A process theory of physical illness: medicine and psychotherapy[1]

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πάθη λόγοι ἔνυλοί εἰσιν[2]
Aristotle, *De Anima* I,1,10, 403a, 25

1) Introduction

The central theme of my paper concerns *the influence of psychological factors on the onset, the maintenance, and the cure of physical illness.* I try to found this theoretically, and with research findings. A process theory is a model that is broader than the mere physical explaining of becoming and being ill and of healing, it is a model that involves the role of the psychological.

First I want to say: The core concept of the theory is the coming together of what Gendlin (1997a) calls the old model and the new model. The old model of thinking is: Everything is separated into units; this thinking begins with the units. The new model tries to understand everything not in units but in process terms, for example: implying and occurring. Gendlin shows how the two models go together as old-model-thinking-*in*-new-model-thinking.

We will speak about the body as object (which is an example of the old model) and about the body as subject (the experiencing body, example of the new model). Both must have a place, they must find a place in a unity, namely a unity of body-object-*in*-body-subject. Ideally cure is the result of this unity.

In his book *Phenomenology of perception* Merleau-Ponty (1970) distinguishes 'le corps objet' and 'le corps sujet', the body-object and the body-subject, the objectified body and the experiencing and experienced body. He devotes a chapter to "the body as object and mechanistic physiology" (Merleau-Ponty, 1970, pp. 73ff.). He writes that I can only have knowledge of the body-subject "by abandoning the body as an object and by going back to the body I experience at this moment" (ibid., p. 75d). The body has "intentionality and sense-giving powers" (ibid., p. 174). He also calls the body-subject the phenomenal body: "(T)he objective body is not the true version of the phenomenal body (…), it is indeed no more than the latter's impoverished image, (it) (…) exists only conceptually" (ibid., pp. 431-432). The body-subject is prior, it is the real body; the body-object is an abstraction of it.

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[2] A possible translation could be: *Experiences are 'words'-in-matter*. Or: *Sufferings* (the word 'pathos' is in 'patho-logy') *are 'words'-in-matter,* in the body. Sufferings are not just in the body, they are 'words'-in-the-body.

The ‘two bodies’, so to speak, are the product of two approaches. The body-object is the body as it is seen by the objectifying view, the view of classical medicine. The body-subject is the body as it is seen by the subjectifying view, what is the matter in psychotherapy.

2) Two approaches to the body

Medicine looks at the body as an object, in the same manner as it looks at a machine. A first remark to make here is that a body seen as purely a mechanistic object cannot fall ill, because an object cannot fall ill. So to think illness there must be more. A second point is that in this object-model everything is separated in parts and subparts. These parts - separate units - can interact with each other. Air and lungs are two separate things; they can interact with each other, but the relation they have is external (just like the components of a machine do not have from themselves a relation with each other). Thinking this begins with the units. It is mechanistic thinking. This approach to reality is very successful: without mathematics and physics and logic, one could not build machines like airplanes and computers. In the object model one has a complete understanding of something if one can take apart every component of it and then put them together again (Gendlin, 1999, p. 232).

But if we would do this with living organisms and with the human organism they would die, because the interaction-first relation that the ‘parts’ have with each other would be taken out of it, life would be taken out of it[3]. So they cannot be understood well in this object-model. They need another approach, another kind of thinking where not the units are first but the interaction. Their being-in-interaction precedes the parts or the units: It is an interaction-first thinking or a process thinking. The products of the process come in second place: the cells, the skin, etc. We can look at them as separate units, as made entities. But the making itself, the process is first. *Without being involved in the process and subprocesses they cannot even exist; in fact they àre subprocesses.* For example, breathing is air-coming-into-expanding-lungs; air-coming-in and expanding-lungs cannot be separate, they are inextricable, *they can not even exist as units*. The relation they have is internal, inherent; they have *from themselves* a relation with each other. Process thinking tries to understand an event before any separation. So it sees the environment not as something separate from the body and not as something around the body, but as something participating within the living body (environment-2; Gendlin, 2018, p. 4). In the same manner *organs cannot exist as units, they can only exist as interactions.*

The new model sees the process first. A process or an organism has an own implying, it implies its next moment. Also a machine implies a next moment but this is not an *own* implying but an implying that is externally put in it (it is switched on and off). The process

[3] The old-model-relations (between entities, external) that the parts have are not taken out, but the new-model relations do (the relations they have from themselves, internal).

approach shows the crucial difference between an object and an organism. This difference returns in the difference between the human body considered as object and the human body considered as subject; later we will see how both of these can go together in a particular way.

So far the difference between an object and an organism. Now medicine.

3) Medicine and the body

Medicine approaches the body as an object, in which different parts and subparts can be seen, organs that interact with each other and with the environment. This consideration remains at the level of the objectified body, the physical level, the level of the ***tissues***, tissues conceived as very complex objects. The physical body can become ill and can be cured. This medicine is very successful; for example in discovering many effective drugs. Also Gendlin (1970b; 1986, p. 135) defends the combination of psychotherapy with pharmacotherapy when necessary.

But a human being is ***more than tissues***; and tissues are more than objects (see below). We are tissues (plant bodies), behavior (animal bodies) and symbolic processes (human bodies). More precisely we are tissues and tissues that become behavior, we are behavior and behavior that becomes symbolic processes/experiencing (Gendlin, 1991, p. 130). We are all this at the same time, in one event. "For instance, when we write or speak, our bodies imply (and carry forward into) the next bit of muscle-tissue process, which is also the behavior of our hands or lips and vocal cords, and also the next words" (Gendlin, 1991, pp. 130-131). In this example you already see how the body object (the muscle process in my writing hand) and the body subject (the meanings that I write down) are inherent in each other. And you see that there are three levels – tissue, behavior, symbolic - inherently connected with each other; psychotherapy is situated at the symbolic level.

For example, when the doctor gives medication, he[4] doesn't give it to a body-object that is separate from the environment, although many think doctors they do; they only see the physiological and pharmacological aspects. A medication is not given to a sick brain or sick lungs or sick intestines but to an organism-in-interaction; interaction at the three levels. The effect of the medication is not only determined by physiological variables but also by interactional variables at the three levels, which in addition function inherently in each other. An old example given by Gendlin (1973, pp. 330-331; 1997a, p. 387): LSD administered to somebody in isolation causes a 'bad trip'; the same product in the same dose given to the same person but in an environment with friends in a nice and cosy atmosphere may bring on a 'good trip'. To evaluate the effects of an antidepressant, the interactional circumstances in which the person lives must also be taken into account. To work only with the variables

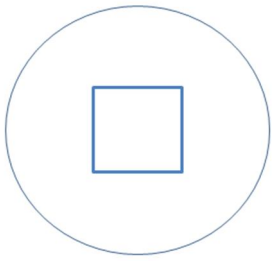
[4] 'He' can everywhere be substituted for 'she', 'his' for 'her', and 'him' for 'her'.

‘drug’ and ‘physical body’ (body-object) is insufficient. This is understandable from an interaction-first process conception of the human being as a being-in-interaction with its environment *on all levels*. It makes clear why effective change involves a psychotherapeutic component, in particular why psychotherapy can ameliorate the effect of certain psychoactive drugs and conversely why certain psychoactive drugs can ameliorate the effect of psychotherapy (Gendlin, 1970b; 1986, p. 135).

A human being is more than tissues that can become ill and can heal. First of all a human being is a subject: I *am* my body, I am a body-subject. Becoming ill is not merely something of the tissues but something of the whole person. When I get a physical illness how is the súbject in this becoming ill and in healing? What then is a súbject’s becoming ill and becoming healthy? These questions are forgotten. So it seems that we have to take back the body-subject. And to bring it in relation with the body-object. In which way? The body-subject is the wider body, the body-object is derived from it. The body-subject really exists, the body-object exists only conceptually, as Merleau-Ponty (1970, p. 432) says. The two can be seen as separate but in fact they are inseparable. They are two views on one and the same body.

Body-object and body-subject are only two in our conceptualisation, in reality they are one. For example, I am in the kitchen, I have not eaten for a long time and I am hungry but suddenly some very bad news comes in and my hunger disappears: it is the same body standing there in the kitchen with meanings overruling the physiological processes.

Both views of the human body are necessary and they are not independent from each other. We can visualize them as follows: a square area surrounded by a wide circle area.



The square area is the ‘straight’ approach of the body as object (there you have: units first, mechanistic, objectifying, the sick body, the purely medical approach). The circle area[5] is the ‘whole’ approach of the body as subject (interaction first, process first, life, subjectifying, the sick person, the psychotherapeutic approach). Because the human body is first of all a body-subject and the body-object thus a reduction of it, *the circle presents the wider area*

[5] The circle area contains interaction-first, life, process, implying; and this in a hierarchy: as plant (tissues), as animal (behavior), as human being (symbolic processes).

encompassing the square area[6]. We have to consider their unity as body-object-*in*-body-subject (an example of old model-*in*-new model).

So why is a process approach necessary to think the human body and illness?

The body-object does not exist on its own, it only exists within the body-subject. To *understand the fact that it lives and that it can fall ill we need* more than units-first thinking, we need interaction-first or process thinking. *The body-object exists only within the life area*, the area where it is not possible to take apart every component of it and then put them together again. It exists only as the square area-within-the circle area.

4) Research data

Before we continue let us look at some research data. Theory and empiricism must go together (Kant).

I did a search in the medical literature for studies that may support the hypothesis in this paper. I don't have the means and the time for a systematic search. But still I collected more than 200 studies. I cannot present here all the data I have found, just a few examples.

We search for an answer to the question: can meanings influence the physical body, can they influence processes which in the common view are merely physically determined? It appears to be so. For example a significant date may have a meaning leading to the development of a physical illness; a woman may suffer not only psychologically but also physically when she comes close to the anniversary of her aborted fetus (Philips et al., 1992, p. 540).

More precisely our question is: can blocked meanings influence becoming physically ill, and can free meanings influence healing?

4.1) I wanted to find data that support the hypothesis that ***psychological factors may have an influence on the onset and the development of a physical illness***.

There are some research findings:

- After a history of a traumatic experience there is 20% more risk to symptoms of angina pectoris, heart failure, or a stroke (Spitzer et al., 2009).
- The psychosomatic factors alexithymia, type A behavior, irritable mood and demoralization have an influence on certain physical illnesses (Porcelli & Rafanelli, 2010).
- A pessimistic explanatory style of a person appears to predict poor physical health at ages 45 through 60 (Peterson et al., 1988).

[6] Also the tissues need the circle area (life, interaction-first; the cells cannot be taken apart and then be put together again; also tissues are interaction). And tissues, behavior and human symbolic processes are inherent in each other (see above: example of writing; see below: I am cancer-ill).

- Insecure attachment is found to occur frequently in patients with primary hypertension, almost twice as frequent as in non-clinical individuals (Balint et al., 2016).
- The meaning of an event can be so overwhelming that it causes sudden death. During the first days of the Gulf war in 1991 there was a sudden rise in the incidence of acute myocardial infarction and sudden death (Meisel et al., 1991). On the day of the earthquake in Northridge (California, 1994) there was six times more sudden death than the days before or after (Leor et al., 1996). Acute serious emotional stressors can elicit stress-cardiopathy, a sudden transient systolic and diastolic dysfunction of the left ventricle in a symptomatology that resembles but is not a myocardial infarction (Templin et al., 2015).
- A recent and large study concerning almost 164.000 patients shows that psychological distress leads to an increased risk of death by cancer (Batty et al., 2017). In a couple after the death of his wife the husband's probability of dying increases by 25% (Helsing et al., 1981; in Ray, 2004 p. 37).
- In an experiment rhinoviruses were dropped in the nose; the result was an infection (common cold) if the perceived stress was high, but no infection if it was low; the same with stressful life events (Cohen et al., 1991). A similar and recent study showed the protecting effect against this experimental infection of social and affective support (Cohen et al., 2015). So 'mental factors' play a role in the development of or the protection against this physical disease.

4.2) Research data shows that ***psychological factors may have an influence on the healing of a physical illness***

In my search I also wanted to find data that support the hypothesis that *psychological factors may have an influence on the healing of a physical illness.* 'Psychological factors' must be broadly understood here, I mean: positive experiences, elements of psychotherapy, psychotherapy.

Several studies show that a personally important date or occasion - important in the sense of getting attention, being at the center of attention – can have a strengthening effect on the will to live and can result in the person 'postponing' his or her death until after that date (Ray, 2004, pp. 37-38).

There are studies that show that psychotherapy or elements of psychotherapy can change gene-expression in a way that it has a positive effect on physical health. I cannot elaborate this here, but here are some references (Rossi, 2004; Feinstein & Church, 2010; Muehsam, 2017).

Psychotherapy or elements of psychotherapy can have a positive effect on the immune system. Writing therapy can lead to positive changes in the immune system (Frattaroli, 2006), and the more this writing is experiential the greater this effect (Lutgendorf & Ullrich, 2002, p.

185). This means that working at the level of meanings and meaning-unfolding (which is the area of the body-subject) can have an effect on the body-object. Some people may think: we can act directly on the body-object, and introduce these changes in the immune system with medication. But then the whole process of the body-subject is left out, because then the writing and the unfolding of meanings by this writing has not been able to take place, which is a process for which the body needs language or another symbolisation. *It is an error to think that a pharmacological intervention and a psychotherapeutic intervention can lead to the same effect*. If meanings cannot develop a fundamental occurrence is left out.

In a meta-analysis of 34 Randomized Controlled Trial-studies about the influence on the immune system of "mind-body therapies (MBTs), including Tai Chi, Qi Gong, meditation, and Yoga" Morgan et al. (2014) conclude that "MBTs may reduce inflammation [thus a physical effect: FD], particularly among clinical populations. In addition, a few high quality studies suggest that MBTs may increase virus-specific, cellmediated immunity at rest and in response to vaccinations" (pp. 10-11).

There is much literature concerning the effect of psychotherapeutic elements on illnesses in diverse organ systems. I will give only examples in the area of cardiovascular illnesses.

One study shows that transcendental meditation (a mind-body intervention) with patients with heart failure can lead among other to a significant amelioration on the 6 Minute Walk Test (Jayadevappa et al., 2007); thus an effect in the physical area. A similar result is obtained with Tai Chi as meditation technique (Yeh et al., 2004; 2008).

In their consensus of what is good clinical practice German cardiologists (Albus et al., 2014) write that psychosocial factors must systematically be screened and must be addressed in the treatment. What concerns the treatment, "psychosocial interventions have shown positive effects (…) partially also on the cardiovascular morbidity and mortality" (ibid., p. 598Ac); this means that they have - next to the mere medical treatment – a positive effect on the physical area. According to them the doctor himself must also have a psychotherapeutic mentality for the patient. He may offer 'psychosomatische Grundversorgung' (basic psychotherapy).

In the consensus (Ladwig et al., 2014) of the German Society for Cardiology (Deutsche Gesellschaft für Kardiologie, DGK) a class I evidence level A (IA) recommendation (the highest level in evidence based medicine)[7] is given for the need to look at psychosocial risk factors in the evaluation of coronary risks. The same high recommendation is given for the need to integrate routine psychosocial counseling for patients who undergo heart surgery.

Now the question is: How can we understand these data?

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[7] Class I: there is evidence and/or general agreement that a given procedure or treatment is useful and effective.

Level of evidence A: recommendation based on evidence from multiple randomized trials or meta-analyses. (Ladwig et al., 2014, p. 3).

4) Meanings and the body

We can have an effect on the body via both areas. *Not only physical and chemical factors* (square area) *but also meanings* (circle area) *have an effect on the body*. That meanings have an effect on the body is well known.

But how can we understand that meanings can have an effect on the body? Another question to approch this issue is: How does the body create meaning? Meaning is generated in the interaction-first event of body and situation.

With most small daily things the processing of meanings occurs smoothly, without focusing: "most of life and behavior proceed on implicit meanings" (Gendlin, 1970a, p. 140a). But sometimes it doesn't occur smoothly. Then we have a problem and we need direct reference and let a felt sense form. The body forms meaning and can develop it to a felt sense and 'resolve' it in a felt shift and an explication. This is meaning-processing with focusing. We will see that this has an effect on the physical body.

4.1) Healthy influence of meanings on the body

So, let us look first at the event of a héalthy influence of meanings on the body and a process explanation of it. How the body-subject initiates meaning, and can then develop it to an implicit meaning, and can 'resolve' it in a felt shift (*three moments of the experiential change step*) hàs an effect on the body-object. We all know this: we are touched heavily by something happening in our neighbourhood and we feel this also physically in our body. Or, when something meaningful gets a solution we feel a bodily relief. In fact there is already a small bodily relief with the formation of the implicit feeling, and there is a big relief with the felt shift.

The process event of an experiential change step - an event of the body-subject, in the circle area - has an effect on the body-object; namely it has physical effects which can be measured and objectified. So it has physical effects; but it cannot be reduced to these, *because merely a body-object cannot have such a process.*

Experiential theory and practice have shown that the moments of meaning formation and bodily relief are crucial for a psychotherapeutic approach to be effective. Psychotherapeutic interventions are directed to the circle area, namely the field of the body-subject, and this encompasses the body-object, in fact it is the same body. We see here that a psychotherapeutic effect on the body-subject *is* an effect on the body-object.

4.2) Ill-making influence of meaning blockage on the body

We have seen how meaning is processed without and with focusing, and we have seen the healthy – relieving - influence of it on the body. Now, what happens when meaning-processing doesn't succeed, when the implied process (the implied steps or the intentionality) cannot go on, and what is the effect of this on the body? Let us look at the event of an ill-making influence of meaning blockage on the body and at a process explanation of it.

4.2.1) 1-, 2-, and 3-manner

First, let us look a little bit closer at the three moments in the meaning-processing.

Before the person lets an implicit feeling of a problem form, the meaning that the problematic situation has for him is in some way already 'in' the body. Already something meaningful has happened, already some meaning-processing has been initiated. This is the moment of the process before the implicit meaning, namely when the body is affected by the situation, but the person may not be aware of it or may not pay attention to it. The person may not know *that* he is affected. The person is not yet focusing and does not yet have the implicit meaning; he may not yet have a knowing *that* he is affected, let alone about what the being affected has to do: the person does not yet have the being affected as a 'something' or as an 'it'. We could call *this manner* in which the body is meaning pre-implicit or unconscious (in the sense of not knowing that he is affected). This manner can stay there blocked for a long time, if the person does not let an implicit meaning of it form. It stays there as meaning *tendency*. This is the first manner in which the person 'has' or rather *is* the problem; let us call it the 1-manner.

When the person directs his attention to it and the direct referent forms, then he has the problem as an implicit feeling (the 2-manner). This is a further forming, the meaning tendency is formed further to a meaning, it becomes an implicit meaning. And, after the explication of it the person has the problem in the form of a solved problem (the 3-manner); then it is incorporated or 'dissolved' or integrated in the freely functioning implicit experiencing. We also can name these three moments of meaning processing by the body: meaning tendency, implicit meaning and explicit meaning.

What has not yet become implicit and remains in the 1-manner - i.e. what has not yet come in his conscious attention - still is unconscious (see above). Here we can put the words of Aristotle πάθη λόγοι ἔνυλοί εἰσιν and understand pathè more precisely as 'meaning tendencies' which remain in the body (in hulè, in-matter) and thus bring on suffering (pathos), suffering which you must try to get out from with words (logoi). In that sense pathè are meaning-tendencies or 'words'-still-in-matter.

4.2.2) What remains in the 1-manner expresses itself in the body-subject and in the body-object

Some meaning processings don't succeed or take a long time, sometimes the 'painful area' remains for years. This will express itself in the body-subject and lead to structure-bound behavior patterns (Gendlin, 1970a). Instead of succeeding to form and to process an implicit feeling (direct referent), the person doesn't come to that or keeps avoiding that and falls always into the same 'slot' of behavior, in the same repetitive pattern.

When the processing of meaning remains in the 1-manner of the body-subject, this will also express itself in the body-object. "The unconscious consists of the body's stopped processes, the muscular and visceral blockage" (Gendlin, 1970a, p. 162). "The unconscious is the body" (Gendlin, 1973, p. 333). For, when the meaning processing *goes on* in experiential change steps which – as we have seen above - express themselves in physical and physiological changes, then it is easy understandable that the *not going on* also will express itself physically.

4.2.3) The body can express its psychological dysfunctioning (its 1-manner) *as a whole* or *in a certain area*

When a meaning tendency remains unprocessed, then this is often clearly registered in the appearance of the person, for example in his facial expression. Or it may be felt in an inner sensation: A frightening situation may give the body a feeling of being enclosed; such an experience is often literally translated in a constricted feeling in one's chest. Sometimes we can take it very literally that meaning is a formation of the body indeed: it can be translated physiologically, for example a person 'in' migraine or 'in' asthma (bronchoconstriction and wheezing) experiences a torment or a squeezing. It looks like *somehow* and *somewhere* the body assumes the form of the manner in which the situation is a problem for the person.

The body can express its psychological dysfunctioning *as a whole*. This is the body as "monument" (Gendlin, 1978b, p. 73) of its problems. Gendlin (1978a, p. 343) writes: "Every moment the person's body is like a monument, a statue, representing the situations that are wrong in its twisted-up inward muscles and stomach tightness". Here is a good place to mention Whole Body Focusing for experiential work with 'the body as monument' (McEvenue & Fleisch, 2008; Fleisch, 2008).

So the body as a whóle may express its psychological dysfunctioning. But in the quote Gendlin also mentions 'stomach tightness'. So often it seems that the psychological dysfunctioning (we can also call it blockage of the intentionality: see further) takes place in

the sense of ‘takes *a* place’ *in a certain area* of the body. The lungs, for example, in asthma. Another example is a blockage of the hand, in not being able to put one’s signature on something. This blockage is not physically caused by an anatomical defect or a paralysis. The blockage is physical but it is mentally or psychologically ‘caused’. But we cannot conceptualize this causation as that the mind uses the anatomical hand to be able or not to be able to put the signature, because then we are again in the dualism. No, just like the body-object is not used as instrument by the body-subject but also *is* the body-subject, the hand is not the instrument of the mind, the hand is not the means that is used by the mind, the hand *is* mental. The hand is not the means that is used by the mind, the hand is im-media-tely mental.

So also the hand is mental when the signature does succeed. Here we also think of Merleau-Ponty’s (1970, pp.144) example where he says about the capacity of touch-typing (blind typing): “It is knowledge in the hands”. *The hand is part of the mental, or the hand participates in the mental, in the intentionality.*

So the blockage of the intentionality may seem to take a place in a particular area of the body (a member, an organ). The meaning cluster which searches for expression remains blocked and this 1-manner ‘centers’ itself as it were in the stomach, or in the hand, or in the skin (example below) for example. I have collected a lot of research which shows that psychological factors partly can lead to physical illness.

I didn’t find research about a *specific* meaning blockage which leads to a particular kind of physical illness. As a matter of fact such research may be impossible because we have to be careful about the danger analogous to that which exists in dream interpretation, namely that one links a fixed meaning to a particular dream image (Gendlin, 1977). We must be careful not to link a blocked fixed meaning or meaning cluster to a particular body part and its physical illness. After all an experiential meaning is unique for the person and for the moment.

Nevertheless one sees how the psychological, the body-subject can play a role in the development and the healing of the physically being ill of a particular body part or organ. For example patients with alopecia areata (AA) (hair loss, in particular spot baldness or bald spots on the scalp) reported twice as much psychotraumas than a control group of patients who consulted for skin surgery (Willemsen, 2010, p. 537; see also Willemsen et al., 2009). This is research by a dermatologist who integrates hypnotherapy in her treatments. In a pilot study of patients with extensive alopecia which remained resistent to the usual medical treatment a number of hypnotherapy sessions was added to this treatment, with the result that 12 of the 21 patients showed significant new hair growth.

5) What can we learn from the circle area about physical illness?

What can we learn from the circle area about physical illness? Let us do an exercise. We can start an ***understanding of a physical illness from a process theory viewpoint*** with the following question: What do we see when we look at a physical illness through the circle area? Because that illness is also in the circle. Looking through the circle at a physical illness we look at it through the facets of the circle area: life, interaction-first, subject, being, intentionality, situations, meaning, therapy directed to 'being a physical illness', etc.

In the circle we find a subject. And, subject is being, not just having. The experience 'I have a cold' is different from the experience 'in a certain way I am a cold': I'm ill with a cold. When I have cancer 'in a certain way I am cancer': I'm ill with cancer (as it is said in English). *Having cancer is also a specific being*. Language itself says it; spontaneously we say: "I am ill" and not "I have an illness".

Illness *is* something of the circle area. The body seen as purely mechanistic, as purely an object, cannot fall ill. This is because an object cannot fall ill. Therefore we speak of body-object-*in*-body-subject, before the split. In considering physical illness we cannot but start with the circle area. Only in the circle area we can fall ill. Here we must see two things. First, tissues are also in the circle area because they are embedded in interaction-first processes (in life processes). And second, in the circle area tissues, behavior and symbolic processes are inherent in each other (see above: example of writing): a change in one is a change in the other two (Gendlin, 1991a, 129-131). The body is not merely physical tissue process but it is also psychical through and through, this means it is experiencing through and through. And the psychical is not merely mental but it is physical tissue process through and through. It goes in both directions. This means: when there is a mental change then this has an effect on the tissue process (see also Gendlin, 1973, p. 335). This is why the body-subject who *is* ill with cancer may benefit from psychotherapy (which belongs to the symbolic level) also in its tissues, as well as needing chemical and radioactive means to improve.

Another example, chronic obstructive pulmonal disease (COPD). 'I have COPD' versus 'I am COPD'. People with COPD have very deep difficulty in breathing. For these patients it is not that their lungs are ill while as a subject they are healthy. It affects their being; their way of living has deeply changed. Next to the physical facets of the disease in a certain way they *are* COPD. Just as the hand in the example above is thoroughly permeated with mind, here the person's being is thoroughly permeated by the physical illness. This is an example of: ***a physical illness affects the being of the person***.

Beside looking through the circle at having and being the illness, it may be interesting to look through the circle for causes and for treatments. Research shows that interventions directed to the body-subject may be effective for some physical manifestations of COPD.

A meta-analysis of 20 studies (Farver-Vestergaard et al., 2015) found that mind-body interventions such as mindfulness based therapy, yoga, and relaxation in COPD can have a positive effect on physical manifestations of the illness such as lung function, dyspnea, exercise capacity and fatigue. By the way, for these physical outcomes *only the results of the mind-body interventions were statistically significant*, not the results of CBT.

Now alopecia areata: We are used to look at it only through the square area. But if we look at alopecia through the circle area we find suffering at the subject level, we find trauma in the history, and we find a positive effect on it of hypnotherapy. This is an example of: the being of the person affects the physical illness: ***the being traumatized correlates with or partly causes the physical illness, and therapy of the trauma ameliorates the physical illness.***

It would be a challenge to do this with any physical disease, and so to discover that many of them are more than mere a physical disease. With some diseases this exercise will be rather easy, with other it will be very difficult.

6) Two areas, two orders: How are they together?

We see the two areas and what happens in them. What is the relationship between the two areas? Alopecia is shown here as an example of the body-object *and* the body-subject going together. We want to understand this going together and find a way of using both of them; we will see that this will be a back and forth.

They are two ways of approaching the same person in his being ill, an objectifying approach and a subjectifying approach. Seeing the human body as body-object *and* body-subject, is an example of units-first thinking and process-first thinking going together.

First let us look theretically at this going together along the following steps.

1) Process is *first*, units come from it.
2) Interaction-first thinking is prior to units-first thinking, but *both are important.*
3) The two *help each other* to make progress. For example, applying concepts and techniques in psychotherapy can be helpful but always happens in reference to the implicit layer in the client.
4) Both are important, not separate as two next to each other, but *in a unity*: old-model-in-new model. For example, the sentence: "Since implying implies a next occurring, and since occurring changes implying, therefore implying implies a change in implying" (Gendlin, 2018, p. 12). Both are in the sentence as a unity: The sentence is logically correct, while the content is process language.
5) Both the order of units and the process order must work together *in a back and forth.* "We understand a difficult text better after reading it many times" (Gendlin, 1997a, p. 399), thus by going back and forth many times between the text and our understanding. The explicit

side remains fixed but the implicit load is growing. "(H)uman beings can be understood by moving back and forth between the logical and the responsive order" (Gendlin, 1997a, p. 384). Let us paraphrase the sentence to: Sick human beings can be understood by moving back and forth between the logical and the responsive order. This is a core point of this study.

6) When we speak of back and forth, then the next question is: When and how do the *transitions* come?

7) Medicine and psychotherapy becomes medicine-*in*-psychotherapy

7.1) Body-object-in-*body-subject: example of old model*-in-*new model*

All this shows how the old model and the new model can go together. Now, how do the body-object and the body-subject go together?

Above we have considered physical illness through both the square area and the circle area. We have tried to show that in illness body-object and body-subject are one, a unity where the body-subject has priority, thus a unity that we have to consider as body-object-*in*-body-subject, in the line of old-model-*in*-new-model.

Taking into account the two orders in medicine means going back and forth between body-object and body-subject, with each time the body-subject - the wider order - as the most basic.

7.2) Back and forth in the cure

Let us look at the *contact* of a doctor *with a sick person*. There are two ways to start the contact. The usual way is that the doctor collects information by listening to the complaints and asking questions, that he does a clinical examination of the patient and if necessary laboratory and technical investigations, and then makes a diagnosis. This is the objectifying approach.

What we plead for here is that the doctor starts by listening experientially to the person and his being ill, and that he helps him to deepen his experiential speaking; and when it is necessary that he makes space - within this kind of contact - for the objectifying approach. And after that, he can return to the subjectifying attitude.

7.3) Medicine-in-*psychotherapy*

This is the medical-***in***-psychotherapeutic approach, with the psychotherapeutic approach as the most basic. Let us spend some more time with this example of old model-***in***-new model.

How can we in practice carefully preserve the findings of medicine, and at the same time bring into the treatment the experiencing of the patient and the healing power that can come from there? Formulated in the form of our thesis here the question becomes: how to bring in medical interventions in a psychotherapeutic approach to a patient suffering for example from stomach cancer?

In a psychotherapeutic approach to the person suffering from stomach cancer we have to find ways of opening the search for possible meanings about how this-person-with-this-being-ill is involved in his life. This side – the experiential side – of the doctor-patient contact is not directed to the stomach cancer or to a fixed meaning of it, not to the having stomach cancer but to the being (ill with) stomach cancer. It is directed to the situations of the patient, to the possible past implying and the actual and future experienced implying of the stomach cancer. Possibly there is a past implying that became fixed in the stomach cancer - see above the large study with 164.000 patients - just like, as we saw, a past psychotrauma can become fixed in alopecia. Then the question is: how is this in (part of) the body, how does it form (part of) the body as monument? And can we understand this monument?

Understanding stomach cancer from that point of view implies the broader model. The findings of classical medicine about this being ill and its recovery are put within this broader model. We must address the stomach cancer of the patient both as body-object (medication and other physical means) and as body-subject (psychotherapy). Thus the problem is posed of the mutual transition between both approaches, how to move from approaching this suffering as body-subject to approaching this suffering as body-object, and in reverse.

7.4) When and how to make the transitions

So the general question is: *how* can the objectifying and the subjectifying approaches go together? In particular this becomes the question about the *transitions* between both approaches.

The first question is: In the concrete contact with the patient, when and how must we make the transition from the mere medical approach (directed at the body-object) *to the psychotherapeutic approach* (directed at the body-subject)? One answer is: each time we see and feel that the medical model does not have an answer for *the more* that is there. We must be open for that ‘more’. This is the point where the wider model comes to the fore.

Second question: when and how to make the transition from the psychotherapeutic *to the medical approach*? We can make this transition each time the situation asks for old-model-handling, for mere medical acting. For example, when a patient has cut his wrists the *first* thing to do is not a psychotherapeutic session of listening and helping the person focus but to stop the bleeding, bring him to the hospital, give him new blood, and suture the wounds. And *then* listening and helping the person to focus. For example, a bone fracture asks for a literally mechanical intervention; the wider order 'stops' and the logical order comes to the foreground.

Summarized, for example, for the family physician: when and how to switch in a session between medical intervening and experiential listening? The answer is twice: when the situation needs it.

7.5) Some other examples of the transitions

Above we have already given some examples.

Example 1. As a doctor shall I give a prescription of an anxiolytic when an anxious patient asks for it? Or shall I motivate him not to take this as a solution, just in order to make psychotherapy possible? Just taking an anxiolytic leaves the psychological anxiety problem untouched. And with this issue also trying a combination of anxiolytic drugs and psychotherapy is counterproductive because the feeling of experiences is numbed by these drugs to such a degree that these feelings are much more difficult to access, and so processing the anxious situations is much more difficult or impossible.

Example 2. The patient is depressive and tries to explore the dejecting situations. But the doctor feels that this is not sufficient. For a moment he leaves the psychotherapeutic position and screens with the patient the symptoms of depression, and he concludes that besides the psychotherapy an antidepressant is necessary and he prescribes it if the patient agrees. After that the experiential exploration can go on. Thus medication in the second place, and embedded in a psychotherapy process.

Example 3. With a patient with cancer the doctor addresses the illness itself: where it is localized, which kind of cancer it is, how far it is evolved, are there metastases, and so on. But it is good at the same time (and not afterwards) and continuously to have an eye for the patient as person. What is going on in his experiencing? It is good to follow it attentively. When the patient shows a sign of distress during the encounter – even the smallest one – the doctor tries to tune in to what the patient is experiencing. Can the doctor give it the space it needs?

Example 4. The medical exploration gives precedence to the experiential exploration

P[8] Since two months my menses returned after they stayed away for six months. It's confusing for me.

D (Short silence) You don't understand it well.

In the usual medical contact the doctor would ask some further questions about the menses themselves and eventually he would say: "We will examine it". Here the doctor takes another direction. First he waits a while to see if the patient spontaneously makes something more clear about this 'confusing'. And then he gives it back in a reflection, as an invitation to examine it further. He clearly gives precedence to the experiential exploration.

P The staying away of the menses was a shock. I had to become used to it. After six months I was habituated to it, and suddenly it returns. (…). I really had not expected it.

D Do you have certain suppositions about how that could happen?

P Yes. A couple of sessions ago I spoke about A [her oldest stepdaughter] who is reaching puberty and that I am *a bit envious* of it and yes maybe … yes maybe *my body is responding to that*, I don't know.

D That your body becomes more feminine again?

The envious feeling was about her stepdaughter beginning to get female curves. In that session six weeks ago the patient said: "Not real envy but … rather it is the pain of the missing: I was not able to have a child myself. Also because of that I have not been able fully to be a woman".

P Yes (silence). Also I find it strange: in the past when I had a lot of stress then I didn't get the menses, for example during exams. I have had a lot of stress recently and it still returns: that is strange (silence). And, yes, *it makes me a bit uncertain about what I am now.*

D How do you mean that?

P As if, menopause or no menopause, that it affects my identity.

D How do you mean that, that it affects your identity?

P That first they were gone and now they return.

D How do you mean that?

P Yes, I had to become habituated to the fact that I was in the menopause, *that the being feminine was gone a bit*. Now it is back and maybe next month it is gone again: it is confusing.

D It is about your identity as a woman?

P Not that I feel myself a man, it isn't that far … I am really in the confusion 'how is it now?'

[8] P is patient. D is doctor.

D ‘How is it now?’ is ‘to what extent am I a woman?’

P Yes. Maybe *it happens because the last year we had much less sex*. First it was once in a month, now once in two or three months. Not that I don’t have need for it, it is my husband. (…)

At this point the session takes about ten minutes and we see that the patient already can go deeply in such a short while (of course not all patients succeed in that). That makes it possible to fit it in in a medical consultation.

First the doctor helps this short piece of process to occur, and after that he examines medically the possible physical problem with the menses. *Let us consider for a while, if this patient’s complaint was approached only medically, that then the whole important meaning cluster which begins to unfold here, remains unexpressed. If the patient cannot say all this, what then happens with it? Maybe it remains a menses-problem in the 1-manner.*

Example 5: The medical exploration is forced to give precedence to the psychotherapeutic approach

At the beginning of the consultation with her doctor the patient says: ”I have decided to accept Mary [her own forename] as she is. I smoke. I drink. I refuse to wear my dentures when I come outdoors”. At first sight these are not good intentions. But later in the consultation the meaning of her words becomes clear. Her son urges her to reduce her smoking. Her brother makes comments on her drinking. Her mother continuously says that she may not come outdoors without her dentures and that she must put on other clothes. These people are expecting all kinds of things. But the patient appears to have become more assertive with her mother and also with other people. So it appears to be about a healthy tendency, namely that she doesn’t want to live up any more to other’s expectations and to imposed rules.

One sees that the physical problems are interwoven inextricably with important psychological elements; they cannot be treated separately, moreover they cannot be addressed first without forcing the patient. If the doctor remains on the level of the purely medical problems, on the level of the purely medical approach, then there is a big chance that there will be no progress. A *deeper exploration* by the doctor will make clear that in the first place the point is not smoking or drinking or dentures, the point is *not wanting to live up any longer to other’s expectations*. This tendency is a healthy tendency, and must be met before other things become possible. *This psychological health* must be encouraged.

8) Medical approach and psychotherapeutic approach by the same person

In this way of dealing with physical diseases it is best that the going back and forth between the medical approach and the psychotherapeutic approach is done by the same person, the doctor. It is best that it is done by the same person, so that the patient actually experiences in the way the doctor is dealing with him an approach that unifies body and mind. That he experiences no separation of body and mind, no separation of physical body and experiencing body.

Each doctor should have the basic psychotherapeutic skills. I plead for a thorough psychotherapy training as part of the medicine training itself, and already integrated there with the physical approach. Of course this is not arguing against the many psychotherapists who are not a medical doctor, on the contrary they are badly needed. My plea is for a wider treatment of patients with physical complaints and illnesses, a treatment that consists of a particular medico-psychotherapeutic combination that needs somebody who is trained in both, and can go back and forth between both.

But there is much of a risk that medicine will hardly be able to accept all this. The power of the old model is so strong, people are so occupied by it that they can hardly leave it.

When we speak of the power of the old model, one element of it may be that from only the old-model-thinking itself it doesn't seem necessary to look at such a thing as a new model. But from that which the model is about, it appears to be necessary indeed. The doctor must have a 'feeling' that there may be 'more' and an openness for how something of that 'more' may be important in the treatment. A first task seems to be to make medicine sensitive to this. It seems a task for philosophy to point to the new model.

9) The resistance of medicine – new Vesalius needed – towards a new model of medicine

9.1) Transitions to the wider model are not made

Let us go back to the transitions, in particular the transitions to the more, to the wider model. One way towards a transition is to look where the medical approach *fails or has shortcomings in its practice*. For example, discovering that talking with the patient about the causes of his depression brings little or no change. What medicine does not tend to do at such a point is pausing. Pausing at a specific shortcoming is going to the experiential level of this point, to let a felt sense form. At that point we feel the wider order, and from the felt sense we can the wider order let do its work. *In this way we cóme in the wider order of medicine, from where a change of it can come.*

Another way towards a transition is to look where the medical model *has shortcomings in its explanation*, for example, of the placebo effect. One gives medication to a patient, but one discovers that also a pill with the same color, the same taste, the same form but without the pharmacologically effective chemical gives the same effect in a certain percentage of the patients.

Another placebo effect is the doctor himself. Research has found, for example, that with one family physician there was 5 percent placebo respons in a group of 30 patients, and with another doctor there was fifty percent placebo in his 30 patients (Kirsch, 2008). Also this cannot be explained by the classical biological medical model; it is an effect of the doctor-patient relationship. Where in medicine the relationship as explanation will be seen as a contamination for its model, on the contrary in a process-first thinking it will become a primary factor, next to the experiential work.

With the placebo effect we come at the limit of the biological model, where that model falls short, where it cannot do anything further with the data nature brings in. *We can get to this limit with many other examples.*

But medical theory regards the placebo effect as a contamination (of their 'pure' model), as kind of a pollution, which they just accept as bothersome. They don't keep the sound scientific attitude. The sound scientific attitude means the following: if you approach a piece of reality with a certain model and that reality responds in a manner that doesn't fit your model, then you may not put aside that reality as something strange or try to adapt that reality to your model, but you must reconsider your model. This is what followers of the medical model don't want; or they are not able or they don't dare to look at what the placebo effect really means or - more generally - what psychotherapy really means, namely that the classical medical model cannot explain its effect. They don't have the courage to look.

9.2) A new Vesalius is needed

In this respect a new Vesalius is needed, says Jan Hendrik van den Berg (1989), a Dutch phenomenological psychiatrist. Vesalius discovered anatomy because he didn't turn away his head and in contrast with his scientist-predecessors he *did* have the courage to look at the dead bodies on the gallows-fields (ibid., p. 21). He did dare to look at the reality of the dead bodies, instead of staying with the handbooks. He did dare to look and to see. And he did dare to go counter to the faults and mistakes that medicine had copied from its authorities for more than thousand years.

In that way he was able "to pull out the impersonal from the person" (ibid., p. 31) – the impersonal, namely the anatomy, the *Fabrica*[9]. Nowadays the problem is the other way round, namely how to pull out the *person* from the impersonal. "Modern anatomy arose when

[9] Cf. the title of his book *De humani corporis fabrica* (1543).

an old basic understanding was substituted for a new one. As long as the old understanding was the standard, it was not possible to open the human body. Nowadays it is impossible to pull out the person from the impersonal" (ibid., p. 31). Now a 'new Vesalius' is needed, says van den Berg, because the powers that prevent coming to the thereto necessary new basic understandings[10] are very big. "Our current mode of existence is bad insofar it imprisons the personal between two impersonal powers, the internal domain of the anatomical and the external domain of the technical equipment. It is waiting for a new Vesalius who, like the famous old one, doesn't turn away the head. It looks so simply. But exactly such an encompassing upheaval is needed as the one of Vesalius' era. It is not simple in the midst of a world which massively adores the impersonal as a holy thing to restore the single, individual, irreplaceable person" (ibid., p. 31). So what medicine today requires is a new Vesalius who *does* have the courage to look.

9.3) Towards a new model of medicine

We said: nature responds in a strange way. Here 'strange' means: not understandable in the prevalent terms of current medicine. In other words, nature responds in a way that is broader than is expected by the order of current medicine. This broader order is the responsive order (Gendlin, 1997a). The reality of health and illness has a response which appeals for more than the units-first model that has elicited that response, and this reality appeals for a revision of this approach.

But medicine simply continues with the same model. For example, with psychosomatically complaining people or a patient with illness phobia many doctors continue with the same kind of answer: they keep doing examinations and blood tests in order to exclude any possible physical illness, and they don't come to a therapeutic speaking with the patient. But this way of doing doesn't grasp the real problem, namely that the bodily complaints with which the patients keep coming back refer to something of their experiencing that asks for another approach in order to change. If one cannot lay hold of 'the mind' behind these complaints, then *this is the consequence of* only *staying in the basic attitude of classical medicine* and of continuing to look at this kind of problem merely from the units-first thinking and in this manner maintaining them.

Thus what is needed is that medicine change its model. What this medicine has found and discovered must be preserved, but it must be *fitted in in another thinking and in another practice* of dealing with illness and healing, healing not only as result of physico-chemical means but also of psychotherapy. Then it will also be possible to come to a new, broader model of illness.

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[10] The question is: what are currently the necessary basic understandings to 'discover' the personal or the body-subject?

10) What in the patient is addressed by the doctor who opens his mind to the psychotherapeutic approach?

10.1) Making brief moments where the experiential body of the patient can come to the fore

What is the essence of the psychotherapeutic approach in the back and forth treatment I am pleading for? I answer this question from experiential psychotherapy, which states that the experiential must get a chance for therapy to be effective. How can the doctor realize this? The essence is that he can help the patient to make *brief moments* where next to the body-object the experiential body (the body-subject) can come to the fore. Because the experiential body is the basis, the best is that all the other things occur on this basis. With 'experiential body' we mean the patient who experiences situations and tries to contact this experiencing in such a manner that it expresses itself (Depestele, 2014).

In psychotherapy this does not go by itself. The patient meets with obstacles to come to this manner of speaking. For example, instead of speaking *from* his experiencing he has the tendency to speak *about* himself and about his complaints in an objectifying manner; and this will certainly be the case with a patient who consults the doctor with physical complaints.

10.2) Trying to experientialize the physical illness

Thus the goal is to achieve (possibly brief) experiential moments of attending to and explicating implicit meanings. When meaning-processing remains blocked in the body-subject, this will express itself in the body-object too (see above). Psychotherapy helps because it addresses the experiential layer in the body-subject and in that way can achieve the body-object.

In that way *psychotherapy can achieve the experiential body as 'being' the cancer*. If the experiential body – together with the physical treatment - is *also able to help cure its cancer*, then this occurs via these experiential moments, *via moments of experiential change*. This is trying to ***experientialize the physical illness***; by letting experiential feelings speak. Also by letting experiential feelings speak it is possible to achieve the body-object in a healing manner. This is *a hypothesis*. It has never been investigated thoroughly; so much research is needed.

The point is to be able to 'prime' *the healing experiential body*. 'Being in therapy' is specified as 'the body is in therapy', which also means 'the body-object is in therapy'. In particular, can we via the experiential body *with psychological interventions attain to the physically ill body*? This appears to be possible, as is described above. The experiential

change step gives a relieving effect and this effect is physically measurable. Experiential writing can have an effect on the immune system, and this effect has its repercussions on the physical body. This is understandable with the three levels we described – tissue, behavior, symbolic processes; which are inseparably connected – three levels where psychotherapy is situated on the third level and the physical on the first level.

10.3) Obstacles to experiential speaking

The doctor helps the patient, where it is possible, to make brief experiential moments where he says something experiential, where he can express implicit feelings.

But often there are obstacles to come to experiential speaking (Depestele, 2013). A common problem is that the patient keeps asking the doctor for a solution and doesn't become reflective, despite the invitations of the doctor for that. In so doing the patient avoids real psychotherapeutic speaking, and he may tempt the doctor to return to the mere medical approach. This will be even more the case with patients who come to their doctor with physical complaints.

Often the patient will speak non-experientially. There are many manners of speaking non-experientially. For example, talking *about* his state or about himself. The patient is talking about and not speaking. Real speaking is genuinely saying things *from* oneself. Or the patient is making assessments, or giving descriptions, or giving an account of what he feels inside, or searching for causes, etc. He does a lot of things but not the waiting and sensing inner experiential attention for something new that may come there. Then the task of the doctor is trying to bring the patient beyond these obstacles.

It is possible that both, the doctor as well as the patient, stay with the body-object. The patient who deals with himself as with a body-object and who says: "I take a pill; the pill will do it" or who imposes on himself: "I will go for a walk every day". Or the doctor who together with the patient stays with the body-object and discusses with him the diagnosis and does not 'go broader'. Or the doctor who remains in the mode of handling and treating at a moment when a transition to the psychotherapeutic mode is needed. Some patients also want to be dealt with medically with their psychological problems; for example, they want to receive clues about what to do rather than go into their experiential depth. Other patients need much help to bring them from inwardly forcing themselves (another widespread obstacle) to relating to their experiencing with an open mind.

10.4) In practice: how to overcome these obstacles

But there are ways to overcome these obstacles (Depestele, 2012; 2013). Sometimes it requires a lot of work, but not always. When the patient has 'found' the experiential level, I

believe that it is possible to bring the patient to such moments with a few interventions (see example above of the patient whose menses returned). It must be possible to elaborate how the doctor can do that.

It is about brief moments. In a therapy these are embedded in the speaking and the telling of the patient. Indeed first the patient must get the opportunity to outline the situation a little bit before he can let the implicit felt meaning about it form. But now and then in that 'textile' of speaking, one can help the patient to go deeper.

For the purpose of the work of the doctor - imbedding psychotherapy in the medical practice – it's worthwhile to try to examine closely such moments and try to search for ways in order to go there more rapidly.

Specific *examples of brief interventions* may help. For example, quite early in the beginning of the conversation just dropping the question in between: "Apart from your complaints, how are you?" Or in the phase of exchanging information, paying attention to small verbal and nonverbal cues which can be a possible entrance to experiencing. Or in case of a physical complaint, for example stomach trouble, asking – at first glance a strange question in a pure medical context – "What could that complaint be about?"

The focusing subskills (Depestele, 2014) are handles with which the doctor can help the patient to go deeper. For example, asking the patient to pause with a sentence he said and may possibly bear a lot of meaning, like 'my life will not change for the next ten years, and it will be over'. Of course all this experiential work of doctor and patient is only possible if their relationship is good.

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