2.
PRESENCE IN THE HEALTH CARE RELATIONSHIP

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I would like to enter into the field of ethics departing from our experience of being in relation and exploring, in particular, our being present within relationships. To do this I shall propose a journey, which may be synthesized as in Figure 1. Departing from different theoretical perspectives, like constructivism, phenomenology and situated action theory, we shall focus on presence, understood in terms of the acted and embodied subjectivity in the relationship, and we shall explore its implications in terms of openness, honesty and co-responsibility in health care relationships. Presenting some clinical examples we shall look at how these characteristics of a relationship lead to uncertainty and we shall explore how we can move within it when experiencing presence. This will exemplify what we mean by ethics in practice.

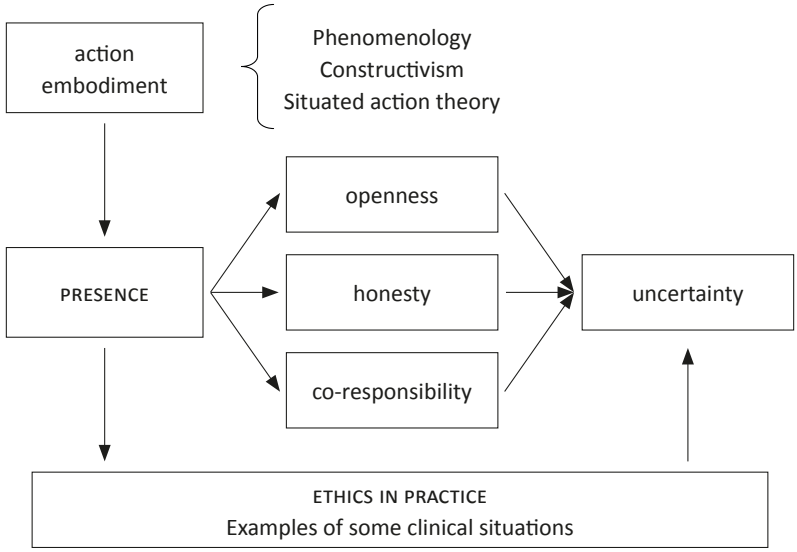

Figure 1. – Outline of the chapter.

2.1. What presence means

First of all let's see how different perspectives bring to the fore presence by focusing on experience as embodied action. Phenomenological thinkers like Husserl, Heidegger, Schultz and Merleau-Ponty are those who probably focused on embodiment more than everybody else. The central concept of *Desein* stresses the centrality of «being-in-the-word» and underlines that the way in which we encounter the world is practically like a place in which we act (Heidegger, 1927). Merleau-Ponty (1945) suggests we substitute the Cartesian «I think» with «I can», namely what we *can* do with things. We usually are not aware of what we are doing, as we are not aware of our eyes watching the world until we focus our attention on them, because, for instance, our sight is disturbed by an eye disease. This kind of experience highlights the distinction between «ready-to-hand» and «present-at-hand» introduced by Heidegger (1927). An object is ready-to-hand when we act through it but it disappears from view as an independent object. It exists for us only because of the way in which it can become present-at-hand, i.e. when I act on the object being mindful of it as an object of my activity. This way Heidegger stressed that the world has meaning for us in the ways in which we encounter it and the ways that it makes itself available to us.

Within a constructivist perspective Maturana and Varela (1980) argue that living systems are cognitive systems, and the process of cognition is the actual acting or behaving in the domain of interactions. Action is not necessarily a reflexive process, but rather a sudden and oblivious organization, like the movement of a swarm of bees is. Varela (1999) refers to it as «enaction». Kelly (1955) also points out that our psychological processes are channelized by the way we anticipate events and this anticipation is a «questioning act»: «we know an event through our own act of approach to it. We ask questions about it, not merely academically, but also experimentally» (Kelly, 1979, p. 26). This way he underlines that we encounter the world practically and opens the way to the recent attempts to integrate personal construct psychology with theories and techniques more focused on embodiment (Cipolletta, in press). McWilliams (2010) proposes integrating mindfulness with constructivist psychotherapy and Leitner (2007) proposes integrating techniques originally developed within other theories into experiential personal construct psychotherapy, suggesting an even more interesting integration between theory, technique and person. In particular, he states that «To the extent that my 'techniques' do not spontaneously arise from within me as genuine reactions to the encounter in the therapy room, therapy is shifted from a 'being with' to a 'doing to'» (p. 35). This way he focuses on the present inter-action.

Finally, the concept of presence is used in media and social studies to indicate the ability of a communication medium to make the interlocutors available to one other. Currently it is used to indicate the overall experience of being in a mediated environment, especially in a virtual environment. Spagnolli *et al.* (2003) proposed a situated action-based approach (Suchman, 1987), which considers presence as the ongoing result of the action performed in an environment.

This situated view is very similar to the phenomenological approach, which focuses on existence in the present moment, and teaches upon the Buddhist perspective, which highlights the emptiness (or vacuity) and impermanence of the phenomenal experience. Within this perspective we cannot isolate an essence or identity inherently existing because all the phenomena are impermanent and empty of a pre-defined nature (McWilliams, 2009; Varela, Thompson, & Rosch, 1991). This implies that we cannot attach ourselves to our personal identity or to anything else as if it were something existing *per se*, but we can only consider ourselves and others (things or persons) as being transitory. This leads to the practice of mindfulness as a way of being present through an attitude of acceptance, combining attention and the suspension of judgement.

In mindfulness presence is opposed to mindlessness, «the relative absence of mindfulness», which occurs «when an individual refuses to acknowledge or attend to a thought, emotion, motive, or object of perception» (Brown & Ryan, 2003, p. 823). Then, we may consider presence and absence as the opposite poles of the same construct, but, if being in the present means living, as phenomenologist authours suggest, absence would mean dying. Within the emergent pole we may better collocate the two opposite poles of in-there or out-there, as the pyramidal Figure 2 shows.

It is difficult to transpose in a few words what I mean. It is easier to do it by directly observing a situation which illustrates a shift from being-in to being-out. I chose two pieces from a television series, which you might already know, «In-treatment».

I am not interested in the contents or «the patient problem», but in what happens in the relationship. In the first piece (episode 12 minutes 3-6) you may notice the difference between two distinct moments: when the therapist is in relation (he feels embarrassed and disappointed) and when he goes out (he looks absent, being elsewhere). It is even more evident in the second piece (episode 6 minutes 3-6), where the therapist is absent since the very beginning (he maintains a detached attitude, poses script questions, and finally clears his throat to regain composure in front of a whirl of emotions) and the patient recalls him asking «What?». In this case she is acting the therapeutic role of commenting on what is happening between them. Here I do not mind about why this happens: this is not the topic of this chapter, but I only want to focus the attention on what happens, on the ongoing experience.

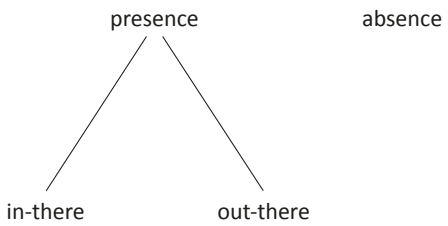

Figure 2. – Pyramiding the construct of presence.

Most of us can recall similar moments, when we were embarrassingly not present in a conversation with a client or a friend or in some other situation. We may have been looking directly into the other person's eye, probably staring at them or even nodding our head in apparent understanding. «Our lights were on», so to speak «but we were not home». «People who know us or are attuned to the subtitles of our presence may call us on such lapses: 'Are you with me?', 'Where are you?', 'Hello, in there …?'. More often they are polite and say nothing» (Mahoney, 2003, p. 16). Anxiety [1] may prevent the therapist from giving an authentic answer and engaging in the encounter because it might pose him or her in front of an unknown territory and this might be scaring, thus the therapist might prefer to refuge in well known territories.

On the contrary, «the present moment» (Stern, 2004) is a moment of encounter, which goes further than any technique. Presence is at the heart of psychotherapy, as Mahoney (2003) states: «The therapist should be as present as possible and invite a genuine contact with the client as another human being. It is crucial not only for starting the session but also for fostering the continuing human relationship that is the essence of the practice. Sometimes, on my way to greet a client, I intentionally slow the pace of my walk, take a deep breath, and recite the simple phrase 'Be here now' silently to myself. […] At the beginning of my relationship with clients I try to be attuned to what they are seeking and their level of comfort in being with me. In general, I find that they are more comfortable with me when I am comfortable with myself. Opening is a process that is facilitated by relaxation, and I often concentrate on relaxing» (p. 16). Childs (2007) proposes mindfulness as a way of experiencing presence as it is intended in phenomenological terms, referring in particular to Heidegger (1987).

However, how to explore and practice presence in the clinical context remains an open question. We shall explore it departing from some clinical examples, which will show how presence opens the field to uncertainty and how uncertainty is intrinsic of action, but before we do, let me share with you some considerations about the implications of experiencing presence.

2.2. Openness, honesty and co-responsibility

The first implication, as outlined at the beginning of this chapter is openness. It means to accept into one's own horizon the other's horizon in a hermeneutic perspective (Gadamer, 1960), but also to practice «maternal reverie» (Bion, 1961), the capacity to sense (and make sense of) what is going on inside the infant, similar to Winnicott's maternal preoccupation. I am fond of my patients insofar as I take care of them. Of course this does not mean to relegate them to an infant position of passivity, but to accompany them in their journey as a mother accom-

[1] Kelly defines anxiety as «the awareness that the events with which one is confronted lie mostly outside the range of convenience of one's construct system» (1955, p. 533).

panies her children in their growth. This implies to convert cure into care, as a lot of narrative medicine scholars suggest and placing understanding at the centre of the therapeutic process. Understanding is not meant as a cognitive explanation of the patient's experience, but refers to subsuming the other person's system under one's own one (Kelly, 1955). This process may be represented as embracing someone. It is a corporal, intuitive process first rather than a rational one. It consists of putting yourself in a position to be taught by, to be affected and changed, to «stand under», as in Mair's words (Mair, 1989). This position requires practising humility, which allows us to consider ourselves only as a part of an integral world (Bateson, 1972; Leitner, 2011). I prefer to recall this aspect honesty.

Honesty refers to the phenomenological acceptance of being present as being thrown into the world (Heidegger, 1927) and not-judgement of mindfulness (Childs, 2007), which allows us to experience emptiness and irrelevance. This implies interacting with the other on the basis of one's own fault, considering fault as a constitutional feature of existence. Some phenomenologists talk about the «injured therapist» indicating the possibility to get more readily in touch with the patients through one's own fault. Jaspers (1986) suggested it as being a useful way for physicians to understand their patients better, too. Also Lacan (1964) suggested that analysis begins when the analyst ceases to be «the subject supposed to know». Then a therapeutic relationship really begins to be a collaborative enterprise, which is founded on co-responsibility, the last implication of presence I introduced above.

Both the participants (the therapist and the patient system, which may be a person, a couple, a family or a group) are responsible for what is happening in the relationship. For instance, if I notice a standstill in the therapy I do not accuse the patient, saying that he/she is resisting, nor do I think it is my fault due to lack of skill or because I made some mistakes. I understand the standstill within the relationship by making the following considerations: what does it mean? What is preventing us from going further? This perspective opens up to reciprocity, but I think it goes even further because it focuses on the personal responsibility of each person: what do I put in this relationship which takes it to this point? Maybe, for instance, the patient is simply reproducing with me his/her usual way of relating to others and is frightened of the possibility of doing something different. Maybe I also am threatened by breaking this pattern because I fear he/she may interrupt therapy and I may feel abandoned or failed. If I can honestly see this option I can probably adopt a different approach.

Courage is an unexpected derivation of the interweaving of these aspects. Let's see how.

2.3. Uncertainty

Following the directions opened by presence you may find yourself in front of an open field where you really do not know which way to go, and do not know what is going to happen. You are making a bet and you can only share it with

your client and accept it as a game to play. Stern (2004) refers to these situations as «now-moments», which suddenly happen and question the well known relationship, posing the therapist and the therapy in front of a crisis, which need to be solved. Two situations in particular come to my mind. What they have in common is that in both cases I and my patient were at a point of the therapy where we could only make the leap and accept the bet or else finish the therapy, and this I expressed. In both cases finishing the therapy would have meant to stop at a superficial level of change and in both cases the patients did not want this. Anyway this was not sufficient to guarantee that both would have actually really accepted following this direction. One patient did it with aggressiveness [2] and we could feel it because our sessions became more collaborative and exciting, while before they had moved on a much more rational level that allowed the patient to control the direction of each session. On the other hand the second patient reacted to the new situation with constriction [3] and hostility [4]: in contrast to her usual role of the «good patient», who is «always in movement» and who readily shows her progress to the therapist, as she did in the first phase of the therapy, this time she was paralyzed. A heavy silence fell between us and she could not bear it. Experiencing and elaborating what was happening between us finally allowed us to get in touch in a new and more fruitful way.

As I recount these stories, they seem so easy and predictable, but I assure you that in the exact moment you accept the bet, you really do not know where it will take you. You are there with all your person, experiencing it at first hand, and you do not have, nor do you want to have, any armour or screen in front of you: this is only you and the other person. I am often asked what the difference is when you are with your mum or child, friend or partner, and I answer: «None», you are as naked as you are in bed with your partner or in your mother's arms. That is why it is not so important what you have learned or studied, but what you are. An Italian phenomenologist said that you go to the bottom of the well with the patient (Benedetti *et al.*, 1979), but what takes you back to the top and helps the patient go back with you?

I think it is your professional understanding and I do not mean only the theory you have learned, but the theory you embody, which allows you to stay where the patient cannot stay without being sucked under because it is only a possibility for you among many others and not the only one, as the patient lives it. This idea is similar to the Buddhist concept of impermanence and emptiness and psychotherapy may help the patients to experience it. They often expect that psychotherapy aims to change something in themselves and they look for this. Thus they are excited when they feel they are changing and may also fall in love with the idea of changing. It is often the first step of a change, but inevitably per-

[2] Kelly defines aggressiveness as «the active elaboration of one's perceptual field» (1955, p. 533).

[3] Kelly (1955) defines constriction as the process of reducing one's perceptual field in order to avoid incompatibilities.

[4] Defined as the «effort to extort validating evidence in favor of a type of social prediction that has already been recognized as a failure» (Kelly, 1955, p. 533).

sons discover that it is not enough: after a first moment when they feel good, they may experience that they are coming back because they are «repeating» an old experience or may feel they are missing something. The first experience derives from the shared and well known western concept of change as linear growth. The sensation expressed in the other case, on the other hand, refers precisely to the partiality and incompleteness of this kind of movement. The successive movement is going beyond a specific goal, beyond good and bad, and simply accepting experience, pleasant or unpleasant, letting it go and accepting it as impermanent.

This may lead to a strong feeling of impermanence and uncertainty because you do not have anything to cling on to anymore, at least nothing solid or unequivocally «true», but you can feel much more rooted, maybe rooted more than ever before. What makes you feel rooted is not any certainty but accepting uncertainty and using more appropriate tools to move within it.

In the medical field, this means to accept uncertainty intrinsic not only of some illnesses (Cipolletta, Beccarello, & Galan, in press) but of every disease. In fact, diagnosis may never be based only on evidence because the evidence based data must be interpreted. Greenhalgh (1999) used as an example a praecox diagnosis of meningococcal meningitis based on the doctor's knowledge of the family to show a possible integration between evidence and intuitive response. Jaspers (1986) argued that when a physician acts on the basis of his or her humanity, he or she becomes similar to God. This does not mean that he or she is omnipotent, but that like a philosopher, he or she embraces other human beings through a process of hermeneutic understanding. Using the term «embracing», Jaspers underlined how the relationship between a physician and a patient is not based on a detached, rational examination, but on an embodied understanding. Care becomes more linked to the contact between the physician and the patient, recalling the original meaning of care as touching the body of the ill person (Gadamer, 1993).

This practical nature that characterizes a medical clinic more than medical research makes medicine similar to a service to the patient, where caution and respect are central to art. Art enriches the rationality of medical science, which is limited to giving medicine such as the vaccine for polio with the wisdom of an ecologic understanding (Bateson, 1972). This super-ordinate understanding deals with the natural and social world (Gadamer, 1993). It is not by chance that Keeney (1983) entitled a book that deals with the application of systemic epistemology *The aesthetics of change*. What characterizes such a perspective? What are its premises?

Without entering in a detailed examination of systemic epistemology, I would only like to underline some of the antinomies that characterize the passage from an objectivist and modern perspective on knowledge and life to a constructivist and postmodern perspective. The first antinomy is represented by the shift from a conception of the relationship between knowledge and reality in terms of match to one in terms of fit (Glasersfeld, 1981). Believing in a unique reality is not possible anymore because reality is defined by the context where it is observed and may change depending on it (as a key function depending on the lock, it must

open). Then it becomes plural. Moreover, knowledge becomes reflexive because it depends on the knower and must be applied to the process of knowledge itself. Consequently, it is not so solid and reassuring as it was, but becomes «fluid» (Bauman, 2000) and risky. At the same time, it becomes more innovative than conservative, open to new questions rather than closed to well known answers. Finally, knowledge is no longer directed to reach an aim but is inserted in a larger system where no part can have unilateral control over the whole. This leads us to abandon the Occidental belief that there is a delimited agent, the «self», which performs a «purposive» action upon a delimited object (Bateson, 1972) and to substitute it with a concept of coherence as coordinated action (Dell, 1982).

So we have come back to the beginning of this chapter and its central topic, our being as being in relation. This issue also takes us to the end of our discussion, which strictly deals with ethics.

2.4. Ethics going forward …

To go straight toward one of the central themes in the field of ethics and to conclude this chapter, I would like to pose a question: If in the ecologic view of the human being proposed here we cannot isolate an essence or inherent identity, where does responsibility eventuate?

Some argue that in this way personal responsibility is avoided because if we cannot determine anything, then we cannot be responsible for anything. This critique of nihilistic relativism has been discussed by personal construct scholars (Butt, 2000; Raskin, 2001; Stojnov, 1996) and we may respond to it that, even if we do not cause others' reactions, we participate in the inter-action where they are placed. Therefore, even if we can no longer be considered responsible for the «reactions» of others, we are responsible for what we are doing with them. Moreover, if our doing is our being, as Maturana and Varela (1980) propose, we end up becoming even more responsible because responsibility deals not only with our actions, but with our whole being.

Ethics, more than a set of norms and values that tell us what to do (morals), becomes knowing how to do things, a knowledge that organizes everyday actions (Varela, 1992). It orients the immediate and pre-intentional action that makes us choose before deciding. I am not entering into the vast field of decision-making literature (Alfredetti & Cipolletta, 2010; Alfredetti & Gius, 2009), but I want only to highlight the transition from a rationalistic model of the decision making process to a constructivist one that considers choice a way to trace a trajectory of movement by an agentive person positioning him or herself in relation to the environment.

This perspective in the meantime allows and forces us to move within uncertainty because there are no more predefined and certain answers but only different possible ways of moving in the world. There are no truths to discover or reach, but only existential choices. Existence becomes the territory where the

ontological uncertainty proper of human beings joins the uncertainty that deals with choice (Tannert *et al.*, 2007). This territory is more governed by our actions than by pre-determined moral rules as the conception of ethics in practice proposed in this book.

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