THE STRUGGLE FOR MEANING IN THE FACE OF BODILY DETERIORATION: PERSONAL CONSTRUCT THEORY IN PRACTICE

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Abstract: *Serious illness or physical injury often marks a profound turning point in a person's life, disrupting the very foundations of identity and one's overall life perspective. Although clients struggling with such experiences frequently seek therapeutic support, these encounters challenge not only the therapist's theoretical knowledge but also their emotional preparedness. This paper explores the psychological impact of bodily disruption through the lens of Personal Construct Theory (PCT), emphasising the crucial role of the therapeutic relationship in providing a safe space for clients to grieve and gradually form new pathways of meaning. The paper aims to honour the complexity of this work, offering a potential path that the therapist can follow when both parties are confronted with the unknown.*

Keywords: *Personal Construct Psychology, Meaning-making, Bodily deterioration.*

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1. INTRODUCTION

It is difficult to imagine a scenario in which a serious deterioration in one's health does not profoundly shake the very foundations of the person's existence. In practice, clients who seek help due to a decline in their mental state following the onset of illness or a physical injury are relatively common—at least, that has been my experience. Looking back on my work with them, I find that the theoretical knowledge I acquired left me quite unprepared to face this kind of suffering. My impression is that this does not have so much to do with the shortcomings in the available literature, but rather with the fact that few things confront us with our own fragility and limitations as much as these kinds of conditions do—and it seems to me that this applies to both sides of the therapeutic relationship. Why is that so?

2. THE BODY AND THE CONSTRUCTION OF MEANING

It is difficult to explain the overall significance of the body for functioning without referring to the concept of core constructs. As Kelly (1955) notes, these constructs form our identity and govern the processes of self-maintenance, constituting the basis of our existence. Furthermore, Mahoney (2005) explains that our everyday life and present moment experience would not be possible without organizing processes which operate at a low level of perceptual awareness and suggest a tacit dimension of core ordering processes (COPs). We are not consciously aware of the formation of thoughts in our mind or sensations in our body — we simply exist, and it is precisely these processes that allow our experience to be organized in a meaningful way. This author goes on to say that our body and our sensations are fundamental to experience

personal identity, as the body serves as a centre of operations. Leitner and Faidley (2019) further emphasize that the role of the body is clearly much more significant than it might initially appear, and that it actually serves as an important container of meaning. Because we come into this world as meaning-making creatures, our body is basically medium for the first constructed meanings.

An interesting point raised by Bronheim (1996) is that how we cope with physical illness often depends more on experiences from the first two years of life than on any other period. This author, in explaining the significance of the earliest period of childhood, refers to the concept of object relations, the internalized images of significant others that the child incorporates into their psyche, influencing their emotional and psychological processes. In the earliest stage, an infant is entirely helpless and thus must depend on the mother or father to fulfil basic needs and provide a sense of security. When parents are adequately attuned to the child's needs and capable of offering soothing, a solid foundation is established for managing future challenges. This is in line with Leitner's perspective (2019), as core constructs are developed early in life, primarily through interactions with family and caretakers; and the quality of those early relationships will largely determine whether the person will later in life be able to form close connections based on mutual vulnerability - that is, role relationships. When such early relational exchanges fail to meet the child's needs in a way that fosters safety, a structural arrest may occur (Leitner, 2019) - a disruption in the meaning-making process, resulting in close relationships being perceived as threatening, echoing the child's early relational experiences. In that case, we should pay attention to the following three dimensions: Self versus Other - which refers to the earliest differentiation between the self and the environment, where the skin itself may be experienced as the first boundary; Self-Other Permanence - involving the perception of self as stable and others as present and existing even in their physical absence, where disruptions can give rise to intense fear of abandonment; and Self-Other Constancy - which reflects the capacity to perceive both self and others as coherent wholes, and to integrate changes without experiencing them as threatening (Leitner, Faidley, & Celentana, 2000). In my experience, clients who already exhibit a structural arrest often struggle to cope with the sudden changes brought on by the onset of illness or injury. Even when this was not the initial issue, such experiences are almost certain to pose a threat to one's sense of being, which Kelly (1955) described in terms of the awareness that one's core structures are about to undergo comprehensive change. However, the individual's ability to establish meaningful and significant relationships with others can greatly facilitate the process of adaptation.

3. MAKING SENSE OF BODILY DISRUPTION

What happens when clients experience illness or injury? As Viney (1985) articulates, clients are compelled to find ways to make sense of their altered circumstances. However, the constructs that previously guided their anticipations may no longer retain predictive efficiency, resulting in anxiety, understood in Kelly's (1955) terms as "the recognition that the events with which one is confronted lie outside the range of convenience of one's construct system" (p. 365). Given that such new conditions can profoundly transform the client's existence - affecting their physical appearance, autonomy, and overall daily functioning - it becomes evident that the response to these challenges must be understood within the context of the client's personal construct system. The corollary of individuality defined by Kelly (1955), highlights the considerable variability in how individuals construe experiences of illness or injury, despite identical diagnoses or injury types (Viney, 1985). If the therapist has already effectively mapped a client's construct system, it will be possible to make approximate predictions regarding the client's meaning-making processes in response to these events. Critical questions include: Can the

client visualize themselves as injured or ill? Have they previously conceptualized such a position? What trajectory does this envisioning suggest for their construct system? Ideally, this process facilitates the integration of new experiences and the revision of constructs.

Interestingly, in my experience working with clients who have faced such circumstances, most of them did not expect that something like this could happen to them - a response that closely aligns with Bronheim's (1996) description of such events as ego-dystonic, and as something profoundly distant from one's sense of self and anticipated life course. It is entirely expected that the client will need to undergo multiple transitions, and the extent to which they are able to integrate these new circumstances will largely depend on the permeability of their superordinate structure.

Having in mind that emotions represent natural expressions of a person's attempts to protect or regain a sense of meaning, order, and control in their live (Mahoney, 2005), it is obvious that this process carries an immense emotional weight: the realization that their life is now irrevocably different, that they themselves have changed, and that this change was often both unanticipated and undesired. In my view, such experiences fundamentally shake core assumptions about life and what one must do to remain safe—bad things happen to good people, and often without any logic or order. My impression is that sadness - as a form of transition - is the most dominant theme. It is, essentially, a mourning process. Considering that sadness can be defined as the awareness of the invalidation of implications of a portion or all of the core structure (McCoy, 1997) and it is a feeling of a loss, it is easy to imagine that a person in such a situation is confronted with loss of their former self, previous relationships, and past life.

Furthermore, such a change cannot occur without a strong sense of threat. Any form of bodily invasion carries a potentially traumatizing effect (Leitner & Faidley, 2019). We cannot separate our identity from our body, which makes it difficult to imagine that something which threatens the body - or penetrates the skin, the outer boundary between the internal and external world - would not have a profound impact on our very sense of being.

Certain physical conditions result in temporary limitations in a person's capacity for independent functioning, while others, unfortunately, lead to permanent consequences. As noted by Robbins and Bender (2006), individuals diagnosed with dementia often display signs of despair, as the accumulation of invalidation—resulting from failed expectations—continues to grow over time, frequently leading to a sense of personal incompetence and meaninglessness. In accordance with this, one can expect the emergence of intense feelings of guilt - as a result of deviation from one's core role (Kelly, 1955) - as well as shame, which is more closely related to perceived expectations from others (McCoy, 1977).

We now seem to arrive at a crucial point - the impact of such transitions on the formation and maintenance of relationships with others, particularly close relationships. As Leitner (2019) has emphasized, human beings have a fundamental need to establish meaningful, intimate connections, which he refers to as role relationships. However, such relationships require a certain degree of vulnerability, allowing others to see our wholeness as well as our imperfections. In this sense, those who are able to see us at our most vulnerable also hold the greatest potential to hurt us. Because of this, many individuals find themselves caught in a dilemma: on one hand, these types of relationships give life a sense of meaning and substantially enhance its quality; on the other hand, they carry an inherent risk. Consequently, some may choose a safer but emotionally hollow life, opting to avoid vulnerability in front of others. Even individuals who are not (at least currently) experiencing serious health issues may struggle with this dilemma - but sudden injuries or the onset of illness often intensify it significantly. My reflections lean toward the idea that such

circumstances significantly complicate the ability to choose either option within the aforementioned dilemma. Even individuals who have managed to maintain emotional distance from others - often paying the price through, for example, overburdening themselves as their primary resource or experiencing a hard-to-articulate sense of emptiness - may find it increasingly difficult to do so, as decreased mobility forces them to involve others in their daily functioning. On the other hand, considering that the person's identity has been shaken by the new circumstances, and that they can no longer continue to exist in the way they previously had, we can begin to imagine the weight of shame and guilt they may carry - making vulnerability even more difficult to bear.

If we define love as an awareness that one's core structure is being validated (McCoy, 1977), and as something grounded in the experience of being accepted as a whole, it becomes evident just how vital it is for one's ongoing functioning. Robbins and Bender (2006) present the case of a man diagnosed with dementia, for whom his wife's love played a crucial role in stabilizing his core structure. As they explain, within the relationship itself, he maintains a sense of cohesive wholeness by borrowing his wife's structure - relying on her judgments in situations where he can no longer trust his own. The mere fact that he can do this points to her role as a validating and stabilizing presence for his core structure, which greatly alleviates the daily burden of invalidation. However, clients who already experienced relational difficulties before the onset of illness may find it significantly harder to establish such a relationship. It seems to me that the simultaneous necessity of forming such a connection and the threat it entails corresponds quite closely to what Leitner (2019) defines as terror – a conglomeration of emotions, including threat, fear, anxiety, hostility, and guilt.

Interestingly, literature that addresses therapeutic work with medically ill individuals often notes a tendency toward regressive behaviour (Bronheim, 1996; Viney, 1985) typically identifying two dominant patterns: those who become overtly noncompliant and problematic, and those who gradually slip into helplessness and overly compliant behaviour. Given the context, both responses appear to be understandable. It is also important to consider that these classifications are often constructed by medical staff themselves - professionals who may find it easier to work with patients who do not ask too many questions or take independent actions. Noncompliance with medical staff can be understood as an expression of anger, or more specifically, as a reaction to the experience of invalidation that leads to hostility (McCoy, 1977), consistent with Kelly's (1955) conceptualisation of hostility as persisting in attempts to obtain validation for a social prediction that has already proven inaccurate. This may indicate difficulties in integrating the role of "the ill person" with their prior identity, and possibly reflects the perception that this new role places them as an element on the undesired pole of some construct. At the same time, such behaviour can be seen as an attempt to re-establish control within the given situation, and potentially as a form of aggressive exploration (Kelly, 1955). The second behavioural pattern - compliant and passive behaviour - can also be interpreted as a strategy to establish predictability in a disorienting context, by relying on others, for example, medical staff, as external sources of stability.

There are indications that such circumstances may lead individuals to rely on a second line of defence, as Kelly would define (1955) - namely, dependency constructs. As Bronheim (1996) points out, there is a tendency to employ splitting as a defence mechanism. Consequently, we may observe the idealization of certain figures, such as doctors who appear capable of "saving" the ill person, alongside the devaluation of others who themselves appear helpless. This kind of black-and-white and preemptive construing underscores the extent to which such experiences shake the individual's construct system at its core. The person is overwhelmed by the high degree of uncertainty and cannot tolerate the ongoing sense of threat. As a result,

they may exhibit a certain degree of impulsivity, driven by the difficulty of accepting the unknown - not knowing what their life will look like moving forward. This state significantly restricts their ability to view the situation from multiple perspectives, as would be possible through propositional construing.
While such behaviour is entirely understandable, it unfortunately often contributes to additional challenges. It may further complicate the formation of close relationships and prevent the process of adaptation to newly emerged life circumstances.

4. THE ROLE OF THE THERAPIST

In what ways does the therapist support and help the client? An idea that often stays with me is Mahoney's (2005) suggested approach, in which he distinguishes three interrelated levels that can be addressed in therapy: the level of problems, the level of patterns, and the level of processes, offering one way of organizing and making sense of the client's experiences. Problems are usually the most visible and are often the reason clients initially seek help - they notice that something is not working as it should. In fact, problems can often be understood as strategies for solving other, underlying problems, but often come at a high emotional or psychological cost. The next level involves patterns - clusters of interrelated problems that tend to recur in recognizable ways. The final level - the process level - is, according to Mahoney himself, the most difficult to articulate. Processes are described as the engines of our experiencing; they reflect what is happening in the here and now and are often hard to express verbally. Accessing this level requires attunement to the present moment and a focus on what is happening within ourselves as well as within the relational field. This process-oriented level appears to be particularly fruitful when working with clients facing health-related difficulties, as it allows for a more embodied, experiential understanding of their suffering.

What I often find particularly useful in my clinical work is sharing my own somatic reactions to what is occurring in the therapeutic space with the client - starting from the assumption that what I am feeling is part of something co-created in the encounter between the client and myself. I often ask myself whether what I am experiencing might reflect how the client feels, or perhaps how people in their environment might feel. By directing attention to my own bodily sensations, I was able to articulate my reaction - for example, a tightening sensation in my throat and weighted sensation in the chest area, as if something was preventing me from speaking. Of course, I did speak during the sessions - not only because verbal expression is a central part of the therapeutic process, but also because I felt a strong internal pressure to say something. Very often, I would have the sense that no matter what I do, it would not be an adequate response, and mistakes could come at a high cost. Over time, and through checking in with clients, I have come to understand that this reaction often reflects the implicative dilemmas clients are facing. On the one hand, if we do not speak about what has happened, it may feel as though it isn't truly real - potentially minimizing the significance and impact of the change that has occurred. The client may be left with an illusion that they can somehow return to their previous state. Yet, even under such circumstances - and perhaps at a low level of perceptual awareness - the idea that this is not going to happen often persists. Avoidance of open dialogue around the issue can leave the person feeling profoundly lonely in the process.

On the other hand, I have encountered situations in which simply validating that what happened (such as a physical injury or a surgical procedure resulting from illness) was indeed a difficult experience, has triggered strong emotional reactions in clients. Sometimes, even just a facial expression or a particular look from me would unleash a wave of anger, beneath which lies deep suffering. I had the impression that my facial expression - or the tone of voice I used to acknowledge the struggle - served as a kind of

mirror for the client, making it much harder for them to avoid confronting their sadness. For this reason, I find that sharing my impressions is sometimes the most effective way to address the elephant in the room, offering the client an opportunity to reflect. In my experience, this kind of attuned articulating is almost always followed by a sense of relief - on both sides. Naturally, what follows is the confrontation with the grieving process and the emergence of numerous questions about how to move forward with life - questions to which even the therapist may not have immediate answers. Additionally, such an intervention can show them that their reactions to the situation are completely valid, while also sending an encouraging message to be vulnerable in front of others. Furthermore, it helps them understand how others may feel around them - how certain topics remain unspoken, not due to a lack of care, but because of an inability to address them.

When applying this approach, several considerations must be taken into account. It is, of course, essential to allow for the possibility that such an intervention may not always be necessary, and one should not presume that the client will inevitably encounter difficulties in accessing and articulating their emotional experience. Furthermore, when sharing one's impressions, it is important to bear in mind that the client retains the full right to reject or reinterpret the meaning offered. Finally, even when the therapist judges that such an intervention may serve the client's well-being, it is not always easy to act in the ways previously described. If the therapist is not fully aware of their own countertransference, they may be tempted to implement the intervention prematurely, for instance, to avoid the discomfort of silence within the therapeutic process. At the same time, even when the intervention is deemed appropriate, its execution may remain challenging, as therapists themselves may find it difficult to confront themes of loss and helplessness inherent in the client's experience. As Mahoney (2005) notes, the therapist's role is, to a large extent, to hold on to hope even in the most difficult circumstances - someone who can communicate to the client that their life remains worth living. As previously mentioned, most people do not anticipate that they will ever need to radically revise their existence and daily functioning due to illness or injury - and at the end of the day, therapists are human beings too. This is why it is essential to remain aware of one's own resistance to change, particularly because clients deeply rely on the working alliance and the sense of safety that it provides in order to begin experimenting with new ways of construing and reconstructing meaning. As Kelly stated (1955), the therapist must help the client to develop constructs that will connect their past, present and the future and establish their life role. Lane and Viney (2006) emphasize that that we need to provide support in order to affirm and promote the other person's processes of construing. They argue that the essence of this lies in establishing a specific type of role relationship, referred to as a supportive role relationship, which aims at facilitating the forward movement of the other's construing processes. This effectively illustrates the kind of strategy a therapist may adopt - on one hand, being fully present in the moment by attuning to the despair and chaos the client may be experiencing, and on the other, helping the client to consider what can be done with that experience and how they might move forward in a meaningful way, reflecting what Leitner (1995) defines as the optimal therapeutic distance. Such an approach requires a careful balance between honouring the client's pain and despair, and encouraging them to see their struggles as part of the human experience and to continue living a meaningful life.

5. CONCLUSIONS

Serious illness or physical injury often constitute a profound turning point in an individual's life, disrupting the very foundations of identity and challenging their broader sense of meaning. Through the lens of Personal Construct Theory, it becomes evident that such experiences compel clients to reconstruct their understanding of self, relationships, and the world. The therapeutic

relationship, therefore, plays a crucial role in providing a secure space in which clients can process grief, explore their emotions, and gradually establish new pathways of meaning.

The approach I propose involves sharing the therapist's own somatic reactions that arise during sessions, on the assumption that these responses may reflect, at least in part, what is occurring for the client, while remaining mindful of the possibility that this perception may be inaccurate. Such transparency on the part of the therapist appears to create a space in which the client can also allow themselves to be vulnerable, collaboratively exploring and constructing new meaning alongside the therapist. While this approach can be challenging for both parties, it offers the potential to support the client's resilience and the capacity to remain hopeful during emotionally demanding experiences.

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