More Grounds for Gestalt

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Interpersonal Boundaries in Hospice Work:
A Gestalt Therapy Approach

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This paper is based on a talk given to the California State Hospice Association on April 14, 1994. It was presented to an audience that was generally unfamiliar with Gestalt therapy. I apologize to readers who are already acquainted with Gestalt therapy theory. The first part of this article presents material with which you are very likely familiar. I would ask however that you do not abandon this piece altogether, as the article does develop ideas that will, I hope, be of interest to you—particularly if you are a Gestalt therapist involved with issues of death and dying in your clinical practice.

Acknowledgements

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Gestalt therapy

Gestalt therapy is a process-oriented, existential approach to psychotherapy in which we pay particular attention to the here-and-now experience that is unfolding in the therapeutic

encounter. Gestalt therapy grew out of the psychoanalytic movement. Its two primary founders, Frederick and Laura Perls, were both analytically trained. They were German Jews. Fritz was an MD and Laura was a psychologist. Fritz was very interested in acting and directing. Laura's loves were dance, music and literature.

Gestalt therapy came into being in the nineteen forties. Frederick and Laura Perls created a therapy that was more direct in its approach, less time consuming and less authoritarian in its structure and theory than psychoanalysis. The old psychoanalytic method of having the patient lie on the couch while the analyst sat behind the patient was discarded; instead, more contact between patient and client was encouraged by having them sit facing each other. The old method of having the patient freely associate was discarded; now the patient would be helped to focus and concentrate on here-and-now experience. The old method of having the therapist make interpretations, now seen as authoritarian, was discarded in favour of viewing the therapist as the facilitator of the client's own experience and awareness. Now the therapist was seen as a co-explorer with the patient rather than the doctor with the 'cure'. The stance of the therapist remaining neutral in order to encourage transference was discarded also and the therapist now became present and active in the therapy hour. All of these changes of method encouraged greater liveliness and interaction between therapist and client.

The Gestalt therapy values of non-authoritarian relationship, authenticity, liveliness and holism fitted very nicely into the Zeitgeist of the sixties—particularly the 'counter culture' movement. Fritz Perls became a popular figure at that time. He gave many Gestalt therapy demonstrations for mental health professionals and for the public, some of which were filmed and widely distributed. His demonstrations, while valuable, were sometimes misunderstood as comprising the essence of Gestalt therapy. Gestalt therapy

is, however, much more than a set of demonstration techniques. Its psychological and philosophical roots are rich and varied. They include psychoanalysis, existentialism, Zen Buddhism, gestalt psychology and field theory. Modern Gestalt therapists have also integrated material from Chinese philosophy, object relations and self psychology. Gestalt therapy remains today the most popular of the humanistic therapies with training centers throughout the world. Gestalt therapy is not a rigid set of beliefs or rules. Each practitioner integrates her own interests and experience into her own style of doing Gestalt therapy.

This paper will address only one aspect of Gestalt therapy theory—that of interpersonal boundaries. Please note that Gestalt therapy theory is quite multi-dimensional, and the Gestalt approach to boundaries by no means comprises the whole of the Gestalt approach. The Gestalt therapy approach to boundaries does, however, contain a set of concepts that is central to the Gestalt approach.

First, here is some background that will help to clarify the relationship between Gestalt therapy, the Gestalt approach to boundaries, and hospice work. In hospice work, we are interested in helping patients and their care-givers work together in a mutually supportive way through the illness and dying process. Gestalt therapy theory views the family as a whole system which can tend toward healthful contact and support between its individual members or, conversely, it can tend toward lack of support and contact. The term we use in Gestalt therapy for the interpersonal system (in this case the patient and the patient's care-giving community) is the 'field'; the field includes the individual and her environment. No-one exists in isolation and at every moment every person is a part of one or more fields. Within the field exist individuals, and the space wherein those individuals meet is known as the 'contact boundary'. The term 'boundary' refers both to

how individuals are separate from each other and how they meet each other.[1]

Boundaries exist in nature as they do among people. Animals stake out territory, the ozone layer is a boundary that protects our habitat from space, our skin is a boundary. Boundaries are basic to the existence of all varieties of living communities that contain a diversity of individual elements. In this paper I will be presenting Gestalt therapy concepts about boundaries and will be using them to help provide some tools for working with families in hospice work.

The relevant field in hospice work is the care-giver – care-receiver field. Care-givers and their terminally ill family member (care-receivers) are engaged in a very complex, delicate, and ever-changing field. The boundary issues that emerge are constantly changing as the patient loses her capacity to care for herself and becomes increasingly dependent upon care-givers for maintaining her life functions. In this ever changing field of care-giving and care-receiving, this give and take, each person is challenged to respect the

[1] 'Boundary' is a term that is used in many different ways. To the casual reader, the term may imply something like a fence or a border crossing. However, in Gestalt therapy the term implies a place where individuals are both distinct from each other and where they meet. I will be using the term boundary in several different ways throughout this paper. I use the phrase 'setting boundaries' to refer to limit-setting behaviour. Sometimes I use the term boundary in reference to making psychological space, physical space or a distinction between individuals. I use the phrase 'where to draw the boundary' in referring to decisions the hospice team must make at times around issues of how much influence to exert over a patient. I use phrases such as 'isolative boundaries' or 'confluent boundaries' to describe a particular style of interpersonal relating. I hope that the context in which the word appears will make it clear to the reader which meaning I intend. The phrases 'boundary disturbance' and 'boundary style' are defined and discussed at some length in this paper.

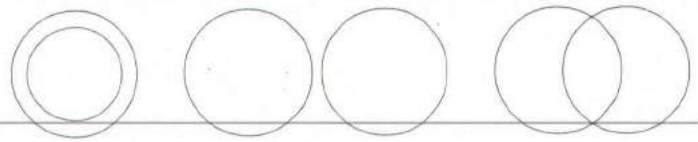
boundaries of the other even while the need for more intimate contact will undoubtedly become necessary. Perhaps you could imagine how you would feel if your significant other had to change your diaper, clean up your vomit, feed you and give you water. Your usual physical and psychological boundaries would be crossed. The need for awareness of what would be acceptable for you and what would not, of what you would need and how you would get that need met, are all issues involving the contact boundary.

In hospice work, the boundaries between care-giver and care-receiver are constantly shifting; we continually strive toward providing optimal autonomy for our patients and balancing that need against optimal patient safety. From a Gestalt perspective, the problem can be framed in the following way: there is a polarity—at one end of the polarity is patient autonomy and at the other end is patient safety. Families are frequently in conflict with each other over how much safety the patient needs as opposed to how much autonomy. On a parallel level, conflicts often arise within the interdisciplinary hospice team around autonomy versus safety. Each individual on the team will have a different viewpoint regarding where to draw the boundaries in each case. When the hospice team is working well, the hospice professionals are in a collaborative mode and are listening to each other's point of view. When the hospice team is in a less contactful mode with each other, then those on the team who want more patient autonomy may call those who want more patient safety 'controlling' or 'scared to take risks'. Those who tend more toward valuing patient safety will call those who value autonomy 'too loose' or 'not willing to make the tough calls'.

Boundary styles

In the diagram on the next page the three sets of two circles represent boundary styles: *confluence*, *isolation* and *contact*. Next, these boundary styles will be defined. Case examples

from the author's clinical experience in hospice work will illustrate how these patterns of making interpersonal boundaries get played out in the families of hospice patients.



Confluence Isolation Contact

Confluence

Represented in the diagram by the concentric circles, *confluence* is a quality of relationship in which there is insufficient distance and distinction between individuals. Family therapist Salvador Minuchin refers to this quality of relationship as 'enmeshment'; enmeshment and confluence are closely related concepts. The essential problem with confluence is that the individual is not able to identify or assert her own preferences. Frequently, identifying one's boundaries requires listening to oneself in a particularly subtle way; this subtle listening and honouring of one's preferences is typically disturbed in individuals whose tendency is toward confluence. Such individuals will have difficulty separating out their own preferences from those they imagine to be held by those in their field.

An example of confluence I sometimes see in hospice work is the patient who makes excessive demands upon her care-givers. This is the patient who disregards the autonomy needs of her care-givers and rules the family with an iron fist as long as she has the strength to do so, and frequently up to and beyond the point of death. She assumes that all family members are in agreement that all aspects of the care-givers' lives will be placed on hold until she no longer is in need of their unwavering attention. In such cases the repressed anger in the care-giver can become so great as to make her fearful of the intensity of her

own anger. The boundary work then is to help the care-giver make a boundary between the patient's expectation of her and her expectation of herself.

Another piece of the work with such confluent families is to help them explore the inevitable feelings of unexpressed anger in an appropriate, contactful, non-abusive way. It can be helpful to bring the family together and work with them all around letting the patient know what the realistic limits are for the care-giving at this particular moment. To give these families permission to disagree and to help them appropriately express differences of feeling, opinion and perception is to help liberate them from the suffocating experience of confluent boundaries.

One phenomenon seen frequently in the confluent system is the boundary disturbance of projection. In the confluent care-giving – care-receiving field, everyone assumes what the others are thinking and feeling but do not check out whether their assumptions are accurate. It is therefore therapeutic in such families to facilitate communication around differences. Another example of confluence in a care-giving–care-receiving field is the family in which everyone assumes that it is not appropriate to talk with the patient about her illness and dying process because they assume that it will be anxiety-provoking or depressing for the patient to do so. Frequently, however, it is the care-givers rather than the patient who are experiencing the anxiety and depression that they project onto the patient. Their attempts to shield the patient are in reality sometimes rooted in an effort to save themselves from feeling overwhelming emotions such as anxiety, abandonment feelings, and anger. In such cases, the therapeutic intervention should focus on reality testing (that is, how does the patient really feel about discussing her dying and imminent death) and helping those who are projecting their emotions onto the patient to tolerate those emotions and thereby own them as their own. When I know, for example, that it is I who am scared, and not necessarily you, then I can talk with you about my fear rather than avoid it by

pretending that I am protecting you. Through the contact of shared feelings we may both be comforted.

One further example of confluence in hospice work is the confluence that sometimes occurs between hospice professional and one individual in the care-giving – care-receiving field. I am referring to the times when the hospice professional becomes overly identified with one person's point of view in the family and then fails to treat the family as a system that can function more healthily. I have worked with many families wherein one family member attempts to make me side with her position in the family's conflicts and I have sometimes to watch myself from becoming overly confluent with that person's point of view if it begins to cloud my own perspective.

Isolation

Represented in the earlier diagram by the circles that do not touch and are separated from each other, *isolation* is a quality of relationship in which the individual feels cut off and alienated from others. Isolation may be seen as the polar opposite of confluence and as such has much in common with confluence and much that distinguishes it as a unique boundary style. In isolation, the individual does not meet the people in her field with a sense of connection. She assumes that others are not interested in her welfare and feels alone, alienated and cut off from both herself and the others in her environment. Isolation is a style of relating in which the boundaries between individuals in the field are seemingly impermeable; that is, each individual lives within her own armour and does not allow herself to be touched by others.

An example of isolation I sometimes see in hospice work is the patient who does not want to make demands upon her care-givers. This is the patient who would rather be in pain than ask for medication. She may feel that it is not OK to disturb anyone else and may experience herself as insignificant. This feeling of insignificance may be exaggerated when

the status of the other is perceived as greater than the patient's status. Thus we see the phenomenon of the patient who will not tell her doctor or her hospice nurse about her discomfort and pain. She simply cannot imagine that her experience is significant enough for the other to respond to. Patients who have been shamed throughout their lives will often create isolative boundaries. These patients will not come out of hiding quickly or easily. In such cases, it can be helpful to bring the family together and explicitly invite the patient to express her needs. The hospice professional may also want to spend extra time with the patient and to persist in asking about her internal experience.

Sometimes the impermeability of isolation is promoted by the blaming patient who pushes everyone away from her by blaming them for all kinds of things. These are the families that keep the hospice workers from helping them and then become angry with the hospice team for not helping enough. I once had a patient who fired our hospice team because our pharmacy was too far away for him to get to it; he was very upset about the inconvenience of our pharmacy and wrote the hospice administrator an angry letter. What he did not mention in the letter was that we had repeatedly offered to deliver his medicines to him. He had in fact consistently refused to let us deliver the medicine. He refused our help and then blamed us for failing to help him. Underneath this game is the same fear that the patient who will not complain to her doctor has: that you don't care about me, you will not respond to my needs. Therefore I have built a wall around myself that is impermeable. The interventions with such individuals must include a patient expression of your care and concern for them. This expression of concern does not condescend or dismiss the accusations. Instead, it affirms that you can appreciate their anger and you still want to respond to their needs. Another possibility, especially when the patient or family's refusal of help is indirect, is to bring the refusal of help into the foreground by asking the patient to express the refusal

openly, or even exaggerate the refusal in order to assist bringing it into awareness.

Contact

Represented in the earlier diagram by the circles that touch each other, but also are separate, *contact* is a quality of relationship that is both more complex and healthier than confluence or isolation. In contact, the individual can support relatedness and individuality at the same time. Contact is a sense of knowing oneself as an individual with individual preferences as well as being closely related to others. It is a sense of being related to the people in one's field without being either alienated from them or engulfed by them. Contact is the quality of relationship in which the patient in the care-giving – care-receiving field is neither a tyrant or a victim; where the care-giver attends both to her ill loved one's needs and to her own limits. In contact there is a permeable boundary that defines and distinguishes me but is open to you. I do not abuse or neglect you nor do I disempower myself from getting my needs met.

Paradoxically, contact is at once more complex and simpler than confluence or isolation. It is a more complex boundary to maintain because I am taking in much more information both from my own experience and from my experience of the others in my field than if I am isolated or confluent. On the other hand it is a simple way to relate in the sense that it is efficient. Action, in the context of healthy interpersonal contact, will tend toward maximal meeting of everyone's needs. Issues tend to be resolved quickly and without undue anger in systems that tend toward good quality contact.

An example of the contactful family is the family that is appreciative of what the hospice team does for them, and lets the team know when there are things that the team may have missed, or were not aware of. These families will likely be able to express their emotions to each other and will

have a greater capacity for relatively unambivalent care-giving, care-receiving and love.

Boundary disturbances

Now we can move on from the styles or tendencies of boundary making to the boundary disturbances. These are interpersonal patterns by which we avoid contact. These are analogous in many respects to the psychoanalytic concept of defense mechanisms. It should be noted that we all engage in all of these boundary disturbances to varying degrees. The goal is not to eliminate the boundary disturbances in ourselves or our clients, but to promote awareness. In so doing, we may assist our patients in making conscious choices of how they deal with boundary issues, rather than dealing with them outside of a conscious awareness of their own process.

The boundary disturbances are: *introjection*, *projection*, *retroflection*, *deflection* and *confluence*.

Introjection

Introjects are attitudes, feelings and 'shoulds' that the individual has taken on without sufficient differentiation as to whether these are really true for herself.

For example, an introject may be a statement like 'I should always be extremely well prepared when I give a talk'. Now on face value this probably sounds like good advice, and something your mother might have told you as helpful advice. However, it can become problematic to leave that introject unexamined, particularly if it has also come to mean something quite severe such as 'any talk I give must be perfect'. Then I just may never give a talk in order to avoid this introjected admonition. In this example, there is insufficient boundary between my mother's advice around giving a talk and my own approach to the same issue.

With the introjector, we help her to make a boundary

between what is expected by others and what she expects for herself. In hospice work, we see introjects very frequently. For example, I worked in an HIV support group with a client who contracted HIV through having sex with a prostitute. He had introjected the value that he was not worthy of emotional support, because of his self-judgment of his behaviour. When the group confronted his introject that those who engage in high-risk behaviour are not worthy of emotional support (which turned out to be a derivative of childhood injunctions against masturbation and sexual enjoyment) he became aware of the introject and its origins. He eventually developed the capacity to see himself as worthy of the support of the group.

Projection

The projector is unaware of some of her own thoughts and feelings. When she has a feeling that she is not 'owning' as hers, she may become intensely aware of this feeling in others. At times her fantasy about how others feel will have more to do with her own disowned feelings than about how they truly feel.

For example, the mother of a hospice patient may feel very angry at her son for having contracted HIV by using IV drugs. Seeing herself as a good mother, however, she feels that she should not be angry at her dying son. So she takes the hospice worker aside and tells the hospice worker that her husband is seething with anger at her son, and that in turn makes her feel distant from and angry at her husband. In this instance the mother is projecting her anger onto her husband. While the husband may indeed feel some anger, the issue for the mother is that she experiences her own anger through the boundary disturbance of projection. The work then with the projecting mother is to help her experience her own disavowed feelings without unduly harsh self-judgment and to help her separate out her feelings from her actions. In this case, she could own

her anger at her son while continuing to act in a loving and gentle way with him. The need is not necessarily to express the anger directly to the patient so much as it is to acknowledge and feel the anger within herself; to be honest with herself. Then she will not need to project the anger onto her husband. If she stops projecting her anger onto her husband, she may in fact find more support from him, which may in turn decrease her feelings of isolation and lessen her anger at her son.

Retroflection

The boundary disturbance of *retroflection* is a turning of one's energy against oneself. Retroflection describes those times when an action or feeling that would most effectively be directed outside of the self is instead aimed at the self.

I have seen the following retroflection in hospice work: an AIDS patient was rejected by his parents because of their prejudice against his homosexuality. The man with AIDS was angry at himself for being gay and identified with his parents' critical judgment of him which he then translated into self-hate. The work with the client with the boundary disturbance of retroflection is two-fold. First, the therapist's acceptance of the client is essential. Secondly, the client needs support in expressing his anger about those people he is really angry with. Frequently in retroflection there is identification with the aggressor and a consequent self-hatred. In this case, the healing required a process of creating a boundary between the way this man's parents viewed his sexuality and his own experience of it. The healing also required him to experience the anger directed appropriately at the parents rather than directed inwardly at himself.

Deflection

I use the boundary disturbance of *deflection* when I act as though the contact attempted by another toward me did not

occur. As clinicians, we are sometimes being deflected when our comments are not responded to.

For example, the therapist asks a patient whether her husband has been abusive to her, and she responds with a complaint about her mother-in-law. This may appear to be responsive to the question, but it is of course a response to another question, one the therapist did not ask. The therapist relies on her clinical judgment as to appropriate timing, but generally will want to bring the client back to the material that is being deflected. So, in the above example, the clinician might say to the client: 'I noticed when I asked about whether your husband had been abusive to you, you were reminded of your mother-in-law and I'm interested in what you are saying about her, but I'm also interested in whether your husband has been abusive, so let me bring you back to the question about abuse. You know, you don't have to tell me about it. It's up to you.' She may respond by telling the clinician about abuse or that she is not ready to talk about it. In either case, the interaction has been made more contactful, and the client may feel more safe next time talking with the clinician about it.

Confluence

Confluence is the last of the boundary disturbances, and we discussed this phenomenon earlier in our discussion of boundary styles. Confluence can be seen as both a boundary style and a boundary disturbance. Confluence again is the contact disturbance of enmeshment in which self and other are not sufficiently separate and autonomous.

The care-giver – care-receiver field

Let us use the Gestalt therapy approach to boundaries to assist in understanding the care-giving – care-receiving field. In hospice work, the most obvious thing we observe is that the situation is very dynamic and is in a state of

constant change. The patient's medical situation is in constant change and relationships within families are also subject to change. So, we begin with the supposition that within a dynamic field the boundaries between individuals in the field must be equally dynamic. Today, respect for the patient's boundaries may mean that the care-giver essentially leaves the patient to her own devices and gives her the space she desires. Tomorrow, it may be appropriate for the care-giver to give the patient an enema, bathe and feed her. There can be no fixed rules for making appropriate boundaries.

Because the hospice patient has a generally declining state of health, she becomes increasingly dependent upon care-giving to maintain her life functions. This means that previously observed, once-appropriate boundaries will have to be crossed. Just when the boundary is moving inward on the patient in the sense that others must do for her what she once did for herself, she is beset by other problems such as inability to talk and inability to move. When the patient loses the capacity to set boundaries with her care-givers as she becomes increasingly weak, unable to articulate her needs, and unable to act on her own behalf, the maintenance of respectful boundaries becomes an exquisitely delicate dance between care-giver and care-receiver.

Hospice professionals are constantly responding and making decisions between two ends of a polarity. At one end of the polarity is patient autonomy, at the other end is patient safety. The boundary is always shifting depending upon the patient, care-giver and hospice team's perceptions of how much autonomy the patient needs as opposed to how much safety. For example, at one point in time the hospice team may not get involved if a patient is refusing to take her medications, knowing that she is doing so of her own free will and is cognizant of her choices. At another point in time, the team may decide that she is no longer capable of making an informed decision about whether to take her medication and may exert more influence on her.

This increased pressure on the patient will represent a necessary shift of the boundary away from patient autonomy toward patient safety.

I have found judgment calls involving patient autonomy versus patient safety to be a source of conflict not only within families but also within the interdisciplinary hospice team. Each hospice professional brings her own style to bear on how to make these important and difficult decisions. Such decisions sometimes carry life or death consequences for the patient. When the interdisciplinary hospice team is contactful with each other, the feeling in the team may evolve from a tenor of mis-understanding to one of mutual respect. In the spirit of contact, the team may place great value on the give and take that occurs between hospice professionals as they decide where to draw the boundaries at any given time in the care of a dying patient.

A parallel situation occurs within families when one member wants more patient safety and another member wants more patient autonomy. Sometimes families become divided around issues of patient safety and autonomy. Frequently family members on each side will attempt to win the hospice professional over to their point of view. In such situations it is frequently helpful for the hospice professional to step back and take a broad view of the whole care-giving – care-receiving field and to promote communication between those with differing views and values. The hospice professional may help family members appreciate that within the polarity of patient autonomy versus patient safety, judgment calls about boundaries will need to be made continually as the situation changes. It will be necessary to respect each individual's point of view and to work together to make the tough calls.

Conclusion—Gestalt therapy theory and practice as a support for the hospice professional

Gestalt therapy theory and practice can lend the hospice professional a great deal of support for her challenging work.

First, the Gestalt approach does not seek to change the client; instead the emphasis is on awareness and self-acceptance. This emphasis fits nicely with the hospice approach in that we work toward patient and family acceptance of the dying process rather than toward cure. The hospice's emphasis on the patient's dignity is also well supported by Gestalt therapy which emphasizes an equal, non-authoritarian relationship between therapist and client. Gestalt's 'here-and-now' emphasis is especially useful in working with people who know that they have a very limited time to live.

The emphasis in Gestalt work is on the here-and-now experience between therapist and client. Fritz Perls would say that Gestalt therapy can be summed up as the practice of 'I and Thou; here and now'. With the spotlight focused on present experience, boundary issues become a major focus of the therapy, for boundaries are always being established in the context of the field in the here-and-now.

Gestalt's attention to the field or family system in which the patient operates gives support to intervening at a variety of different levels, whether this means working with the patient, family, hospice team or even broader social service and medical systems, all with the goal of fostering support for the patient and family. This is support that neither suffocates with over-control nor isolates with benign neglect. Instead, it is support that gives priority attention to the ever changing needs that determine where boundaries are to be drawn in the here-and-now.

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