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PSYCHOTHERAPY AND PHYSICAL ILLNESS

INTRODUCTION

All of us, patients and therapists alike, get frightened on some level when either we or those close to us are faced with physical illness. Our sense of vulnerability, frailty and helplessness is stimulated when our own physical well-being or the physical well-being of our patients is threatened. This fact of life was the initial concept for this issue of our journal. However, as I invited others to contribute to it, the subject was broadened to include other aspects relating to the interface between physical illness and emotional illness, character and emotional variables associated with physical illness, and the psychotherapeutic treatment of the physically ill. The focus of this issue is, nonetheless, about clinical psychotherapeutic concerns which arise because of physical illness in patients and/or psychotherapists--a troubling, yet common, occurrence in our lives. Rather than a philosophical discourse about the relationship between the mind and the body, our goal is a practical/theoretical discussion of the overlap of the physical and emotional aspects of psychotherapy.

The orientation of this issue is from the vantage point of Crisis Mobilization Therapy which views psychotherapy from a medical/surgical perspective. Central to this theory is the idea that the therapist is the instrument of change. In ongoing intensive psychotherapy the therapist has to protect himself/herself from over- or underidentification with patients while being strongly involved with them. The psychotherapy of the physically ill patient poses special problems because the therapist's fears which are stimulated by the patient's physical illness often stress the therapist's personal boundaries and objectivity.

Following a brief literature review by D. Baker, two controversial yet complimentary articles challenge some common psychotherapy assumptions. R. Hook invites us to accept the notion that the physiology and the emotions should be treated as one and the same, both by physicians and psychotherapists. R. Bar-Levav redefines the goal of psychotherapy and guides the clinician in making the difficult decision of who to treat and who not to treat. These articles are followed by a compelling therapy case which illustrates the difficulties experienced by a physically ill patient and by me, her therapist during her treatment. Two other experienced clinicians respond to the case material, S. Rutan from an object relations perspective and L. Horwitz from a psychoanalytic one. To continue our dialogue, I then respond to their clinical and theoretical concerns. Then we have the unusual opportunity to hear from the patient herself, who also happens to

be a mental health professional. Finally, a sampling of relevant Tuesday Seminar assignments and responses adds another dimension to the discussion: candid reactions of therapists to the prospect of serious illness in themselves and in their patients.

This issue aims to address these problems in an honest, straightforward and clinically relevant fashion. The theoretical/clinical mix should provide ample opportunity for a thoughtful discussion by clinicians and theoreticians alike, and I invite our readers to participate in an ongoing dialogue regarding these issues. It is my hope that this venture makes a significant contribution to the health of our patients and to our own lives.

Natan HarPaz, Ph.D.

PSYCHOTHERAPY AND PHYSICAL ILLNESS
A Literature Review

David A. Baker, M.S.W.

Long before psychotherapy was practiced, people knew that physical illness and emotions are integrally related. At a time of deep despair King David lamented with almost palpable agony:

> I am poured out like water,
> and all my bones are out of joint.
> My heart has turned to wax;
> it has melted away within me.
> My strength is dried up like a [clay pot],
> and my tongue sticks to the roof of my mouth...(Psalm 22)

British anatomist Henry Maudsley remarked, "The sorrow that has no vent in tears makes other organs weep" (as cited in Finell, 1997, p. 19). Freud (1923) noted that "the ego is first and foremost a body-ego" (p. 27). Fenichel (1945) claimed that not only resistance against infections but all life functions are continually affected by the emotional state of the organism.

What writers have long known from personal observation is being proven scientifically in recent years. After studying the effects of life's stresses on babies, Selye (1974) documented three typical steps in their reactions: alarm, resistance and exhaustion. After hundreds of these cycles occur, each person develops reaction patterns which eventually become a basic aspect of his or her personality. Sapolsky (1992 a,b) noted that the alarm response which most infants have when afraid, hungry, pained or frustrated eventually develops into a chronic pattern of stress-related bodily reactions even when there is no current stress present. These reactions include the well-documented release of norepinephrine at nerve endings and epinephrine by the adrenal medulla, and the increase of glucose levels in the bloodstream. In a related study, Gold (1984) found that these hormonal responses not only affect short-term memory but also long-lasting neuronal functioning.

Glaser's 1990 study found that students placed under academic stress had suppressed immune system functioning. The IL-2 receptor gene expression

was curtailed and the production of the IL-2 messenger molecules was depressed. New York University researchers (Wadholz, 1993) noted a thickening of brain neural pathways as a result of emotional trauma, and postulated that a neurological change in brain structure occurs in cases of post-traumatic stress disorders. Goleman (1995) cites studies which found actual shrinkage of the hypothalamus, which impacts short-term memory and susceptibility to flashbacks, nightmares and concentration difficulties. To most observers of emotions and the physiology, these conclusions come as no surprise.

It has been long recognized that many patients seeking treatment for physical complaints also have emotional disorders, as Blacker and Clare (1987) noted in their review of the literature. There is also evidence of a high incidence of physical illness in the psychiatric population, as Koranyi and Potoczny (1992) concluded in their review of 21 studies spanning 45 years. They found that about half of the psychiatric inpatients also had physical diagnoses. With the overlap of symptoms between psychiatric and physical illness, however, it is not surprising that the physical illness had previously gone undiagnosed for about 25% of psychiatric patients in these studies.

Psychotherapy as treatment for patients who are physically ill is sporadically documented in the literature. Harman (1991) reviewed 11 outcome studies of group therapy with cancer patients and found significant therapeutic benefit. Guthrie's summary of the literature (1996) concluded that psychotherapy had little effect when applied indiscriminately to patients with organic disease, but showed promising results with patients who somatize. Sifneos (1975) highlighted the importance of thorough psychiatric evaluations for physically ill patients and proposed principles to govern the kind of psychotherapy needed in such cases. The Tavistock Clinic attempted to treat physically ill patients who presented management problems in the general hospital with weekly group therapy sessions (Temple, Walker, Evans, 1996).

Explorations of character issues which underlie physical illness typically focus on emotions which have not been expressed in more healthy ways. Winnicott (1960) discusses physical illness as a call for a competent "mother" or caretaker, often by patients who experienced significant deprivation in infancy. Rodin (1984, 1991) hypothesizes that physical illness which arises during the course of therapy can be the patient's effort

to get comfort from others, including the therapist, and may well be a repetition of failure in his or her primary relationships. McDougall (1991) also focuses on the infant's earliest relationships, and describes physical illness as the failure to introject a truly caring "mother-image," thus allowing the child to become a self-loving adult. In her well-documented book on psychosomatic illness Finell (1997) suggests that "the failure of the mother to help the child transform its new sensations and stimuli from within and without floods the immature ego with helpless shock...[making] indelible impressions on the most primitive reactions of the brain" (p. 8).

Psychotherapy with physically ill patients raises many clinical issues, some of which are addressed in the sources mentioned here. Wolberg (1989) highlights the challenge of accurate diagnosis for the therapist faced with both organic and functional physical conditions. Dewart (1989) spells out some of the problems in establishing a therapeutic alliance with patients who present with significant physical illness, including their defenses to reduce emotional discomfort. Halleck (1988) takes on the daunting task of questioning to what extent patients are responsible for their illness. He proposes a conceptual framework to answer this question and suggests how the conclusions may guide the course of the treatment.

Effectively treating these patients in psychotherapy typically stimulates anger, fear and sadness for therapists, and requires coming to terms with their own vulnerability and their defenses against experiencing it (Adler, 1984). The therapist's defensive reactions to the patient's struggles may include boredom, helpless concern, and sleepiness (Finell, 1997). Another common challenge is the therapist's unrealistic anger or fear in response to the patient's frustration. Bronheim (1996) notes that "one of the most challenging kinds of patients...is the one with chronic illness who is non-compliant" (p. 522). Groves (1978), in his article on the "hateful patient," highlights the powerful countertransference that therapists and medical staff can experience in such situations.

Of related interest is Chernin's account (1976) of his own physical illness which prompted a leave from his practice. In the process he discovered his defensive sense of omnipotence. He also spells out the impact his illness had on his patients and how this real event was worked with in therapy.

In summary, while specific literature on psychotherapy and physical illness is limited, much has been reported in related areas. Highlighted here are

sources on the correlation of physical and emotional illness, the psychotherapeutic treatment of patients with physical illness, character and developmental theory regarding the emotional basis for physical illness, and clinical issues in the psychotherapy of physically ill patients. From this cursory review it is clear that we are on the frontier of new understanding in this exciting arena, and that much remains to be explored in order to enhance the effectiveness of treatment.

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