Psychotherapy with Physically Ill Patients

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Conceptual and Clinical Foundations

Psychotherapy with patients who are afflicted with so-called psychosomatic disease is one of the most challenging areas in our profession. Not only the knowledge and the technique of the therapist, but also his personal resources, face the greatest test in dealing with these patients. "Psychosomatherapists" have limited theoretical concepts and frames of reference in dealing with these patients, in comparison to those available in the treatment of neurotics, character disorders or borderline patients, and even psychotics. Craddock (1) has noted how the therapist's limited knowledge and experience make work with somatic patients discouraging.

The most striking influence in the field of psychotherapy with psychosomatic patients has undoubtedly been the application of psychoanalytic al principles to the study of the so-called "holy seven"—bronchial asthma, dermatitis, hypertension, thyrotoxicosis, peptic ulcer, rheumatoid arthritis, and ulcerative colitis. While Dunbar (2) investigated the correlation between particular personality dimensions and different diseases, Alexander (3, 4) examined the relationship of specific intrapsychic conflicts to specific psychosomatic disorders. These types of theoretical models still constitute the core of working hypotheses for practitioners who are engaged in the treatment of such patients. Later work of Wolff (5, 6), Rahe (7, 8, 9) and others has addressed itself to social and environmental crises in the lives of patients, thereby initiating an era of stress-oriented, short-term approaches and the extension beyond orthodox psychosomatic disorders to encompass the recently renamed "psychophysiological" reactions (10), as well as diseases such as myocardial infarction, migraine headaches, anorexia nervosa, etc.

The conceptual foundations and application of psychoanalytic theory and psychodynamic principles to the treatment of psychosomatic disorders are well reflected in the case studies of Sperling (11, 12), Jessner (13), and Castelnuovo-Tedesco (14, 15). The basic psychodynamic thesis of Sperling, for example, is based on her work with children who have severe psychosomatic disorders, especially ulcerative colitis and bronchial asthma. She has concluded that "every case of psychosomatic disorder has its origin in the mother-child relation of dependency.'' That is, "no matter how independent and self-sufficient a patient's life may appear to be, we find on closer inspection in every psychosomatic case… that the patient lives in an emotional symbiosis with one object in his environment, who does not have to be the actual mother but who somehow, in the patient's unconscious, serves the dynamic function of a mother figure. The psychosomatic patient cannot consciously tolerate his pregenital impulses ... he, therefore, denies them completely and they are converted into somatic symptoms and in this way gratified'' (11, p. 286). Castelnuovo-Tedesco (14, 15), who worked with adult patients, has emphasized the roles of fantasized or real alterations (i.e., real or threatened separation, coercion or intrusiveness in significant object relationships of the patient) which play a major part in the exacerbation of illness.

Although some success with psychoanalytic techniques has been reported by individual therapists, research findings have been nonconfirmatory (16, 17, 18). The application of analytical approaches in the therapy of psychosomatic disorders has not synchronized with the wide acceptance of its theory. Thus, few therapists still continue to treat these patients in a traditional psychoanalytical manner. Their reluctance is compounded by the general opinion of the public and the resistance of referring physicians, whose view of psychotherapy for psychosomatic patients has been less than favorable (19).

Moreover, not much support has come from within the profession itself. Sperling (11) stressed the uneconomic aspect of therapy with these patients. Sifneos (20) suggested that some patients actually get worse from the

psychodynamic process, and that, for the majority of patients with psychosomatic disorders, dynamic psychotherapy is contraindicated.

Similar statements could be made about any group of patients. Certainly, analysis of neurotic patients is no less uneconomic, and one may comfortably state that, for the majority of the patient population at large, an analytical approach would be contraindicated. One should not forget, however, the heuristic value of working with these individuals, as well as the contribution that psychotherapy could make to the health of such individuals who are suffering from intractable chronic illnesses, no matter how few they are and how expensive it might be.

The above attitudes certainly have not encouraged psychosomatherapists to continue the arduous task of working with these patients. Most psychiatrists in the field have therefore confined their work to consultation-liaison services and brief intervention approaches. Alexander's (21) "platonic ideal" of teamwork between the psychiatrist, the medical specialist and others on the wards is not necessarily an unachievable goal. In fact, relative success has been gained in such collaborative efforts on liaison services. Rather, a major difficulty is the lack of accepted theory and a working hypothesis that one is relatively sure about and can share with others. The latter, I believe, is the main source of therapist countertransference in working with these patients, as discussed in the writings of Fain and Marty (22) and Wolff (19).

Nonetheless, research work in this area has continued to explore the efficacy of psychotherapy. Lazarus and Hagens (23) have utilized brief psychotherapy in their attempt to decrease postoperative delirium in cardiotomy patients. Layne and Yudofsky (24) have reported positive results with even single interviews, and Surman et al. (25) have replicated these favorable findings. These brief approaches utilized supportive as well as educational techniques, including rectifying possible misconceptions about forthcoming procedures, teaching patients a simple autohypnotic technique, etc.

The aim of this chapter, however, is to delineate some of the specific practices of long-term individual psychotherapy with patients who have a medical illness, addressing psychological components in initiation, maintenance, or etiology of the disease.

It may be hypothesized that all medical diseases have psychological components. The earlier theories, that there are specific factors in the psychological makeup of the patients which make them susceptible to certain somatic diseases, have not been confirmed by research findings. But controversy on the matter is still quite alive, as exemplified in theories of the dependency struggle of ulcer patients, or the hard-driven personalities of patients with cardiac disorders. Others have focused their attention upon more generalized factors, such as the patients' cognitive organization, defense mechanisms, and attitudes, e.g., inability to verbalize emotions, denial of psychic conflicts, and a major manifestation—profound resistance to therapy. Reckless and Fauntleroy (26) viewed such denial as an archaic defense against feelings of anxiety, and emphasized the difficulty of these patients in expressing emotions, especially their aggressive feelings against others. O'Connor (27) pointed out the psychosomatic patient's need to have his physical symptoms for the very purpose of warding off psychological insights. Wolff (19), in fact, believes that somatic disorders often develop because emotional conflicts and impulses are not allowed direct expression. In addition, most somatically distressed patients are usually unaware of their being under stress (28). Thus, they will consciously deny the psychological contributions to their illnesses with a facade of emotional strength, regarding the show of emotional problems as signs of weakness, or as synonymous with malingering (29). Others have focused on the fundamental character problems of patients with psychosomatic disorders. A so-called "psychosomatic character pattern'' has been formulated with the following manifestations: lack of libidinal affect, impoverished use of language, operational thinking, inability to regress, and lack of neurotic behavior (30). Sifneos (31) observed these patients' poverty of fantasy life, constriction of emotional

functioning, inability to find appropriate words to verbalize feelings, and absence of ability and motivation for self-examination, which occurred within the therapeutic situation. He termed this composite of characteristics, “alexithymic.’’ McDougall (28) recognized a "psychological hardiness’’ in these patients, a need to refuse to reveal or give in to their dependency, disappointment, anger or despair. Castelnuovo-Tedesco (14) spoke of the ulcerative colitis patient’s aloofness, detachment, and contentious demandingness, which tends to come to the fore in the analytic situation. Reckless and Fauntleroy (26) described this overall posture of psychosomatic patients in treatment as “a negative attitudinal set.”

Nevertheless, these hypotheses and observations have not been sufficiently translated into the language of practice so that they might be applied to the actual treatment of patients. In describing this, I will focus my discussion on the treatment of patients with peptic ulcer or myocardial infarction, with whom I have had the most contact, although I believe that the following generalized principles are clinically applicable to most somatically disturbed patients.

The Treatment Process

Treatment of illnesses like acute ulcers and myocardial infarctions in an inpatient hospital setting relies upon the therapeutic benefits of a great deal of physical and psychological rest and, to a great extent, the actual removal of the patient from his life situation and its stresses. The role of the psychiatrist at this time is usually limited to identifying the sources of stress in the life of the patient. Most patients may not volunteer such material for discussion with the therapist. In general, the therapist’s support and availability are needed, but only tolerated by the patient, his family and physicians. Unfortunately, after treatment of the acute phase of their illness, patients are usually discharged to the same situation from which they came. But these illnesses are usually chronic, and stresses in the life of an individual everlasting. It would be unwise for the therapist to promote the fantasy of a nonstressful existence; however, if the therapist’s relationship

with the patient can be established, the therapist may temper the situation by neither indulging nor totally denying the stress. These efforts by the therapist, unfortunately, are often of little avail, since a large proportion of patients tend to drop out at this early stage of treatment.

In a moderately longer-term treatment, where a manageable stress situation can be maintained, the therapist may attempt to make the patient aware of some of his unconscious needs and defenses, and try to modify his coping mechanisms to life stresses. Here, lack of success in simple reduction of stresses, or rejection by the patient of suggestions of alternative coping mechanisms, may lead to the therapist’s becoming discouraged. In such instances, the therapist may revert back to the typical analytical model with which he is most comfortable.

The psychodynamic working theory for long-term treatment of somatic patients is based on certain assumptions: a) that unconscious impulses are manifesting themselves in pathology of the organs; b) that affective experience is inhibited or repressed and/or somatically manifested; and c) that developmental stages of the individual are arrested and have never reached their symbolic, verbal, expressive stage. Regardless of the validity of these theoretical formulations, such generalizations are of little practical use as such. Moreover, they may actually interfere with the clinician’s careful evaluation of the patient, since they provide ready-made explanations. Such categorical approaches only help to comfort the therapist. Therefore, firstly, the psychotherapist treating psychosomatic illnesses should get away from any generalized formula that may be applicable to all diseases or patients; rather, he needs to explore with the individual patient the role of his symptoms in his life, their conscious and unconscious meanings, and whether there are stresses that initiate them, or conflicts that maintain the patient’s disease. Individual patterns of somatization, the patient’s coping mechanisms and defense structures, instinctual patterns, and his total character organization require careful individual attention prior to assessing the specific patient’s suitability for psychotherapy. Criteria used to

assess the suitability for psychotherapy of neurotic patients and those with character disorders are quite applicable to medically ill patients, that is, ability to establish an interpersonal relationship, insightfulness, psychological mindedness, ability to sustain motivation, etc. Yet, the relative lack of these desirable qualities should not deter the therapist from attempting to treat the patient because it may mean altering his approach. Practitioners modify their approaches all the time to accommodate psychotic populations, less intelligent patients, severe borderlines, etc.

At the end of the initial evaluation of the person, the patient and therapist should share a sense that either the patient's medical illness is reactive to external stresses, or is the result of his failing coping mechanisms (with or without primary or secondary gains associated with illness). It is then possible to formulate a treatment approach that can be acceptable to both parties. Such a negotiation is quite an important aspect of working with somatic patients.

On the other hand, if the therapist does not find external stresses or failure of coping mechanisms, but identifies certain characterological structures of the patient as either causing or participating in the initiation or maintenance of the illness, he may still attempt to do psychotherapy, recognizing that such assumptions are only inferential. Whether the primary goal of psychotherapy is addressed to the maturation of the individual or a resolution of psychodynamic conflicts, it must be understood that the therapist may state only that the patient's illness be secondarily helped by such a process. It is important that the patient agree to a working relationship on this basis at the beginning; otherwise, the question of "what has all this got to do with my illness?" will become a major obstacle in therapy, and the patient will drop out of treatment sooner or later.

The difficulty of keeping these patients in treatment is well-known. This might be due partly to factors relating to the patient per se, such as defensiveness and the characterological aspects discussed earlier, but it is also a result of the psychiatrist's inability to present convincing evidence to the patient that he

might be of help. This is partly related to the fact that we are not ourselves convinced about the nature of these diseases and their psychological treatment, and we certainly do not have enough experience or confidence. There is a lack of a consistent body of knowledge in the field, especially in the application of psychotherapy and its techniques in the treatment of these patients. Therefore, the therapist is very much without adequate tools. Unfortunately, most training programs fail to provide experience in the treatment of psychosomatic illnesses. This, compounded with insecurities from limited knowledge in the field itself, creates an unfavorable condition from the beginning. These uncertainties are consciously and unconsciously conveyed to the patient in the earlier stages of treatment, possibly resulting in disruption of the therapeutic relationship. This is not to say that the therapist ought not have scientific skepticism about what he does and its effects in clinical practice, but the balance has to favor the basic premise of the importance of the therapist's confidence in his work. That is, he must be relatively sure of his theoretical frame of reference, his goals to be accomplished, their feasibility, as well as how he will go about performing his therapeutic tasks, i.e., his techniques.

Unfortunately, psychosomatherapists are handicapped in all of these areas. Moreover, medically ill patients constantly challenge the therapist, his knowledge, the relevancy of the psychological material to their illnesses, etc. Since the therapist is under such attack when working, these patients typically pose a threat to his self-esteem and self-confidence, and tax his patience. Very few therapists are willing or able to survive such an experience. The typical neurotic patient may confront the therapist similarly, but usually responds favorably when the therapist makes explicit the patient's implicit doubts and questions about his ability. Also, he is more accepting of the therapist when he interprets the negative transference. But generally such approaches have not proven to be successful in dealing with psychosomatic patients. Rather, the clarification or interpretation of the patient's doubt of the psychotherapist and psychotherapy in the treatment of his illness tends to lead to confirmation of the

patient’s doubt; most attempts at the searching into the negative transference only serve to exacerbate the situation by precipitating termination.

In practice, a reasonable therapist would suggest at this stage that he is not sure that the patient’s medical illness would be ameliorated by psychotherapy. But there are probably certain problems in the individual’s life, which may be identified during the sessions, which he would be glad to work on with the patient in the hope that somatic symptoms of the patient might benefit from such treatment. However, most patients are not likely to be favorably disposed to such a proposal and will demand either a greater promise or a more concrete statement from the therapist that symptoms will be helped by psychotherapy. That is usually the end of the relationship. A therapist who overpromises with the hope of keeping the patient in treatment will suffer through each session again and again answering the same questions, but will end up with the patient terminating anyway.

Case Illustrations

A typical case demonstrates some of the difficulties confronting the therapist in the initial interview: A 49-year-old male patient, owner of a large manufacturing company, was referred to me after having his first myocardial infarction. His physician was familiar with the studies of type A personality and felt that his patient belonged to this category and might benefit from psychotherapy.

The patient was a largely built man, weighed about 300 pounds and was 5 feet, 9 inches tall. He was well-dressed, self-confident, aggressive and verbal. He had been married for 20 years to his high school sweetheart and had two children, ages 18 and 16. Both girls were doing well in school and their social lives. His wife was a maternal, somewhat demanding woman, but dedicated and loyal to him. The family situation was relatively stable. The patient was the youngest of three children, with a sister five years older and a brother 14 years

older than himself. His father died when he was 15 years old and left a large business to his brother, himself and his brother-in-law. His mother was living in a nursing home. His older brother had taken charge of the operation of the business since the death of the father, but the patient himself was quite active and successful, especially in a special part of the business. He smoked one pack of cigarettes a day, drank two to three cocktails every night, was sexually active with his wife at least three times a week, and also was seeing other women, mostly call girls, at least once a week while entertaining his out-of-town customers. The patient had no history of other medical illnesses or psychiatric problems. He was put on a diet and anticoagulants by his medical doctor, but he was not complying with these orders.

In his relationship with me, he reluctantly gave responses to my questions in trying to explore his psychological world. He looked annoyed and asked what all this had to do with his heart problems. I told him I did not know, but perhaps he felt there were areas in his life about which he felt distressed. He said that he would like to smoke less and eat less, and asked whether I could hypnotize him for that purpose. He was clearly interested in a quick and effortless result. I told him that I agreed that smoking and eating were certainly important areas for him to modify, that hypnosis might be one of the possibilities to explore in getting help, and asked if that was the only area he considered problematic. He said that there was nothing else that might be helped by a psychiatrist. It was clear that the communication between me and the patient was leading towards a typical ending. I decided to tap some of the other areas mentioned at the risk of further alienating the patient. I asked him whether he was conflicted about sleeping with other women. He said, "No," that this had been his pattern throughout his marriage and had never interfered with his life. In relation to business, he said it was all okay—he was making a lot of money, though his brother sometimes was too domineering, but he had learned to bear with him.

As far as his medical illness (myocardial infarction), he said, "I guess I could have died," recognizing some degree of fear, but bragged about his flirting with

the nurse the second day of his admission to the hospital. I asked him whether that was his way of dealing with his fears. His answer was "No, I always like women." About dying, he said that one day he will die, but he cannot stop and worry about it, and that he is determined to enjoy his life. He had no other interest in matters such as art, music, etc., although he had finished college. He said that he did not fantasize, that his dreams were very realistic. He did say he had some preoccupations, but when I asked whether he could tell me about them he replied, "You would be bored with what's on my mind." When I persisted he responded by saying that his mind was blank at the moment.

I asked him why he agreed to come to see me even though he felt that psychologically there was nothing wrong with him. He said that he came because his physician insisted. He apologetically added that he didn't want to insult me, but thought he was wasting his time and money with me. There was a long silence while I was thinking that he might be right. We looked into each other's eyes, searching for a graceful way of terminating the session. I asked him what he was thinking while looking at me. He said that he was wondering whether it would be difficult to find a cab at 5:00 p.m. in this neighborhood. Our time was up for the day. When I then told him that we should set up another appointment for the next week, he looked rather surprised.

This case illustrates how my attempts to find an area of intrapsychic conflict were responded to with denial, even though his resentful relationship with the brother, his sexual acting out, and his concern about dying were rather easy to identify. Although he did so reluctantly, he responded to the questions enough for me to formulate some understanding of the patient. However, he was completely unaware of the pathological aspect of his own behavior. In contrast to psychopathic persons who would likely make some attempt to justify or rationalize their behavior or manipulatively may express some pseudo-guilt, my patient was quite comfortable with himself, and only annoyed by my search for an ego-alien aspect of his behaviors, feelings or tendencies towards acting out. His feelings toward his dominating brother were kept out of his consciousness,

and my attempts to unearth them created further solidification of his defensive attitude; this was the beginning of his disengagement with me during the interview. His "operational thinking'' (30) was almost caricatured in his wondering whether, "he would find a cab at that hour," at a moment of search for insight, feelings or comments about our interaction. Of course, at the end one could have terminated the session without further appointment. But I have learned with these patients not to take the *no* for an answer. Yet the therapist who takes such a risk must be ready to deal with sarcasm, further questioning, or outright rejection.

This patient illustrates several initial difficulties in working with these patients—reluctance to become engaged with the therapist; lack of suitable material for psychological work; lack of motivation or incentive for the therapy; lack of introspectiveness; apparent absence of ego-alien psychological symptoms; absence of seeds for transference; pensée opératoire par excellence; affective distancing; strong denial and other pathological defenses; and frustrating, challenging and other non-accepting postures towards the therapist. But one should not be discouraged by this conglomerate of negative factors because these are related parts of the overall defensive structure of the patient, and potentially amenable to therapy. These can become workable patients.

A negative attitude or set as initial resistance to becoming engaged with the therapist is typical of many patients with psychosomatic disorders. Basically, they are loners who will maintain their self-image and the relative stability of their psychological order, internally, by using a great deal of denial, and externally, by constantly reshaping their environment to secure their stability. Any threats directed towards these external factors may create disorganization for the patient, whose defense mechanism of denial may no longer be successfully operative. In some patients, the somatic symptoms are manifestations of this particular stage of failure of coping mechanism, the latter precariously kept in balance between the denial and the private order of the external world. Here, these patients' reluctance to engage with the therapist is a

resistance to a real, as well as to a transferential, relationship. I call this avoidance the “resistance to transference” because, in contrast to psychotic patients, these patients’ potential for transference does exist. Therefore, the first task of the therapist is to keep the patient in treatment, which is an inherently difficult task. One cannot expect a typical positive attitude from these patients, as compared to those who are experiencing psychic pain, because of their lack of ego-alien symptoms such as depression, anxiety, etc. As such, there are no given incentives to keep the patient in treatment, nor enough motivation generated during the interview to maintain the patient’s initial interest in treatment (which is usually meager to begin with).

In this regard, I have found certain similarities between somatic patients and adolescents, who are also somewhat reluctant to talk about their psychological problems at the initial stage of treatment. In the latter instances, the therapist has to engage the adolescent actively in the discussion of a subject that is to his interest, i.e. football, jazz, etc. With the patients who have somatic disorders, a common initial ground for patient and therapist is the patient’s daily life, which is his major preoccupation even though he may be reluctant to talk about it. Therefore, in order to engage the somatic patient in a relationship, the therapist has to, at times, learn a great deal about the person’s business life or other daily life, almost as much as about the childhood and interpersonal relationships of the patient. What may appear to be a trivial matter that preoccupies the patient’s mind and a seemingly unimportant detail to the therapist in his attempt to understand the patient may lead to a great deal of information, if the therapist is willing to listen with patience. Interpersonal and work behaviors are always worth exploring because they may give clues to the psychological makeup of the individual as well as his conflicts.

The psychosomatherapist should not make any attempt to replicate traditional psychotherapy by keeping silent and encouraging development of the classical transference. If he is successful at all in his attempts, he will only create a negative transference, which will not be undone by interpretations, and the

patient will end up dropping out of therapy. The fact that the patient is not forming transferences is a manifestation of his object relations in life. Patients that I have treated never had a good object relationship in their lives. Most of the objects in the past have been extremely ambivalently incorporated; therefore, every effort is being made by these patients against the development of transference.

Another feature, lack of affective experiencing, which is commonly mentioned in the literature, is related either to the overpowering aspect of the affect, which is usually negative, or to the fact that the affect is associated with certain somatic experiences and therefore to be avoided. The therapist should not insist upon inquiring into the absence of affects or keep prodding the patient, "tell me how you feel"; rather, he should understand the defensive purpose of the affective block as one of the characteristics of these personalities.

Even during the initial interviews, there are usually longer silences than psychotherapists are accustomed to. This is related to a particular inability of the patient to engage in free associations, verbalization of his feelings, spontaneity, etc. This is consistent with the findings of Marty, M'Uzan and David (30), in their studies of psychosomatic patients. They observed a type of inertia which threatened to bring discussion to an end; the investigator had to make vigorous efforts to stimulate associative material concerning the patient's relationships, life experience and illness; also, significant or painful events were absent unless directly solicited. In such instances, therapists should not stay silent as they might in typical psychotherapeutic situations with neurotic patients.

Mushatt's (32) work with ulcerative colitis patients confirms that these patients cannot tolerate therapists' silences. Therefore, therapists should be as encouraging as possible and actively try to engage the patient to speak. Sifneos (20) also noted that psychosomatic patients find little to talk about. In fact, most of these patients will respond by saying "nothing" to the question, "What are you thinking?" On further inspection, they usually are thinking about minor matters

and details in their lives, and are embarrassed to mention them unless the therapist insists and also reassures them that such realities are important to talk about.

Since material that is necessary for psychotherapy is so difficult to elicit, one is often tempted to talk to the patient about his defensive posture and his avoidance of the therapeutic situation. Again, such an approach generally proves to be rather useless and even further alienates the patient. As a result, the countertransference of the therapist to these patients is a very significant matter to consider; it commonly manifests itself in annoyance, boredom, or belittling statements of an aggressive nature, either in the guise of attacking their defenses or of interpreting the affective distance, which further eliminate the potential for a therapeutic alliance. Since the traditional therapeutic frame of reference is not operative, the typical therapist tends to become defensive. Feelings of impotence, rejection, self-doubt, and defeat emerge. Such unsettling conditions in the therapist are not conducive to creating any confidence in the patient; therefore, the vicious cycle will continue, with a typical statement on the part of the therapist that the patient is not motivated or suitable for psychotherapy. Fain and Marty (22) have pointed out the countertransferential lack of interest that develops from the patient's character and constitutes a chronic narcissistic blow to the therapist's interpretive powers because the patient appears impervious to his special skills. The truth is that the patient has come to at least explore the possibilities, but the working hypothesis of the therapist may not be suitable for that particular patient.

Four years later, the patient I discussed earlier in a case study is still with me. Recently we are in the process of discussing termination of therapy. He does not have any symptoms of MI, has lost 100 pounds over the past two years, stopped smoking and acting out, is complying with his medical doctor's food and activities regimen, has taken up a hobby of his father (photography) upon my suggestion, and has become a more active partner in the business. There are many relatively unresolved issues related to his character structure, such as his

fear of aggression and his strong dependency needs, but he acknowledges them with a sense of humor, expressing his disappointment that he has to lose childhood forever. In summary, I do not want to overestimate what has been accomplished. The patient's characterological problems by and large remain unchanged or mildly modified. But he has gained a perspective over his life and his problems, has learned to think psychologically, and has begun to enjoy himself and to laugh at times at his "craziness." He has explored the other simple pleasures of life, and stopped the sexual acting cut which was guilt provoking (though previously denied). He has become less anxious and made contingency plans in case of death; a reasonable fear of death has begun to emerge. Whether these changes have contributed to his not having any signs of MI, I cannot answer. But if he does have one in the future, I know he will be able to cope with it.

Treatment Recommendations

In considering the totality of treatment, there are many stages of the relationship between the psychiatrist and the patient. Initially, the therapist may have to be involved with the physician, the family of the patient, and the other staff involved in his care. During this stage, the psychiatrist's main locus is diagnosis and management. He will continue to explore the psychological makeup of the patient, but basically treatment is limited to recommendation of medication, changes in the environment, and facilitating the communication between the parties involved. This first phase is applicable not only to psychosomatic disorders, but to all medical illnesses. The therapist is basically a supportive person who is available to deal with the stresses in the person's life, family, job, etc. He may explore the patient's psychological contribution to his illness as well as his psychological reaction to it, i.e., fears of dying, shattering of omnipotence, guilt, frustration, and issues such as money, confinement, etc. The therapist may provide an alternative to the patient's pathological and nonadaptive defenses.

In a chronic phase, the therapist may repeat the issues of the acute phase in a modified way, especially if it is his first contact with the patient. Otherwise, the therapist's role would be one of focusing more on establishment of the working alliance with the patient and engaging with him in the areas where mutual work could be done. Chronic patients are more reluctant than acute ones in establishing a relationship with the psychiatrist. Initially, a session once a week is the best frequency that a patient can tolerate. This allows the patient to be distant enough not to force premature intimacy, but also it will provide sufficient continuity of contact with the therapist. Towards the resolution of the dependency phase, one may increase the sessions to more than once a week. This stage usually corresponds to development of freer associations and the presence of dream material and is, therefore, appropriate in its intensity.

During the initial phase of the treatment, then, the therapist must:

1. take an active role during the sessions in creating an atmosphere of easier interchange;

2. receive initial trust of the patient by a display of acceptance and knowledge of his medical illness;

3. create a working alliance by taking an interest and learning about the daily life of the individual, and tolerating his operational thinking while gradually educating him to psychological introspection;

4. recognize and tolerate the patient's major defenses, which are: splitting, avoidance, manipulating, distancing; and

5. resist the temptation for premature interpretations.

After a successful first phase of therapy, the patient may begin to recognize the therapist as a teacher, ally, supporter, etc. The second phase may be described as the "phase of experiencing.'' This is the time when the patient develops dependency on the therapist. He will begin to open up about his well-kept secrets in his daily life, testing the acceptance of the therapist, and also making an attempt to deal with the guilts and fears associated with it. Even at

this stage, psychological elements of early childhood are rarely present, and the focus of therapy is basically here-and-now. Any attempt on the part of the therapist to interpret increasing dependency is ill-advised, because it usually leads to denial of it by the patient, and very commonly, to a reexperiencing of the somatic symptoms. Stevens (33) noted that the transference interpretations in therapy mobilize enormous anxiety in these patients. Most patients mistakenly view the therapist's comments about their dependency as a threat of termination. Such fear will not dissipate with interpretation or reassurance, which the patient may perceive as confirmation of his dependency, a weak position that he has defended against all his life. The rate of dropouts among these patients is probably higher during this phase than at any other time, except the initial phase of treatment. The therapist is usually blamed for having aggravated the patient's condition. However, in a well-managed second stage, the patient should be able to experience the first positive feelings towards the therapist—affection, dependence, protective friendliness, etc. These feelings usually do not create any somatic symptoms, much to the amazement of the patient, who had withheld all these feelings for a lifetime. With the pleasure of these new sensations, the patient may indulge himself by going into a positive expressive stage, not only with the therapist, but also with some members of the family and friends alike. The therapist should allow this somewhat superficial stage of experiencing positive feelings to go on for a long time. Of course, one cannot necessarily avoid the unpleasantness in a person's life, but experiencing negative feelings should not be encouraged during the therapy sessions. Rage, anger and similar affects should not be explored prior to establishing some somatic comfort along with positive feelings.

Affect has been said to be non-existent in the patient, that is, the patient usually makes every effort not to experience the feelings associated with unpleasant bodily sensations. In the past, headaches, stomach acid, pain in the chest, etc. are experienced with feelings such as anger, anxiety, fear, and later on generalized to include the positive feelings as well, i.e. warmth, intimacy, love,

affection, dependency, yearnings. All affect is to be avoided if one wants to stay somatically well. Therefore, for the patient to express his positive feelings without experiencing bodily discomfort is an important step in the treatment.

The earlier objects of the patient are commonly remembered as undependable. Therefore, the therapist should avoid any behavior, i.e., cancellations, lateness, in order to prevent development of negative feelings during the initial phase of the treatment. During this time, the initial doctor/patient relationship will gradually shift towards more of a friend/friend relationship. Later on, a teacher/student type of relationship may begin to develop. The typical analytical therapist/patient relationship, which has been likened to a father/child relationship, may eventually be established, approximately six to twelve months after the onset of treatment. Only when a reliable dependency relationship has been established will some early material start to emerge. At such time, the affect that is experienced may be positive or negative; at this point the therapist has to monitor the somatic symptoms before he can encourage further regression, freer associations, or the reporting of dream material. The conduct of treatment during this phase is no different from the traditional approach, that is, insight-oriented dynamic psychotherapy. At the same time, the patient may be encouraged to do certain homework in the form of behavioral exercises, i.e., controlled aggression and assertion, sexual intimacy, and the expression of dependency needs to other individuals.

Conclusion

The following guidelines are recommended in the treatment of physically ill patients:

1. First and foremost, the therapist has to create a climate of therapeutic acceptance, warmth, understanding, and empathy in the therapeutic situation, as well as provide all the other nonspecific conditions for a supportive environment. Specific techniques have to be flexible enough to accommodate a range of psychosomatic concepts, such as the psychogenesis of the illness, one’s psychological contribution or

psychological reaction to life stress and illness, maintenance of the disease and symptoms and/or specific psychological predisposition to them, psychodynamic configurations and character structures related to particular somatic disorders, etc. In some instances, none of these elements may be represented; in others, one or more of these possibilities may exist. Therefore, a highly individualized approach to each patient, with specific assessment of his respective psychological picture, is important prior to initiating or formulating the therapeutic plan.

2. A thorough medical and psychological history should be taken on intake. This requires that the therapist must be familiar not only with the disease in question, but with its medical treatment.

3. At the beginning, the therapist should address himself to the patient's understanding of the psychiatric referral itself, about which there are fears and concerns as well as expectations. Most patients do show up for the first interview to pass the test of sanity, but not necessarily to be helped by a psychiatrist. Halsted and Weinberg (34), for example, had observed that the ulcer patient would ultimately agree to psychiatric investigation not because of a recognition of his own needs, but because he was convinced he was doing it for someone else. It is important to recognize this phenomenon at an early session, which has an educational value for the patient as well as helping to create positive relations with the therapist.

4. Therapeutic intervention should be carefully paced. Initially, the patient should not be seen more than once or twice a week because any more intensive involvement can generate excessive anxiety and exacerbation of symptoms. At this time, he should be able to discuss the questions of the patient with regard to his illness without competing with the internist. This interaction will serve to increase the confidence of the patient in the therapist, and will also serve an educative function of clarifying those questions of the patient that the internist may not have answered. For example, Bilodeau and Hackett's (35) study of cardiac patients in group therapy revealed several questions and concerns of their patients, including issues of diminished libido and fear of death during intercourse; yet, no group member had discussed these concerns with his medical doctor, and none of the internists ventured to bring up these subjects with their patients. The patient's misconceptions and misunderstandings about

his illness need to be corrected first as a way of dealing with his anxieties, fears, and concerns about himself. Such discussions usually include the vulnerability and mortality of the patient, his or her fear of dying, issues of separation, etc. On one level, medical illness and its medical treatment are discussed, and on the other, psychological parameters of the illness are explored.

5. In terms of therapeutic technique and its timing, the therapist has to engage the patient initially in reality issues, which may be trivial daily affairs, in order to establish a common ground between patient and therapist. It must be emphasized that, as Sperling (11) has pointed out, interpretation of maladaptive defenses in psychosomatic patients at an early stage of the treatment may aggravate the patient’s somatic condition. It is common, too, that the patient’s psychological condition may also deteriorate. However, precipitation of a psychotic breakdown, however feared by therapists, has been reported as unlikely in actual practice (19).

6. In general, the therapist should recognize that it is not his role to treat medical illness, but that he must be concerned with identifying psychosocial contributors in patients’ lives to their illness. He must help patients to recognize their adaptive and nonadaptive responses to their medical illness and help them to modify their responses where necessary, identify secondary gains associated with the illness in order to prevent maintenance of the symptoms, and anticipate and prevent psychological conflicts which might exacerbate somatic symptomatology.

7. Finally, although I suggest that the therapist establish an authentic object relationship with the patient and try to closely monitor the patient in experiencing affect within the therapeutic context, he must at the same time be *flexible* enough to utilize all potential therapeutic agents which might be suitable to his patient. In this way he will be able to establish an approach that might be not only therapeutic as conceptualized by the therapist, but also acceptable to his patient.

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