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Series: *Applied Ethics: From Bioethics to Environmental Ethics*

Philosophical-Ethical Alleviation of Perceptive Experience of Corporeality in Terminally Ill Sufferers

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Abstract: *On existential level, the diagnosis of terminal illnesses which affect corporeal integrity also affects the perceived identity of sufferers. The physiological disorders occurred induce disruptive neuropsychological changes in their body scheme. For example, subjective awareness of corporeality includes, in various degrees, elements of perception and representation of the body parts configuration and their spatial arrangement. Our suggestion is that philosophical counselling is arguably capable to improve therapists' communication with those who live with these illnesses and develops ways of alleviating the latter's existential suffering. This can be done by helping them change the perception of their condition in general and of their corporeality in particular.*

Keywords: *corporeal integrity; introspective consciousness; existential suffering; wellbeing, philosophical-ethical counselling.*

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Introduction. Corporeal integrity and psychological identity

Patients with terminal illnesses have unique physiological and psychological needs. According to the scientific literature, there has been a significantly increased interest in the psychological dimension of the *corporeal image* concept.[1] Significant research showed its importance for both female and male sufferers of all ages, under multiple aspects including health, shape, weight, and attractiveness. According to Moore et al.,

> The experience of the body/self is thus involved in multiple dimensions, such as sensory, affective, physiological, etc., making a contribution to distinct portions of the neurosignature. Put differently, a pattern-generating mechanism exists in the brain that is capable of sustaining an image of the body upon which sensory [tunes] are played [1, p. 377].

The literature from various fields dealing with numerous types of terminally ill, from cancer to MS, reveals numerous communication problems affecting their care: "studies suggest [the existence of serious] problems in clinician-patient communication because delivering news about the ... diagnosis, treatments, [etc.] can cause the dialogue to falter" [1, p. 368]. In children suffering of

[1] We owe the remarks about cancer sufferers' body image – quoted [1], [2], [3], [4], [6] and [26] – to the excellent survey and synthesis of significant international research in the field made by Aurelia C. Bărbat, and summarized in the paper entitled "Cancer patients' body image under *phronesis*: bettering wellbeing through wisdom" she co-wrote with F. Lobonţ for, and presented at, the National Conference of Bioethics, Cluj-Napoca, 13-16 September 2012. This paper was an improvement of a previous conference paper from 2011 authored by Aurelia C. Bărbat and Dorin Bărbat, entitled "Body image and body message by cancer patients. A pluridisciplinary perspective".

corporeal decaying, life-threatening, illnesses, their self-image is a construct based on material, cultural, physical, social, cognitive and emotional experiences of the so-called *corporeal transgression* [2]. They express themselves quite radically when speaking about their body and show significant levels of anxiety. Adolescents affected by such illnesses experience anxiety and (distressed) self-consciousness triggered by the negative reactions of others, including "lower self–worth, more social anxiety, and more negative body image perceptions, [despite of not being regarded] ... as less attractive by observers" [3, p. 43].

With particular respect to cancer in adolescents, important research highlights experiences in terms of a complex fear: an embodied fear perceived as a threat to the personal self; the experiencing of fear related to the physical body; the experiencing of existential fear; and the experiencing of fear related to the social self [4].

Like in sufferers of younger ages, in case of adults suffering of terminal illnesses the existential dimension of their suffering include the

> diminished sense of self; the prospect of death; increased feelings of alienation, feelings of burden and dependency, or even the loss of the previous foundations of meaning. Even survivors often have difficulties in sharing their experiences with people who have not experienced similar conditions [5, p. 6].

In all age groups the experience of loss (by surgical procedures), or the atrophy of body parts prove to affect sufferers' definition of self. For example, in case of women,

> a mastectomy represents an assault on femininity, beauty, attractiveness, and the perceptions of oneself as a 'natural' and 'complete' woman. Breast cancer patients' perceptions of cancer are negatively affected by the social construction of the disease, which in turn is heavily influenced and shaped by the lay literature and the media [6].

Again with respect to cancer sufferers, but of older ages, Thome et al. describe their images of their identities as directly related to the following perceptions of their corporeality: *diseased* body, *disobedient* body, *vulnerable* body, and *enduring* body. Due to the diminished available physical, psychological and mental capacities, the lived body transforms itself in a restricted body, the disease being represented by the aged sufferer as a "[…] disruption of the lived body rather than as dysfunction of the biological body, reflecting two different dimensions of illness described as lived experience and scientific conceptualization" [7].

Neurophysiological perceptive and representational aspects of body image distortion

In the following, we will focus on the role of perception in relation to the body on the mental level and its relationship with the representation. In D.M. Amstrong's view, alternative perception is an intrinsic process, a component of introspective consciousness. The direct perception of body events is immediately completed by a representation of perceptual content [8]. This is relevant in view of the fact that patients who suffer bodily changes as a result of medical interventions have a specific characteristic of body perception and representation in the new condition. Since introspective consciousness is triggered by changing body conditions, patients require adjustments to how they self-respond to biopsychic change.

It is well known that physiological disorders induce disruptive neuropsychological changes in body scheme. Thus, subjective awareness of corporeality includes, in various degrees, elements of perception and representation of the body parts configuration and their spatial arrangement:

> One can use vestibular, kinesthetic, tactile, and to a limited degree also visual perceptions for inferring the actual position and configuration of one's body. Even in the absence of distinct afferents from these channels, one has a basic 'feeling' of where one's body parts are [9, p. 11].

Thus, in counselling and therapy interventions on suffering patients, corporeal awareness is an essential dimension. Patients have a fundamental knowledge of corporeality following life experience, and this knowledge is well implemented, correlated, mentally and physiologically. The observation of neurological symptoms such as the "phantom limb" and various forms of agnosia and apraxia, results in the major difficulties of body integration through amputatory medical interventions of organs or members, without taking into account the spectrum of specific neurological disorders.

In patients with cancer, a perturbation of the appearance of the body occurs especially when adaptation to the body image is immediate, for example in the case of amputations. Some disturbances of body appearance can be minimized by surgical reconstruction interventions. Surgical operations on internal organs, although not having an effect on external body appearance, trigger a mental discomfort that can be manifested by lack of self-confidence, isolation, etc. Hair loss following chemotherapy, pallor, are associated with changes in external physiological appearance. All of these patients require support from the family group. Women who benefit from breast reconstruction following amputation show an improvement in the frequency of negative cognitions with regard to body changes suffered. At the opposite there are women with disturbed feelings of femininity and concerns about

their perception by partners.

In addition to the necessary social support for cancer patients, the following is added: "People with decisions to make appearance-changing cancer treatment need support when assessing how their thoughts, beliefs, and feelings about appearance may influence these decisions [10, p. 335]." In cognitive behavioural therapy, significant results are obtained in the intervention on body image distortions, and these results legitimize the application of the method to a wide range of pathologies; strengths and vulnerabilities of the body image are assessed, the contexts responsible for negative emotions, the coping strategies, the attribution of physical appearance to a specific body scheme. During the interventions diaries are used, also mirror exposure, monitoring avoidance behaviours, assessment of subjective physical appearance, establishing strategies to control distortions, promoting positive body experiences, etc. [11] Genetic and evolutionary perspectives emphasize the role of context, concrete life experience in body image formation. In this way, the medical context is widened by a biopsychosocial vision, which determines the acceptance that the therapy for cancer patients, and not only in these cases, should also include interventions on body image distortions in terms of physical appearance and body functionality.

Corporeality is the most relevant dimension in interaction with the mind. Through our biological constitution, we have instrumental concepts about the parts of our body that belong to us. The body appears to be "something else." But the appearance of the corporeal at the subjective level "engages what might be called an evocative-integrative treatment of our embodied being-becoming, that is profoundly different from, and usually incompatible with, an instrumental treatment of the body [12, p. 94]." It is obvious that, for the most part, medical treatment favors the instrumental approach. Thus, body-mind therapy promotes a new interpretation of body distortions in specific or associated pathologies. Also, somatic psychology highlights the role of life experience in body image formation. The experience of corporeality becomes a way of interrogation within reflexive consciousness.

Undoubtedly, this vision aims to overcome neurological theories, which explain the mind in the body / the body in the mind strictly on the basis of psychophysical laws, and advocates a holistic, systemic embodiment. In reverse, the mind-body relationship appears as a continuous interaction on neurological bases. In understanding this interaction, we resort to Antonio Damasio's research on the body's cerebral mapping, the formation of neural maps following this process. It was arguably showed that, once formed, these perceptual neural maps persist even if certain body components are amputated and subsequently prosthetized. In other words,

> the brain can simulate, within somatosensing regions, certain body states, as if they were occurring; and because our perception

> of anybody state is rooted in body maps of somatosensing regions, we perceive the body state as actually occurring even if it is not [13] (p. 102).

Consequently, the brain represents the body as it was before the medical interventions. This explanation gives us the opportunity to consider the impediments of patients' adaptation to the new biopsychic alteration conditions related, at least in part, to the neurology of mind-body interaction. In the extension, patients compare their own physical state to that of others. Thus, adaptation to the family group and to the social groups is generally altered because of a discrepancy that exists between the representation of the body before the medical intervention and the body image restructured after this intervention.

In terms of enactivism, corporeal perception is in direct relation to the environment, as it is formed by sensorimotor action, and cognition derives from this relationship, the representation being eliminated. Body information is accessible to the subject as a result of sensorimotor action. We can ask the following question: In the case of patients who undergo medical interventions through which corporeality is altered, can we talk about a sensorimotor perception as it was before? Clinical evidence may help to answer this question in the affirmative way. From an external point of view, the perception of corporeality is framed in a dynamic system of causes and effects that interpose in the mind-body-environment relation.

This type of cognition of corporeality also involves the process of representation. Also, the socio-economic status of the subjects influences the relational dynamics of the brain-mind-body and, ultimately, the subjective perception of corporeality. Starting from this kind of consideration, V. P. Taylor argues in favor of an assembled model of embodied mind through which the perception of corporeality is placed in intersubjectivity, the social brain being considered as inborn. The author relies on research on mirror-neurons and considers empathy to be an essentially human natural gift [14].

"Wise therapies:" philosophical and ethical interventions through *phronesis*

Apart from the century-old primacy held for centuries by religiosity,[2] other forms of spirituality are playing an important, albeit insufficiently recognized, role in how people affected with life-threatening illness cope, in order to regain an integrated existence. On the other hand, the lack or progressive loss of

[2]According to Carmen Bărbat, religiosity contains a classical psychological dimension with three subdivisions (to think, to feel, and to act), and an interactional dimension, emerging from its socio-historical environment" [15, p. 123].

religiosity, or its incipiency should not prevent sufferers from regaining at least some meaning and dignity.

In the treatment of body image distortions in cancer patients assessments and interventions are still at the beginning, which is why we believe that these people can benefit substantially from the integrative perspectives of philosophical counselling. In addition to the perceptual component, the attitudinal component should also be considered in body image assessment, as the values and personal beliefs of these patients are also fundamental in the representation of their self-image.

Our view on the potential usefulness of philosophical and ethical counselling in such cases is inspired by the Aristotelian distinction between the forms of wisdom or skill that correspond to the three main types of activity (*theoria, poeisis,* and *praxis*) namely *episteme* (intellect), *techne* (craftsmanship), and *phronesis* (judgement) that is, practical philosophy that underpins good conduct or virtuous living. We wish to drawn attention to the latter, whose value is judged mainly by the quality of contemplation it promotes [16].

Unlike medicine or psychology, this type of intellectual assistance is not a technique (*techne*). Without being confined to a particular method, philosophical counselling applies reflective skills acquired during the study of philosophy in dialogue with clients. Unlike in case of academic philosophy, "reflective skills are applied to real life persons, the dialogue consists of spoken words, and the time frame is the now, the actual moment the dialogue takes place" [17, pp. 38-9]. This is a form of intellectual consultation quite distinct from psychological therapies.

Philosophical counselling aims at conceptual clarification and wisdom, without explanatory recourse to psychological patterns or mental health constructs. Nonetheless, it … may have beneficial psychological effects that can be broadly described as therapeutic [18, p. 112]. Philosophical counsellors or practitioners generally resist labelling their clients as intellectually "ill" or "dysfunctional," preferring instead to regard them as equal partners in the view-examining dialogue. Many of them find inspiration first of all in the Stoic and Epicurean philosophers, who focused on the use of philosophical thinking to minimize emotional disturbance and restore emotional tranquillity. An increased sense of wellbeing is a natural consequence of wise living, and it is an outcome well worth pursuing for its own sake. "People are not disturbed by things, but by the views which they take of things" (Epictetus).

By employing *phronesis*, counsellors and other helpers can help the clients appraise the force and dignity of their own values, understand their personal experiences and adapt to their existential situation and thereby buffer them against their emotional troubles and devastation.

In other words, philosophical counselling has broadly "therapeutic" goals in that it aims at alleviating anxiety and enhancing personal wellbeing [18,

p.113], not in aspiring to substitute any form of psychiatric or psychotherapeutic practice. That is why philosophical skills need to be supplemented with training in psychological assessment and counselling. techniques. But the philosophical practitioners also advocate a two-way road in the relation between philosophy and psychotherapy: according to Tim LeBon, such philosophical techniques are complementary to other counselling methods which may be better suited to managing a client's potentially troubled reactions and should be welcomed by practitioners who already hold accredited qualifications in therapeutic counselling [19, p. 17], [20, p. vii].

Profoundly informed by philosophy, all "wise therapies" appeal constantly to philosophy's most important elements: its object, methods and systematic nature. Its main domains are metaphysics, theory of knowledge or epistemology, and ethics and theory of values. Among the most important metaphysical questions relevant for counselling are those about the meaning of life, based on the fundamental assumption (shared by logotherapists) that the will to meaning is the main driving force in humans.

In epistemology, the justification of beliefs is reflected in various therapies' attempts to solve practical questions about the ways in which clients' convictions, preferences and decisions can become more rational, making their existence more satisfactory. The theories of life's guiding values are reflected by the attempts to assess the value of counselling and in those of critical analysis and clarification of values that govern the life of clients. The philosophical ideas of right and wrong help counsellors in facilitating the decisions of clients confronted with ethical or decision risks; they are also employed by counsellors confronted with specific ethical dilemmas.

According to Tim LeBon, the utility of philosophy in counselling is proved by its therapeutic engagement via the five methods it had generated, namely critical thinking, conceptual analysis, phenomenology, thought experiments and creative thinking [19, p. 4].

Critical thinking represents the testing of arguments' resistance to critical investigation and the pertinence of the reasons of their acceptance.

Conceptual analysis is a way of clarifying the sense of the assertions made in a given context via language analysis, questing for definitions and making distinctions in order to eliminate confusions. In counselling it proves its applicability both in analyzing evaluative notions (such as that of autonomy), and in clarifying the clients' problems concerning the meaning of life, freedom, happiness, faith, death, etc.

Phenomenology, in its applicative-therapeutic employment, is a

> philosophy according to which the events and the objects are understood in terms of our immediate experience of them, as they appear to us ... The therapies based on phenomenology are

> focused rather on the client's experience about the phenomena than on presuppositions, speculations or inferences [21, p. 136].

Although theoretically one among other methods, phenomenology in this particular sense of "being with the client's material" and the so-called hermeneutic dialogue – that in this context refers in essence to the joint interpretation of that material by the counselor and the client – constitute the dynamic framework of virtually all philosophical methods applied in counselling.

Thought experiments are mental experiments meant to ground, enforce or, to the contrary, to invalidate some aspects of knowledge. In counselling they take the form of scenarios concerning the clients—built together with them—that allow the exploration of things really important to them. The more recently developed philosophy for children devised simplified philosophical techniques adapted to children and adolescents.

There are numerous examples of experiments through which clients suffering from terminal illnesses received significant help in restoring the meaning of their lives, understood and assumed the limitations of human condition, regained their dignity and inner peace through acknowledging and praising their personal values and capacity of living through their reflective-philosophical selves [22, pp. 313-4]. Other techniques included the assuming and acceptance of physical decline and its inferiority to the intrinsic value of (the philosophically examined) life; learning to intensify the cherishing of good memories and the present moment [23, Ch. 3, 12, 13]. Other experiments included the dualist (Cartesian) de-centring of the client's identity from their body to their mind-body complex with the mind as the epicenter of their selves [24].

In its turn, creative thinking (that includes among is methods brainstorming and lateral thinking) has been included recently in philosophy through practical ethics. Whereas critical thinking assesses arguments, creative thinking's role consists in retrieving the thoughts that grounded people's arguments or views, thus helping us to identify the „best problems" (that is, those that can be assumed and examined philosophically and can bring self-worth through self-knowledge) and their solutions [25, p. 29].

Philosophical counselling and medical diagnosis

A number of writers have emphasised that the medical profession has priority in interpreting significant deviations from standards of normal emotional function as symptoms of biological disorders. However, philosophical practitioners should avoid the converse view: When

> equipped with expertise in critical thinking and knowledge of sophisticated worldviews, [one] may be tempt[ed] ... to construe

> all emotional complaints as consequences of philosophical error ... As we learn more about physical influences on mood and rationality, the insistence on exclusively cognitivist explanations looks increasingly dogmatic … [D]ogmatic cognitivism betrays an ignorance of the trend in contemporary philosophy towards theories of embodiment, which emphasise the complex integration of mind and body [18, pp. 115-6].

Moreover, philosophical practitioners who have not been trained in psychological assessment and treatment are not equipped to detect all potential hazards. For example, when analyzing the cancer patients specialists should take into account the so called "chemo brain" syndrome (as side effect after chemotherapy). The symptoms include cognitive impairment, memory, concentration and thinking problems that affect the patient-therapist communication [26].

Conversely, the various therapists from the medical domains *stricto sensu* may not be equipped to deal with diseases entailed by somatic disorders, including at corporeal image level. Just as confronting clients with their logical anomalies (sometimes self-defensive delusions) or dismissing the existence of cognitive disorders may provoke distress and injure their sense of wellbeing, the abrupt handling of the truth by medical staff in communicating with cancer patients can dramatically deteriorate the latter's fragile self-regard and sense of meaning. In the Dutch practitioner Dries Boele's words, "[s]ometimes, [in such] cases … a period of denial must be respected so that the client has time to adjust their complex constellations of interrelated personal sensitivities to the new reality." These are stages in which "some type of non-philosophical therapy may be necessary …, [as in them] a person cannot lead his or her life in accordance with autonomous and critical thinking" [27, p. 46].

Obviously, in such cases the philosophical practitioners lacking relevant qualifications should avoid all non-philosophical interventions and refer such clients to the suitable professionals. This means that practitioners should possess enough knowledge to generally discern whether the client's problems are medical or not. However, the philosophical domain of expertise is not compatible with the imposing or contradicting clinical diagnoses. Yet, Brown writes, this does not mean that philosophical methods should not be employed as a technique to help people with recognized mental health disorders.

> Philosophy can expedite improvements in cognition and wellbeing even for psychiatric patients. But instead of accepting psychiatric patients for therapeutic work philosophical counsellors should be urging the adoption of philosophical training amongst the psychiatric profession [18, p. 118].

As already stated above, medical authority has become widely recognized as

crucial in the diagnosis and treatment of various pathologies that involve distortions of corporeality. We want to emphasize that the philosophical counselling of the symptoms of bodily affections can be framed in the conceptualization of the experience of the human being as a whole. The patient as a human being interprets his mental and physical states in pathological conditions, depending on the social and cultural factors, life experience, that is why the counsellor can use the hermeneutical-phenomenological dialogue in order to improve his existential condition. For instance, James and Kevin Aho reached the conclusion that, alongside medicine, philosophical methods such as phenomenology can shape new horizons of understanding the specific condition of patients as human beings [28].

Conclusion

Terminally ill sufferers deeply need to have their concerns about their corporeal image addressed at self-perceptive level. The deterioration of this image contributes to their feeling of "disintegrated" existence." It is already a commonplace—albeit insufficiently considered—that supportive interactions are able to modulate the neuro-immune function in both healthy and ill people. As the group of severely ill patients / survivors becomes more and more recognized as a "distinct entity," more needs to be done in order to alleviate the effect of perceived appearance changes in all age groups and help them to develop a positive corporeal image. Philosophical and ethical counselling and other forms of dialogue therapy inspired by philosophy can contribute to these improvements.

Without crossing the boundaries of their competencies, philosophical practitioners can provide both patients and care staff with more means of coping with the existential suffering entailed by the life-threatening diseases. Alongside other forms of psycho-social and spiritual interventions, the millenary wisdom retained by philosophical practice can enhance the fighting spirit; reduce the feelings of helplessness; restore (at least in part) the meaning of life or finds inner resources of constructing new meanings, and thus decrease distress, anxiety and depression.

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