. Interruptions. The hospital culture is not rarefied. It is not common practice for staff to pause, knock, and wait for a reply before entering a room. All space is considered fairly public space and staff can interrupt a session for various reasons, to empty a bin, give an injection, or collect a patient for a crucial procedure that's been re-scheduled. Often other professionals don't fully appreciate the importance of not disturbing the session.

7. Anonymity of the therapist, intimacy/distance, and physical touch are challenged. Therapists may be in a situation in which touch is requested or deemed the most appropriate action. For example, therapists have assisted their clients into wheelchairs, helped to position them in bed, administered 'suction' to patients who could not swallow rather than have a nurse interrupt the session every five minutes, repeatedly scratched the itchy nose of a paralyzed patient etc. Attending sessions at the client's bedside also introduces an element of intimacy unusual in conventional therapy. Many of our clients have sessions while partially clothed or in pyjamas. And of course the fact that the therapist may go to the client rather

than the reverse, makes it difficult for the client *not* to attend a session. Due to the unusual setting, clients are perhaps more likely to engage in conversation about the person of the therapist, their own life, and not infrequently how the therapist would cope if they were facing the situation the client is in.

8. Confidentiality and anonymity of the client cannot be guaranteed. Family members, staff members, other patients, may all know that the client is seeing a therapist. Therapy is not anonymous in that referrals and subsequent session dates for patients must be recorded in their hospital medical notes, but the content of sessions are recorded anonymously in a separate team database. Sessions that take place on open wards also do not meet usual therapist expectations for confidentiality – neighbouring patients and staff can at times partially overhear sessions. Therapists frequently encounter their client's friends and families. Family members and staff who know that the client is having therapy may stop the therapist to ask how the client 'is doing'.

Often our clients have requested counselling or psychotherapy[ii] to cope with an immediate medical crisis or related issues. They have come into contact with the therapist because of their association with the hospital – they are medical patients, or relatives, before they are psychotherapy 'clients'. The unique avenue that hospital patients (and their family members) take into a therapeutic relationship may have implications for the appropriateness of working within traditional therapeutic frames.

The Frame

After providing some sense of the vicissitudes of a hospital setting, I want to outline two frame-based approaches to illustrate how they would be difficult to establish in the situation I have outlined above. I will assume some familiarity with the concept of therapeutic frames in order to concentrate on highlighting their more theoretical foundations.

Ann Gray's *Introduction to the Therapeutic Frame* (1994) presents a balanced account of the justification for 'frame therapy'. It boils down to the following argument: Our treatment in infancy leads to *predictable* psychological difficulties. The therapist is entrusted with the task of providing the optimal setting that did not exist in early development; '…we should provide a model of care which is consistent, that continuity is ensured, and, like the feeding pattern which is gradually established, a regular period of time set aside just for the client' (ibid:10). However, the therapist does not attempt to redress past discrepancies in care,

> 'We might say then that the frame is both like and extremely unlike the care that parents provide for their children…its difference is in the prohibition on action… we have to contain our feelings in the service of understanding and at times this can feel cruel… The therapist, through an ability to bear feelings rather than act on them, will be experienced as both frustrating and containing. Similarly, the frame becomes the container for the feelings that are paradoxically caused by it. (Gray,1994:15).

The frame therapist forms a practice around the assumptions he or she has about the world of the infant[iii]. The frame therapist assumes a causal connection between these surmised childhood experiences and later difficulties and then acts on these assumptions so as to elicit the earlier parental relationship. Then, no matter how 'cruel' it may feel, the therapist *causes* frustration by not acting (but of course establishing and maintaining the frame is highly orchestrated action!). Frame therapy leads to 'frame feelings', generating a therapy that treats the feelings it has caused, in turn reinforcing and supporting the rationale behind the therapy.

Gray says the frame is not 'written in stone' and that there are settings in which the frame cannot be maintained 'yet useful work can still be done' (ibid:19). This suggests that psychotherapy *can* be done in the setting I have described above, where frame conditions are not possible, but this raises further questions. What makes non-frame therapy 'useful', and does this also function in frame therapy or is it unique to non-frame therapy? If it also functions in frame therapy, is there a question about what *really* makes frame therapy effective[iv]? If useful work can be done when the frame is not established, and thus without the primary emphasis on the transference relationship[v], should we question this theory more generally?

Frame therapy assumes that without 'containment', anxiety and chaos prevail. This is a crucial assumption of the theory, suggesting that the only order is an imposed one. Gray concludes that 'Without a framework neither participant in the therapeutic relationship

will feel safe enough to experience the complex emotions that are part of all deep and lasting relationships' (ibid:141). This suggests an interesting differentiation between 'frame' and 'framework'. Of course most 'deep and lasting relationships' do not rely on a 'secure frame', so the secure frame cannot be the only framework. I will suggest later that all human interactions *inevitably imply their own* 'framework', so there may be alternative frameworks for understanding therapy, and life.

Robert Langs' Communicative Psychotherapy (1997,1998) presents a variation of frame therapy based upon the idea that the frame *is*, in fact, *the therapy*. The therapist is entrusted primarily with cementing and maintaining the frame so that it can cure the client. According to this theory, the work of the frame is not to make the client feel safe, but quite the opposite, to elicit the client's deepest anxieties regarding death. Lang's view that the frame provides the experience of confinement, the coffin in the grave, and all its so-called 'existential death anxiety' differs from the mainstream analytic view of the frame as providing the safety of the womb, the containment and security of the mother's holding. The intricate contradictions and philosophical quirks of this complex and fascinating theory, and it's concomitant technique, have been explored elsewhere (Madison,2001a). It is significant to notice that adherents of both views see their theories confirmed in their practice. Imagination and perception are intricately woven, and in all our quandaries preconceptions may provide more than a hint of colour to our observations.

Langs points out explicitly that frame therapists attempting to work in medical situations, especially with clients who are facing death, seem to experience 'special problems of technique' (1997:236). For example, therapists are tempted to become 'human' because of their 'own unmastered death anxieties' and to be 'openly compassionate, non-interpretative, and frame-altering' when their patients are dying. Like conventional psychoanalysis, communicative psychoanalysis maintains a strong prohibition on self-disclosure. According to Langs,

> Inherently, all breaks in relative anonymity unconsciously also place the therapist in the role of patient and ask the patient to assume the role of therapist. Harm is thereby suffered by the patient, and the therapist will suffer from conscious and especially unconscious guilt (Langs, 1998:200).

It is not clear how revealing one's own humanness places the patient in the role of therapist. Isn't it possible that self-disclosure partially deconstructs the polarity of these two roles? What evidence shows that this is harmful? Langs acknowledges the difficulty of performing his therapy in medical clinic settings, where frame breaks are likely and complete confidentiality difficult to insist upon, but suggested ways of reducing these deviations in a clinic setting are entirely unrealistic in an acute general hospital, leaving stark choices for such therapists. Witnessing frame therapist's struggles to abide by or to shed their theory in the face of extremis, suggests that in such situations some of these therapists experience their approach as unacceptable, entailing a narrowing-down of possibilities for interaction.

The Clash

Therapists from all orientations have had to adapt their usual way of working to some extent when responding to the unique challenges of a medical setting (see Thomas et. al., 2001), and most clearly when working with the terminally ill. Some react to the collision in cultures between counselling and medicine by developing a flexible approach to practice (Logan,2001:65-78), including visiting clients on the ward when their illness prevents them from attending a session, and negotiating a different understanding of confidentiality within medical teams[vi]. Other therapists have grappled with maintaining their frame approach when working with patients,

> It is generally accepted that secure boundaries are essential to provide containment for the powerful affects experienced in psychodynamic therapy. What is remarkable, given that those who are dying face the loss of all known boundaries, is the fact that the need for a containing therapeutic framework is often neglected in counselling in the hospice setting (Birch, 2001:151).

Birch (2001) maintains that some flexibility may be required as a patient's condition deteriorates, but warns that 'Counsellors who reduce the duration of sessions from the standard fifty minutes may be motivated by their own unconscious fear of facing death rather than by a need to accommodate the specific requirements of the seriously ill …' (ibid:153). She does not explain how *reducing* the session time, rather than sticking to a 'magical' fifty minutes despite compelling circumstances, could indicate an 'unconscious fear of facing death' (perhaps clinging to the frame is as unconsciously death-defying?). Birch is rightly concerned that the counsellor could look for an excuse to truncate the

session because of his or her own difficult feelings, but of course there are many ways of avoiding difficult feelings other than leaving and there are many *legitimate* reasons to shorten a session with a dying patient.

Another frame therapist, Peter Hildebrand, gives an account of working with a gay man dying of AIDS. Hildebrand comes to recognize through his responses to this man that maintaining his frame theory obfuscates a satisfying fuller appreciation of his client's situation, '… [psychoanalysts] do not have any real body of experience or practice with dealing with the dying' (ibid: 467). He says that when such patients come with their 'existential problems', it is difficult for the analyst to maintain their '*inner standards*' (ibid: 467, *italics added*)'. When his patient was on his deathbed, Hildebrand shook his hand and told him to 'keep fighting' though it was clear that death was imminent (Hildebrand, 1992:466,c.f.Madison,1997:7). Michele Crossley, a psychologist involved in research with HIV+ gay men, offers an existential critique of Hildebrand's interaction with this client,

> The negative implications of Hildebrand's inability to conceive of his material in "terms other than those of object-relations theory", are that he fails to orient to the reality of Matthew's situation; to the fact that Matthew was a person dying who perhaps required nothing more than simple human contact. Because Hildebrand fails to appreciate such possibilities, he succeeds in reducing Matthew's experiences to manifestations of unconscious conflict and Matthew himself to an 'object' of transferential/countertransferential processes… The most disturbing evidence of such objectification and dehumanisation is evident in Hildebrand's

> response to his invitation to Matthew's funeral. He states that: "I did not go since in my own mind my business with Matthew had been with his inner world which was now dead and his burial was really a matter for his family and friends not for me" (p.446). Surely, Matthew, like all of us, was a person, not an 'inner' or 'outer' world? (Crossley, 1998:55-6).

These problems are echoed by Mark Blechner (1993) who says that working with AIDS patients places a burden on analysts because the patient's emotions are 'contagious' and can cause an existential crisis for the analyst and his/her beliefs (68-70, c.f. Madison,1997:7). There is an apparent mismatch between orthodox frame techniques, which emphasize *unconscious* anxieties or *fantasized* transferences, and aspects of our human *existence*, 'although psychoanalysis has… the theory of the 'death drive'… psychoanalysis's idea of death "has nothing to do with the problems that may be posed for us by our 'being toward death'", in other words by our mortality' (Laplanche, 1989:50, c.f. Bauknight and Applebaum, 1997:92).

Other frame therapists have chosen to abandon their assumptions about practice in order to respond to the reality of their client's situation. Diane Sadowy, a psychoanalyst with an HIV+ female patient, grasps the opportunity of this relationship to reassess her orientation. She asks herself, 'Where do transference, countertransference, resistance and such have a place when the realities of the situation are so overwhelming?' (1991:205). Unlike Hildebrand, Sadowy responds by leaving her analytic frame to help in caregiving tasks with her patient.

In the article *AIDS, death, and the analytic frame*, Rebecca Bauknight describes her work as a clinical psychologist working with a man dying of AIDS (Bauknight and Applebaum, 1997). The article is written in a poetic style, consistent with the authors' attempts to break what she comes to experience as the punitive restrictions of her theory,

> [the frames'] unmistakeable shatter breaks through the silence as loud as machinegun fire to anyone who listens for the slightest tilting on the edge of the table, the breeze of the disturbed air, the clatter of glass unmistakable to anyone who doesn't question the party line, the analytic lines drawn around the room, the frame… I really don't see these lines so clearly … Does this mean that I too will meet with death?… Will I also find myself crumbling and dying without the sanctity of the frame? (Ibid:81)

According to Bauknight, the act of 'framing' itself needs analysis – it encapsulates a hint of the paranoid-schizoid in its attempt to 'frame any threats to its own demarcations by stigmatizing them as expressions of "resistance"' (Ibid:86). 'The frame tells us where to look, and where not to look…' (Ibid:90), it is an attempt to contain what could never be contained without the tacit agreement, or collusion, of the participants.

In therapy, two (or more) people form an interaction which always exceeds the frame and which can be referred to from within the frame and from outside it. Outside the sessions, client and therapist dream about their encounters, think about each other, prepare for their meetings. As Bauknight points out, the frame is always open (Ibid:90-1). Yet, the

metaphor of the frame encourages the illusion of a sterile Petri dish form of therapy, purely isolated from the contamination of the world outside. *Even the so-called 'secure frame' is more a membrane than a solid container.*

It is clear from the diverse attitudes toward maintaining the frame that stirrings within individual frame practitioners can override theoretical restrictions as to which possibilities of engagement with others are permitted or important. Especially in the face of imminent death, many frame therapists feel compelled to reach out in a gesture of human connectedness. But if this is possible when faced with death, why not in other situations? Where do we draw the line in terms of seeing an outstretched hand as humane, thus excusable, or as 'failure'? How flexible can a frame approach become and still be a frame approach – focused on generating 'frame feelings' (transference or death anxiety)?

The Shift

The hospital setting often involves working with the severely medically ill, the dying, and their relatives. From the frame deviations outlined in the first section, and the problems encountered by frame therapists in working with the dying generally, it seems clear that a frame approach, and its theoretical emphasis, cannot offer an adequate guide to practitioners wishing to respond to all requests for therapy and counselling in an acute general hospital setting. If such work is to be done, it requires a more appropriate approach, a 'framework' not based upon frames.

In the early days of psychoanalysis, Freud practiced in a flexible and variable way, maintaining loose boundaries and dual relationships (Gabbard:1115). For example, he

practiced a style of mutual analysis with his colleague and friend Ferenczi during their voyage to America (ibid:1124). Freud also analysed clients while strolling through the streets of Vienna and during summer holidays at the house of a client's brother (Ibid:1124). From a frame therapy point of view, these are 'violations' of the frame, examples of how our 'impaired colleagues' struggled to 'define the parameters of the analytic relationship' (Ibid:1117). However, if the aim of therapy is not necessarily assumed to be the archaeology of the unconscious, these early attempts may be viewed quite differently.

Irvin Yalom (2001) comments upon the same early 'violations' mentioned above, arriving at very different conclusions. Yalom presents Freud's early work as 'bold' in that he did not remain aloof but sought encounters with his patients beyond what we now consider to be the orthodox 'frame'. 'He made strong suggestions to them, he intervened on their behalf with family members, he contrived to attend social functions to see his patients in other settings, he instructed a patient to visit the cemetery and meditate upon the tombstone of a dead sibling'(Yalom, 2001:76). He also admires Ferenczi's experiment with mutual analysis, calling it 'radical',

> A bold experiment in therapist transparency that has long intrigued me was conducted by Sandor Ferenczi (1873-1933) … Of all the analysts in the inner circle, it was Sandor Ferenczi who relentlessly and boldly sought out technical innovation'(Ibid:81).

Yalom applauds attempts to 'be human' in therapy. He suggests that therapists should be 'flexible, creative, and individualized' in their practice, incorporating thoughtful self-disclosure and appropriate physical touch. Yalom totally rejects the strictures of frame therapy, especially the rule of therapist anonymity,

> [The Blank Screen] is not now, nor was it ever, a good model for effective therapy. The idea of using current distortions to re-create the past was part of an old, now abandoned, vision of the therapist as archaeologist… [these considerations do not merit] the sacrifice of an authentic human encounter in psychotherapy (Ibid:75).

Yalom does not share the theoretical underpinning of frame assumptions and so is free to take a radically different approach to therapy. He suggests that (any) theory in therapy is an attempt to conceal 'the desolation of a purely capricious existence' (Ibid:175-6).

The psychoanalyst Steven Gans, consistent with the approach advocated by Yalom, emphasizes the quality of 'therapeutic engagement'. Gans calls his therapy 'ethical analysis', and bases it on the philosophy of Emmanuel Levinas,

> For me psychoanalysis is an ethical practice; it is the practice of just listening … I want to propose that the existential psychoanalytic process amounts to a lived ethics, the ethics of putting the other first… The other is singular and thus cannot retain its otherness if reduced to the imminence of my own understanding. As

> soon as interrogation, investigation, theoretisation, categorisation, exposure and representation occur, proximity (Levinas's term for ethical relatedness) is lost. These are modes of violation of the other, attempts to capture the other and reduce the other to my own mastery and control (Gans,1999:102-3).

From this point of view, the therapist who starts from a theoretical apriori, as in frame therapy, is displaying a sort of narcissism, not relating on the client's terms but on his own. A less pernicious understanding of frames is offered by Ernesto Spinelli, who suggests that,

> The frame issues may not be important in themselves, but may rather have the same effect as Dumbo's magic feather. In other words, their importance lies in the fact that *the therapist believes them to be necessary for the 'magic' of therapy to work* (Spinelli, 1994:89)

For clients who share this secure frame superstition, a flexible frame can positively challenge the worldview implied by such beliefs,

> The therapy taught me that failure, criticism, and rejection does not automatically ensue from moving boundaries and taking risks, but that in fact flexibility has the opposite effect, as it makes room for other options, options which previously were excluded by rigid, fixed, and hence restrictive boundaries. My life became more open, more forward looking… (Strasser, 1999:99,102)

Contrary to rules regarding the need to strictly control extraneous variables in order to achieve the special frame conditions of therapy, Hans Cohn offers a view of therapy that allows for the variations in practice necessitated by a setting like the general hospital,

> But we can also see psychotherapy as one of the many possibilities of two or more people meeting each other, but distinguished and defined by its particular aim – to create a therapeutic space for a person in need. In this view, psychotherapy needs boundaries like any other meetings, but they will be more loosely structured and flexible enough to respond to the events and developments taking place within them (Cohn,1998:113).

Recent attempts to delineate a 'more humane psychotherapy' (humane in terms of more fully accounting for the client's reality, and acknowledging the impetus in the therapist to 'reach out') include, replacing the certainty of *one* theory with multiplicity (McNamee, 2003), describing an existential therapy distinct from psychotherapy (Colaizzi, 2002) and challenging the accepted limits of the therapeutic enterprise (Spinelli, 2001). These descriptions and others offer an alternative basis for practice in an acute general hospital, and thereby a thoughtful development of therapeutic understanding. What does a model of therapy based upon an alternative to frames look like in a hospital setting?

The Development

As we've seen, the hospital offers a radically different practice environment, seemingly requiring an equally radical re-working of our understanding of therapy. The service that I eventually developed in interaction with this environment was called a Psychotherapy Support Team (PST). Faced with the restrictions of the setting in terms of conventional

practices, plus the extremes of client issues, an existential-phenomenological approach was adopted in order to maintain maximum openness and flexibility. Working phenomenologically encourages the therapist to bracket preconceptions regarding the constituent elements of psychotherapy, including the necessary frame, boundaries, and 'ground rules', while simultaneously remaining open to the possibility that all aspects of the therapeutic encounter may be equally revelatory.

There is no preconceived view that the transference or unconscious death anxiety must be generated and then addressed, and so, there is no insistence on keeping a secure frame around the interaction. If a session is interrupted, these influences from the wider world offer opportunities to explore the client's reactions to others. If the patient is bed bound, the sounds of other patients and the life of the ward are often overheard and appropriately integrated into the session. The session environment constitutes a shared real-time reality, our reactions to which can reveal fundamental aspects about who we are. The therapist is not a neutral commentator upon a second-hand narrative, but is actually *alongside* his or her client, witnessing and participating in their crises and experiences of institutional routine, offering a reflective and reflexive relationship which itself becomes part of the client's experience as it unfolds.

This approach places greater emphasis on acknowledging that the *wider* context in which therapy occurs may have a significant impact on what occurs *within* therapy. This is in contrast to frame approaches, which rule out the world in order to focus the *treatment*. In the hospital setting an important aspect of the wider context is the way in which power relations, based largely upon medical knowledge, can impact upon the patient and his or

her relatives. Therapists working in the hospital setting are likewise affected by a culture that emphasizes hierarchy, competition, and specialized expertise. The 'art' of psychotherapy in such settings can become subservient to its 'corporatization',

> The most serious political consequence resulting from the corporatization process is that mental health professionals are increasingly called upon to use any technique at their disposal in order to sequester experience …, such that deeply personal existential and political questions are primarily addressed through a professional world view. For the goal of therapy under managed care and an increasingly corporatized health care system is not personal growth or personality change, but symptom reduction and behavioural adjustment… (Pingitore, 1997:117).

The danger is that the therapeutic relationship can become subservient to the therapist's need for professional legitimacy, but also to the demands of the institution, and by implication, the demands of society. The therapist's professional interests and the interests of the institution can congeal in ways that deeply affect the client without being explicit enough for the client to challenge. Putting a frame around therapy does not sequester our clients or us from these outside influences – it just rules out talking about them, labelling such talk as 'resistance' or 'defence'. Two potent qualities of the hospital setting for the therapist to consider are, the pervasive way in which 'knowledge' in the form of professional expertise, constitutes power over the other, and related to this, the insipient way in which a boundary is maintained between humans designated as 'staff' and humans designated as 'patients'[vii].

In the PST model, *the intention* is to prioritize a democratic relationship between the counsellor/psychotherapist and the client. Rather than therapeutic techniques (including attempts to maintain a secure frame), psychometric assessments, categorization and diagnosis, or theory-based interventions, the aim is to develop a relationship to the client's on-going lived experience, acknowledging that the reality of what is being endured is happening to a specific *historical* individual. There is also an open acknowledgement that the therapist is equally physically vulnerable and therefore the role of the patient can (and at any moment may) be shared by the therapist. Concerning frames, a transparency is established between the client and therapist so that from the first session the limits of the relationship are explored, negotiated, and then left open to renegotiation. Of course this allows the possibility that a secure frame might actually be the result of such negotiation with a client. Whether it could be put into practice would depend upon the client's condition and hospital facilities.

Variations of the existential-phenomenological stance have recently been presented by Ernesto Spinelli (2001), Emmy van Deurzen (2002), Hans Cohn (1998, 2002), Freddie Strasser (1999), and Mick Cooper (2003). This approach to therapy utilizes the ordinary language of the world we live in, and the client's own understanding of this world, and thus is perceived by clients and staff as immediately graspable and less 'mysterious' than some other modalities of therapy. It does not hypothesize intra-psychic structures, nor does it pathologize clients' modes of experience. Hospital patients and relatives seem to appreciate this down to earth attitude and the resulting relationship between therapist and

client can be unusual in its capability to reveal assumptions, contradictions, and sedimented responses to life's contingencies, both the client's and the therapist's. This form of encounter emphasizes the importance of choice while also acknowledging that our human existence is shaped and limited by the situations we encounter, including illness, and we often have little or no possibility to change these, except through the way we respond to them. The following section offers some examples and further discussion of PST practice, with reference to its philosophical underpinning.

The Practice

Working existentially acknowledges that as humans we share certain givens, so this approach does not introduce a distinction between therapists and patients in terms of the emotional impact of the hospital environment. Likewise, PST facilitation of staff groups emphasizes the lived experience of all staff working in hospitals, and accordingly the therapists do not hide behind a professional 'blank screen', facilitating other's experience while withholding their own, but instead take a collegiate stance and appropriately disclose their own feelings and experiences. However, this is done within the confines of client confidentiality and these groups are a good reminder that the client as patient (or relative) may be in the midst of many significant relationships, of which the therapeutic is only one and not necessarily the most important or most helpful one.

Without a pre-given therapeutic structure or technique, the therapist is required to be creative and to explore different ways of 'being with' the client. For example, some clients have severely restricted forms of communication, sometimes unable to speak or unable to remain conscious. A therapist may sit in silence with a client who is passing in

and out of consciousness. With an intubated patient in Intensive Care, the session may focus on the mutual frustration of communication, or the ramifications of the patient's total reliance on others. Therapy is an exploration of what happens between the people present, their attempts to connect, understand, engage, the obstacles to this, and how each person then responds to these obstacles. Sometimes we are connected by our stories, sometimes by our silence. This approach to therapy explores the complexities of human ways of being rather than interpreting 'psychic disturbance' expressed in a transference or death anxiety.

The analyst Leslie Farber exemplifies this approach to therapy through his focus 'upon a moral, rather than a technique-dominated, and hence safer, professional engagement with his clients' (Spinelli,2001:162). Therapy was not a method practiced under controlled conditions, it was not something he 'did' to people, it was his way of being with people. In the hospital this includes being with people in their own room or at their bedside instead of the 'controlled' therapeutic consulting room. Some clients experience their room as their territory, so they have some security while the therapist is a guest, but others experience being in bed as a position of vulnerability in front of the fully clothed therapist. As you can imagine, all sorts of attitudes and issues can emerge from exploring the interaction that arises between two people in this situation.

I recall my first meeting with a man a month after he'd been shot during a bank robbery. He was lying in bed in his single room fully conscious with his wife standing at his bedside. I introduced myself, and entered the room knowing that both he and his wife were eager to meet me. We spoke for about twenty minutes and arranged the first session

for the next day. When I arrived the following day, the patient told me that the day before he was in fact on the bedpan under the covers and remained so for our entire introductions. His revelation, and associated embarrassment, opened a whole area of discussion regarding his experience of privacy and dignity in the hospital and established our relationship on an open and frank footing, which we maintained during the subsequent eight months of therapy.

Farber would not acquiesce to the professional scientific impetus that sees people as 'more humanoid than human', artefacts of elegant theorizing with 'just those qualities most distinctively human' omitted (c.f. Spinelli,2001:165-6). If meeting is to occur, the obligation is on the therapist to forsake the profession – this type of meeting is possible '*despite* … inequalities in position, status, background, education or awareness' (Ibid:166).

> In his practice with patients, Dr Farber was both far humbler than his more conventional colleagues and far bolder: He was humbler because he approached his patients as a whole human being, not as a semianonymous representative of his profession, and because he has abandoned his profession's claims to objectivity and curative power… It was a brave venture to step from behind the mask of his profession, and a dangerous one… Many other psychotherapists did something similar in the 1960s, of course, often with disastrous results (Gordon, 2000:125; c.f.Spinelli, 2001:163-4).

Working as a 'whole human being' raises questions regarding the role of the therapist, especially in a hospital setting. In the hospital, issues of the demarcation of therapy are

complex and unclear, from the point of view of the institution, the client, and sometimes the therapist. A hospital is an excellent environment to explore our attitudes to time, space, hierarchy and authority. In order to spontaneously negotiate this kind of flexibility, the therapist must carry 'within' himself or herself a clear sense of their motivations, an intention to be transparent, and an ethical stance that prioritizes the relationship with the client. The therapist has no *pre-set* rationale for ruling out possible avenues of engagement.

For example, when issues between the client and other hospital staff become problematic and the therapist could have a beneficial role in resolving these, the therapist may respond to requests to mediate. This of course is done with the agreement of the client, and the client's reasons for making this request and the effect of the therapist taking this role do not go unexplored. The therapist remains aware of the impact, motivation, and meaning of his or her interactions on behalf of the client and refers the client's requests to other professionals when this is more appropriate.

Another example is Mr. Y, who was referred for counselling by a physiotherapist who was concerned about his refusal to engage in his rehabilitation. Mr. Y was a retired army sergeant, a large man in his early seventies, and although his prognosis was excellent, his recovery from surgery had been unexpectedly slow and he had descended into a mood of despair. Mr. Y agreed that talking might help and in the first meeting with the therapist he began to recall the death of his wife two years earlier and soon found himself weeping openly. In the second session, Mr. Y requested that the therapist take him to the shop so

he could buy a paper and then proceed to the cafeteria, where he wanted to buy the therapist a coffee. Before embarking, the two of them discussed openly the reasons for Mr. Y's request and whether it was embarrassment from the previous session or an avoidance of difficult feelings. Mr. Y explained that since his wife's death, and until arriving in hospital, he had always started his day with a trip to a local café where he would read his morning paper. It was agreed to continue with the trip to the shop and the cafeteria, where the two sat at a back table and discussed the previous session, the three weeks spent in bed, and Mr. Y's present mood.

The physiotherapist contacted the therapist the next day to say that the change in Mr. Y's attitude was profound. The therapist met Mr. Y for two more sessions, during which they discussed his change in attitude and the importance of the therapist agreeing to Mr. Y's request. Through this activity and dialogue Mr. Y explained that he was able to recognize himself again and believe in his ability to re-create that routine pre-hospital world which had sustained him since his wife's death. This belief encouraged him to engage in his physical rehabilitation. Rather than 'treatment' or personality change, this therapy was about finding the interaction that allowed the client to believe he could regain some semblance of his way of being-in-the-world.

Perhaps it is frame therapy's imperative against self-disclosure that offers the clearest demarcation between frame and non-frame understandings. Mr. M, a highly successful and respected businessman, was referred for therapy by staff who found him increasingly uncooperative and angry on the ward. Mr. M had been recently diagnosed with an

aggressive brain tumour and was told he had only a few months of quality life ahead. He had agreed to see a therapist and with some trepidation I met Mr. M at the ward dayroom for our one and only session. Before I had fully sat down, he announced in an intimidating tone, 'I have one question for you, what would it be like *for you* to be in this situation instead of me?' It would be obviously self-protective if I retreated into a professional role with edicts against self-disclosure, frame-based or otherwise. I had to take the question seriously and offer a human response, 'I really have no idea how I would feel if I was in your place right now. I find it very difficult to even imagine, but I think I would feel devastated'. Hearing this, Mr. M softened, with tears in his eyes he told me about the insensitive way he'd been given the bad news, how people see him as a strong man 'but in here (gesturing to his chest) I'm just a scared little boy. No one sees that'. We spent the next twenty minutes talking about his life, his future, my view of life, and life generally. Both of us acknowledged how shocking it was for a human being to be suddenly facing death. When the transport team arrived to take him back to his local hospital, we parted with a warm handshake, both of us deeply moved and changed by the encounter. Ernesto Spinelli writes that psychotherapy depends upon the emergence of a relationship that is not only mutually engaging, but in actuality, of mutual benefit (Spinelli,2003). In fact it may be only when the client sees, despite the therapist's attempts at concealment, the therapist's vulnerability, that the client makes a significant shift back into relationship with the world of others.

Rather than a 'secure frame', it may be the sharing of therapist and client uncertainty, confusion, and despair, that is therapeutic. Therefore, it is paradoxically at the moment

when the frame therapist fails to maintain the frame, or unintentionally self-discloses, that they may be most helpful to their client. Perhaps perceptive clients recognize the therapist's attempts to maintain their role and feel compassion for the human being trying to hide and help at the same time. In the hospital setting, I've also felt this move toward me when the client, momentarily forgetting their own predicament, looks with concern directly into my eyes, saying something like, 'this must be a very difficult job, how do you do it?' Though this could be interpreted as indicating some failure on my part as a therapist, or as client defense, it can also be seen as compassion, in its true sense. For a moment at least, the therapist is pulled back from the sterile two-dimensional world of the 'professional'. According to Farber, '*In therapy the paradox is inescapable that the man who is incapable of arousing pity will find it hard to help another'* (Spinelli, 2001:167).

In the hospital setting, such an emphasis is a challenge to the entire professionalization and medicalization of life. On occasions I have witnessed medical consultants prescribing drugs to patients simply because they were distressed. One middle-aged male patient made the mistake of confiding in his consultant that he had not recovered from the death of his wife two years earlier. While describing his bereavement, the patient broke down and wept. The consultant immediately prescribed the patient antidepressants. When questioned about his rationale, the consultant simply replied 'this is a medical matter, and I have judged this man is depressed'. For whose sake is this man being medicated? For whose sake are we offering therapy as treatment, and treatment of what? Farber has deep misgivings about reducing despair to morbidity or an unhealthy state of mind,

> '…and thus refusing to conceive it as belonging inescapably in some measure to our lives as human beings – [this] may be more malignant than the despair itself. (It was Kierkegaard's belief that the worst of all despairs is that in which one does not know he is in despair.) It sometimes happens that despair itself provides the very condition of urgency that brings a man to ask those serious - we might call them tragic – questions about his life and the meaning and measure of his particular humanness' (Farber,1976:94).

Farber views therapy as an interaction in which truthfulness is paramount. Being "truthful" is not the simple telling of a truth, it is a specific mode of human interacting. It can require sitting with meaninglessness rather than running to theoretical content, or retreating into frame repairs or other techniques. Of course we also shrink from the truths of our existence, 'We all lie – to ourselves, to others, to the world itself. It is in our nature to lie, but I think I must add that it is also in our nature not to lie' (Farber, 1976:219). The lie is not the most significant thing, the *response* to the inevitable lie, when it comes, is what redeems or damns us.

Despite the significant absence of accepted frames, it eventually became apparent that deep and effective therapeutic work was occurring in the hospital. So, rather than continually trying to approximate usual practice, the importance of the frame and its theory began to be questioned more generally. While theory is always general, life never is. If specific circumstances could be taken into account in some cases, then why not in

all cases? Who is in a position to decide which individuals could, due to the exceptional nature of their predicaments, override the dictates of frame theory and which individuals remain bound by them? Based upon experiences in the hospital, the view emerged that the incomprehensibility of life itself, with its implicit 'existential givens', is the appropriate 'frame' for therapeutic interaction. In this way, therapy develops as a philosophical practice rather than a 'medical' one, and it seems that in the hospital environment at least, many possibilities would be lost if we reduced therapy to 'treatment'.

The Conclusion

The frame is a metaphor for the collection of rules that many therapists need to fulfil the essential criteria of their therapy. *The frame is a metaphor*. Unlike the frame around a window, the frame of therapy is meant to refer to more than the concrete walls of the consulting room. Likewise, interpretation, whether based upon death anxiety or childhood needs (transference), or existential givens, is also metaphor. *Interpretation is not evidence*. If an interpretation seems to fit well that does not make it fact. It is still, always, metaphor. But metaphor of what? *Something goes on* that remains more than our understanding or symbolization of it.

Rather than offering yet another theory as a replacement for ‘frame therapy’, the existential-phenomenological approach tries to stay with this ‘something’. The philosopher and psychotherapist Eugene Gendlin (2003, 1997a,b,c, 1992, 1964)[viii] has offered explications that point to this bodily-felt level of interaction. We know, for example, that the moment someone sits next to us on the bus our bodies are in interaction.

This immediately includes living *frameworks*. A *frame* does not need to be added on after, or imposed. If I sit too close, the person's framework regarding personal boundaries, which was implied, is now felt by both of us. In therapy we have the opportunity to reflect upon what is usually left implied and unspoken, including how our on-going frameworks and lived assumptions interact, and how they create themselves bodily in each new situation. A secure frame is not necessary for us to do this. With or without a secure frame there is already a far more intricate order than we could ever impose or comprehend completely. In fact our efforts to comprehend the situation moves the interaction onward so that our understanding is always exceeded, never comprehensive. We are not lost in some sort of 'chaos' if we don't impose order. We just have to look closely at everyday life to know this. If it is not true that order must be imposed in life, it is not true in therapy.

Frame therapy, in its insistence on either the transference or death anxiety, reduces the full spectrum of possible human interactions down to one. In contrast, the PST model is based upon a more inclusive existential and experiential philosophy that attempts to return to what already 'is', without presupposing which of the possibilities for human interacting should prevail in therapy. In the words of Ludwig Binswanger, an early advocate of the application of Heidegger's philosophy to problems in living,

> '… Heidegger's phenomenological-philosophical analytic of existence is important for psychiatry [or psychotherapy]. This is so because it does not inquire merely into particular regions of phenomena and fact to be found "in human beings," but, rather, inquires into the *being* of *man as a whole*. Such a question is not answerable

> by scientific methods alone … Heidegger's analytic of existence, by inquiring into the being of the whole man, can provide not scientific, but philosophical understanding of this wholeness. Such an understanding can indicate to psychiatry [and technique-oriented forms of therapy] the limits within which it may inquire and expect an answer and can, as well, indicate the general horizon within which answers, as such, are to be found' (Binswanger, 1963:211).

It has been my intention in this chapter to describe working as a therapist in an acute general hospital, to describe the assumptions and dilemmas of frame therapy in this context, and to outline how a more philosophical stance may offer a basis for therapeutic practice in this setting. The philosopher Martin Buber adds a humbling note to help focus our efforts along these lines, 'The essential thing is not that the one makes the other his object, but the fact that he is not fully able to do so and the reason for his failure' (Gordon,2000:235).

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i The therapy model that I will base my comments on is unique within the NHS. Typically, there is no integrated counselling provision that is accessible to all hospital patients and their family members.

ii Although team members were all UKCP registered psychotherapists, I will not make a meaningful distinction between the terms 'counsellor' and 'psychotherapist', and will assume that in this case they refer to the same occupation.

iii This type of epistemological claim has been greeted with much scepticism in philosophy. It amounts to what has been termed 'maze epistemology', the error of ascribing the observer's way of being onto the observed in order to understand the behaviour of the observed. With infants we run the risk of seeing them from our adult understanding, founded upon the language and culture that does not yet fully exist for the infant. We may forget the qualitative difference between life before language and life after language. For example, we do not know that an infant experiences a separate mother at all, or can distinguish between self-sensations and the touch of another.

iv If the response is that non-frame therapy is useful but not as useful as frame therapy, there should be empirical evidence to substantiate this, but as far as I know this has not been substantiated by research.

v Fascinating questions regarding the transference remain unanswered, for example, is it a universal phenomenon or a deformed interaction induced by certain styles of therapy? If the transference occurs everywhere, why do we need to induce it in therapy, surely we can investigate it anywhere? See Schill and Lebovici,1999:266 for more questions.

vi Though Logan decided to keep details of sessions in her own notes and not share them with the medical team, others have taken the view that they work as part of a team and that relevant information will be shared with other staff (for example, Williams, 2001:138).

vii See Michel Foucault's Madness and Civilisation (1973) for a detailed discussion of these themes. Also, Holmes and Lindley (1998) for a discussion of what defines a profession and the specific problems this raises for psychotherapy. It is worth mentioning that for professional reasons therapeutic provision in the NHS has loosely mimicked medical specialisations, for example, epilepsy counsellors, oncology counsellors, rehabilitation counsellors, HIV counsellors, renal counsellors. While dividing medical science into disease processes or body parts makes sense when treating physical illnesses, does it make sense from a psychotherapeutic point of view to form similar specialist divisions, and what effect does this have on therapeutic relationships, if any?

viii I have attempted to describe how Gendlin's philosophical method of Focusing is useful therapeutically and how it offers an intersubjective reconceptualisation of therapy (Madison, 2001b).