"Sharing a Terminal Illness: Clinical and Theological Reflection"

This workshop will discuss the impact of a psychotherapist's terminal illness upon the client and the therapist alike. The presenter earlier this year was diagnosed with Bulbar onset of ALS (Lou Gehrig's Disease). We will also discuss the issues that need to be addressed, when for whatever reason, you need to prematurely terminate clinical work with a client. Lapses in the therapeutic bond and attempts to repair that bond will be discussed. Actual clinical vignettes will be utilized in this discussion. Furthermore, there will be an opportunity to reflect theologically upon the issues of loss experienced by both parties.

Goals and Objectives. At the end of this presentation, participants will:

A. Be able to identify some of the emotional and psychological impacts of a Therapist's terminal illness on clients, especially those with significant attachment issues.
B. Be able to identify how a terminal illness impacts a therapist emotionally, at least this therapist in particular.
C. Be able to articulate aspects D.W. Winnicott's theory regarding the Holding Environment both "arms around" and the larger holding environment and therapeutic implications.
D. Be able to articulate aspects of John Bowlby's attachment theory and it's therapeutic implications.
E. Be able to recognize some of the effects of premature termination of therapy upon therapist and clients alike, regardless of the reason or circumstance.
F. Be able to reflect spiritually and theologically upon the nature of loss and the predictable impact it has on clients and the therapist as well.

SIX CLINICAL QUESTIONS I ASKED REGARDING MY ALS DIAGNOSIS

These are the questions that the Clinical Vignettes are based upon. I interviewed eight of my clients with these questions:

1. A. Will you share with me how my diagnosis of ALS has impacted you?
   B. Has it surfaced your own mortality?

2. Are there ways that my illness has churned up unresolved issues that you are trying to find healing for and recover from?

3. Has my illness undermined the work in any way? For example, have you been tempted to withhold information from me because of my illness? Or another example, have you been tempted to withdraw emotionally now that you know I am leaving?

4. Is there anything positive about my ALS that has facilitated emotional or relational growth? Have you utilized my circumstances in a way that has proven helpful in facing your pain? Have you felt pressured by the end of therapy in a way that has helped?

5. Based on our relationship and how you have experienced me and what I have said to you, how do you assume the illness has effected me?

6. Any additional thought or reflection that you might want to address that none of my questions addressed for you?

Donald Winnicott and the "Holding Environment"

Winnicott came to psychoanalysis from a pediatric background as a physician at Paddington Green Children's Hospital in London beginning in 1923. His ideas were influenced by what he saw as the nurturing emotional environment that a loving mother provides to her child. From a Winnicottian perspective, a loving mother holds her baby, both physically with "arms around" holding and emotionally by providing a safe environment, and she is attuned and attentive to the baby's needs. Observing this, Winnicott extrapolated his ideas of how crucial it is that a psychotherapist develop a symbolic "holding environment" for psychotherapy clients.

What does the holding environment mean regarding psychotherapy:

A. Maintaining the therapeutic frame—consistency and continuity regarding appointments and location of those sessions. Being predictable and reliable as a clinician.
B. Empathic Attunement—compassionate and empathic connection to the client without impingement. Impingements can come in the form of insensitivity to client need and of course includes, maintaining appropriate therapeutic boundaries.
C. Above all the goal of the therapist is to create as safe an environment as possible so that trust can develop and the client can get at the depth of their pain and woundedness.

Winnicott's concept of the **transitional object** has been helpful as well. Transitional objects are created by the child to help with the transition from dependency to autonomy. They include items like security blankets, special dolls or toys, and other sentimental items. A transitional object helps a child feel safe and secure while separated from the mother. Transitional objects typically are helpful for toddlers, but can also help older children, and even adults, who are facing a transition or loss.

A transitional object helps a child or a traumatized adult when they have not as yet developed **object constancy**; the belief that the caregiver can be relied on and experienced as dependable even when out of sight.

Both Winnicott and Bowlby (below) are significant contributors to the independent group of British Object Relations.

John Bowlby and Mary Ainsworth: Attachment Theory

Bowlby and Ainsworth developed an awareness of how attachment at an early age impacts a person later in life. They found four basic styles or patterns of attachment:

A. Secure Attachment: *Feeling and dealing while relating*. This attachment is characterized by an ability of the infant to feel safe and cared for my the care-giver. They can separate, play and enjoy themselves and then reunite whether out of fear and need comfort or out of a desire to reconnect.

This attachment pattern leaves an adult with a capacity to trust and an openness to others. It gives a child better self esteem and helps the adult to operate so much more comfortably and autonomously in the world. They can feel deep emotions and process them with others or by themselves. They tend to have positive meaningful relationships.

B. Insecure Attachment: *Feeling but not dealing.* This attachment pattern is characterized by a child who resists separation and cannot be soothed at reunion. The child may continue to whimper and cling and refuse to play. The care-giver is unpredictable and tends to create uncertainty in the child.

This form of attachment creates a fearful adult that has difficult trusting, is uncertain of whether they can count on their partner. They anticipate rejection and abandonment. This adult tends not to explore or function well independently. A mother with insecure attachment as an adult can sometimes cling to a child in contrast to working with and resolving issues with their partner.

C. Avoidant Attachment: *Dealing but not feeling.* This attachment style is characterized by a child that protects their affective life in order to function. Throughout play the child displays neither distress at separation nor joy at reunion. It is as if the child is indifferent to the care-giver's behavior. The child, in order to protect themselves emotionally minimizes the importance of the attachment.

This type of adult may function very well in a work setting which requires objectivity and detachment. But they tend to be isolated and are not in touch with their feelings. They have great difficulty with intimacy. If they get into relationships, they are not able to trust easily, communicate effectively or resolve conflict.

D. Disorganized Attachment: *Neither feeling nor dealing.* This attachment pattern is based on a child's intense fear of what will happen next. Perhaps the child is sometimes comforted and soothed and the parent is available, but at other times the parent is absent physically or at least emotionally. Other times the child may be attached and feel safe, but then is abuse physically, sexually or both. Cruel and sadistic parenting over a prolonged period of childhood is sometimes involved in creating disorganized fearful attachment. This pattern leaves the child terrifyingly alone, with no one to count on and no sense of safety.

This attachment style creates an adult that lacks fundamentally an ability to feel safe and/or trust anyone. They have to make it alone in this world. They can end up being an isolated loner that trusts no one. Or they can get into abusive relationships as adults, either the abused or the abuser.

It is this fourth attachment pattern that creates the most difficulty for both the client and the psychotherapist alike. A therapeutic alliance may take years to develop and when an attachment is formed that attachment is most severely challenged by the failure of the holding environment for whatever reason, including premature termination of the therapy. And this pattern of attachment represents the majority of the clients that will be the focus of my presentation today.