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In This Issue:

PSYCHOTHERAPY AND PHYSICAL ILLNESS

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A STATEMENT OF PURPOSE

This journal is part of The Bar-Levav Educational Association's (BLEA) general program to advance the science of psychotherapy and the understanding of the hidden forces that shape individuals and societies. Such an understanding is derived from our clinical work and is useful in the ongoing treatment of patients. Additionally it has been found to have wider implications in practically all areas of human endeavor.

Learning to think critically requires first that we make room for it by diminishing the domain of feelings. These have the power to bend thinking and to distort one's view of reality.

The ability to think critically develops only in the absence of fear and with freedom from the dictatorship of other feelings. The *Journal* is dedicated to examining psychotherapy and human behavior and motivation with the yardstick of critical thought.

All articles reflect the point of view of the respective writers. They are not necessarily those of the Bar-Levav Educational Association. We invite readers with diverse points of view to participate in the discussion of topics presented in the *Journal*. Subject to the availability of space, we will publish all thoughtful comments.

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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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FOCUS ON THE PHYSICAL
The Challenge for the Non-physician Psychotherapist

Ronald J. Hook, M.S.W.

A focus on the physical representations of emotional distress is critical to the success of psychotherapy, and to overall health. Non-physician therapists and many psychiatrists are often weak in this area, getting caught up in verbal content. Since my training was in social work rather than medicine, it has helped me to refer to the people on my caseload as patients, not clients. They are, in fact, living organisms ailing from emotional disorders that are lodged in their physiology. Many practitioners treat emotional illness and confusion as deficits in understanding, calling for cognitive assistance. Their course of treatment follows that assumption, but disappointment is often the result since life *experience* is *not* cognitive.

My own interest in psychotherapy came out of an admiration for psychoanalysis. I harbored a fantasy of exploring for hidden psychic patterns in the verbal productions of my patients. I dreamed of becoming an esteemed benefactor of health through well-formulated interpretations and elegant timing. The analytic model provided the tools to detect primitive archetypes behind the curtain of consciousness, so I anticipated a fascinating life of discovery, secretly holding the fantasy that the patients would forever love me as a brilliant sleuth.

Like most people, I was not comfortable with the stir of emotions deeply embedded in my own body. I must have been half-aware of the sense of emotional pressure there. To ward it off I used my head to become a first-class rationalizer. A decent intellect had drawn praise and had given me a competitive edge from early on, so it had become my subjective center of power and control. Naturally I believed I could help others by that same route.

My faith wavered when I found that a favorite graduate school professor had been twice analyzed, and even he knew he was hardly the picture of health. A new supervisor had done the same, twice, only to be disappointed. Other colleagues had tried for several years each and, while valuing the human support of the analyst, found it lacking in terms of a substantial effect on their personality. I, too, tried it for several years, terminating quite unfinished. And, by this time certain that the analytic

mode was not enough, I somehow could not stop those wise interpretations to my patients...only to see limited progress.

One experience that pulled me away from the cognitive perspective was a training requirement to take a guided personal tour of the gross anatomy lab at a nearby medical school. Until that day the body, to me, was a set of concepts and abstract functions from a biology class. Suddenly, here was a dismembered human leg...could someday be *my* leg. Not far away were eyeballs, testicles, a half-dissected skull and a new whole arrival bloating with formaldehyde as his life's blood slid into the floor drain. Thirty more corpses lay in plastic bags on a top shelf, waiting their turn. As a non-physician, I was startled into the physical reality of death and, by contrast, into the physical reality of life.

After that three-hour experience I could no longer work comfortably from abstractions about neurotic complexes and personality types. Playing on my mind was the actual physical impact of chronic emotional strain over a life span. Digestive troubles, tension-induced pain and malfunction, depression-induced resignation of the system, and all of the other familiar symptoms now produced vivid physical pictures in my mind. The old psychological models seemed removed from real flesh-and-blood life.

A second experience was an extensive course of body work as part of my training at the Radix Institute established by Dr. Charles Kelley, who made advances in methods originated by Wilhelm Reich. Experiences here helped me to sense directly how my own viscera and musculature captured, retained or released emotions. With trusted guidance and through proven physical techniques my own body eventually released long-suppressed sobs, mobilized repressed rage, and over time experienced a gradual muscular relaxation. This softening finally allowed open sadness, and happiness, and greater overall emotional responsiveness.

These experiences confirmed the truth: emotions reside in the body. Physical and perceptual distortions created by emotions reside in the body. Inhibitions to experiencing emotions, or to expressing them, reside in the body. Therefore, the path for cure resides in the body...not in the intellect, not in free association and not in the modification of social circumstances alone.

Because this is true we psychotherapists have to change our focus to the physiology. To accomplish this we need a major shift in our training. We

not only need competent help to get beyond our own intellectual defenses but also experiential preparation by way of body-oriented work with our own emotions. In addition we need education in the relationship between emotions and the physiology. Thus we can begin to prepare ourselves as healers, as persons who treat the body.

Any focus on emotions in the body requires spending time on a review of Reich's work which cannot be understood fully from reading alone. Since people often become afraid of the fundamental change that a pioneer portends, many have dismissed him prematurely without fully realizing the merits of his work. Witnessing many clinical incidents demonstrated in his model, and which also made sense in mine, I began to grasp the clinical power of his assumptions. You, the reader, may well have to witness the same.

Reich (1945) studied emotional processes in man based on his observations of features we share with primitive organisms. [See Darwin (1872).] Building on repeated observations of the physically ill, he identified a natural path of pulsating, life-giving motion through the body. This same physical pathway was also a channel for the natural and spontaneous expression of the various emotions. Reich saw that, during childhood development, fears of parental reactions and other restrictors began to produce physical patterns of restraint within the child. The child's participation in such restraint would include holding its breath and tensing particular muscle groups, including some internal organs. In this way painful or forbidden emotions could be physically "stopped" from expression, gaining the child a greater sense of subjective stability. A physical block could force the emotions into the background, and upon repeated use could force the awareness of those emotions completely out of consciousness. Over time these blocks would develop into chronic, unconscious patterns of tension with distinct features in set parts of the body. As these specific tensions blocked awareness of "selected" inner life, they tended as well to distort "selected" perceptions of external reality. Such chronic patterns of tension would then become part of a larger pressured physical mold, the basis of a character typology upon which Reich (1945), Lowen (1958), Kelley (1979) and others have elaborated. This pressured character mold, insofar as it chronically blocks a healthy flow within the body, contributes to physical symptoms and syndromes.

Reich (1945) referred to the patterns of physical tension as "armor" and determined how it is laid out in several segments of the body. He specified that since the physical habits of armoring originate in the body of the infant

and young child, it is the body which retains the "effects from the past" (p.423) in its structure.

Bar-Levav (1993) observed similarly what he called "tissue memory." He asked, "How can we ever know what happened before the patient had any memory and any consciousness?" and answered, "We cannot know it from what the patient says. But we can deduce it from what the patient is, and what he or she shows characterologically and characteristically" (p.5). Bar-Levav's view is that a sense of subjective fragility is the baby's basic emotional condition, causing tension to take root in the physical tissue of the developing infant's body. He elaborated how certain types of encounters with the earliest mothering person can inflame that sense of fragility, producing a primitive fear either of abandonment or of engulfment.

Claiming that nearly all character structure (including its physical component) is a result of layered adaptations to one of these two primary fears, Bar-Levav (1988) holds another key to the core of human functioning, physically and emotionally. His theory is one that steps beyond Freud and Reich, but more importantly, it opens yet another door to the preverbal core of the physical/emotional structures that we (and physicians) see. To elucidate his assumption that character adaptations to early fear are a main source of emotional and physical illness, Bar-Levav (1988) says:

> The tendency to be sickly is another aspect of the physiologic basis of character. Some people typically respond to subjectively unbearable stress by developing physical symptoms, the direct bodily equivalents of emotions. (p.89)
>
> Even though we idealize the brain in our culture, much more than 'peace of mind' must be found before relief is obtained. It is confusing and incorrect to regard body and mind as separate entities split from each other, since they react together, as parts of a whole usually do. (p.90)

While he did not focus on these specific primitive fears, Reich (1948) too spoke to the issue of a single source of physical and emotional trouble:

> There is a general misconception that the organism is divided into two independent parts: one is the physico-chemical system, "soma" which is destroyed by cancer tumors and cachexia; and the other is

> the "psyche" which produces hysterical phenomena, so-called conversion symptoms in the body, and which "wants" or "fears" this or that, but has nothing to do with cancer. This artificial splitting up of the organism is misleading. It is not true that a psychic apparatus "makes use of somatic phenomena"; nor is it true that the somatic apparatus obeys only chemical and physical laws but does neither "wish" nor "fear." In reality, the functions of expansion and contraction in the autonomic plasma system represent the unitary apparatus which makes the "soma" live or die. (p. 166)

The advent of technological medicine has delayed such pursuit of a unified emotional/physical source as many physical symptoms can now be approached from a more mechanical perspective, perhaps attractive to those doctors uncomfortable with involvement on an emotional level. Ferguson (1980) refers to this as a period of "unleavened" medical science. The emotional shortcomings of technological medicine, the remarkable results from emotion-oriented approaches to physical illness, and our new knowledge of more unified medical approaches from the Far East are encouraging us to again focus on a central disease process, and not just on symptoms.

Physical disease process is accompanied by emotional representations, just as emotional disorders have always had concomitant physical expressions. Some physicians testify that half of their patient visits are essentially emotional in nature. Sophisticated psychotherapists always see physical distortions produced by character adaptation. Therefore, while there has never been much question about a mind-body relationship, there is a compelling need to focus on the intrinsic involvement of emotions with the body.

This intrinsic involvement is active and never truly still. Even tension is, in fact, concentrated emotional/physical activity, a fact difficult for many to see. We typically prefer to see things as fixed. We like to give everything a definitive name, perhaps to gain a subjective sense of control over it. Ferguson (1980) quotes Dr. W. Ellerbroeck, a surgeon-turned-psychiatrist, who said: "We doctors seem to have a predilection for nouns in naming disease (epilepsy, measles, brain tumor), and because these things 'deserve' nouns as names, then obviously they are things to us. If you take one of these nouns--measles--and make it into a verb, then it becomes, 'Mrs. Jones, your boy appears to be measling,' which opens both your mind and hers to the concept of disease as process" (p. 257).

Fixed diagnostic categories and labels, both physical and emotional, frequently serve as an avoidance of truly "being with" our patients. This is a symptom of our discomfort with their internal primitive emotional processes. If we professionals can become internally secure enough to relate deeply, and without confusion, to our patients in their core state of commotion, we can then take steps closer to treating the central motivational process in them.

To summarize, physical and emotional health emanate from within a constantly pulsating, sensate and responsive container. Disturbances in the container, the body, are often created by emotional contractions. Chronic strain produced by these disturbances can finally break into a variety of physical symptoms. It only makes sense, then, that physicians should make an effort to see each patient as a living unit of activity, measling or cancering, depressing or fearing, and to look for the interplay of the patient's emotional process in disease activity. Likewise, it makes sense that psychotherapists "examine" each patient's body to better grasp and work with the interplay of the physical and the emotional, gradually abating the amount of physical distress over time.

How senseless it is to focus on verbal content alone! The sound of the human voice, enclosing a vibration (as a word) and propelling it with the respiratory apparatus into the air, gives a much better reflection of the physical/emotional *experience* of the speaker than the words themselves, which are secondarily selected by the intellect. The lungs and diaphragm work in tandem with muscular and organ tension to produce the propulsion behind the sounds. We, as "professional instruments" listening to and accurately "feeling" the music from inside the speaker, can obtain reliable clues about his or her actual subjective experience. A sensitive diagnostician can see, and to some extent feel, the outline of this process and very accurately identify with the patient. And the ability to accurately identify with the inner experience of the patient is one fundamental step toward cure.

Each time people enter my office for individual or group sessions, I am obliged to evaluate their physical presentation. Sensitivity to music helps me record the rhythm, volume, tone, size and percussiveness almost before anyone sits down. Posture, coloration and localized changes, typically around the eyes or mouth, are all part of the recording. Getting to know these people well over time permits greater sensitivity to subtle change in individual manner and presentation. *We hear what is being said in the context of what is being presented in the body.* These bodies speak

volumes and routinely communicate reactions before the words do and in a much different way. Once the diagnostic read is taken, the next step is to make meaningful interventions in ways that will not only make corrections in transference or projections, but will also produce benefit to the physiology.

Let me broadly describe one group and a case illustration from it:

Patti, 20, leads the way in. While short and quiet of foot, she travels in a straight line to her seat. Her eyes are hidden. Her history is one of withdrawal, and she will not likely speak early in the session. She is very sensitive but often holds her responses deeply inside. She always has.

Peter, a tall young professional in a dark suit, smiles officially and is sure to add a proper "hello." His speech is so fast that individual words are often hard to distinguish. And he smiles much too often. All of this is motivated by his chronic anxiety and his urgent wish for approval.

Todd, 32, is six-foot-three, athletic, and "jock-walks" his way in. His booming voice and manner defend against his sense of vulnerability. Underneath he has had frequent episodes of physical pain and massive anxiety. Over the years he has seen several therapists and has been prescribed numerous psychotropic medications.

Bob, a young man wearing glasses befitting an intellectual, has a soft manner and a mild whine in his voice. He wears wrinkled slacks as a badge of the liberal, is heady and watchful, and often not in touch with his emotions. This is evidence of not ever having felt safe enough with the mothering parent to have his feelings, and therefore his individuality, confirmed.

Belinda has angles, everywhere. She is thin, polite, almost perfectly kept, and almost never raises her voice. She has had a mild eating disorder. Again, the early mothering experience is disturbed in her case. While she can be more in touch with her emotions than Bob, she has a way of putting them cleanly out of sight. She occasionally flares up with colitis.

Nelly, middle-aged and absolutely appropriate, is wrapped with tension showing in a very deliberate walk and manner of speech. She is covered well by tasteful clothing and attitude. Serious headaches are just one of the resultant symptoms. For her too, being "just right" has not left much room for the real her.

Naomi is a fiftyish synthesis of old lady and little girl, crotchety and cute. She is semi-withdrawn, with very strained vocal cords. Her eyes can widen suddenly, or appear remote. She is very bright, but relates better to plants than to people.

These living beings will relate to me and to each other from within their individual physiologic frameworks. During nearly every verbal exchange it is my job to be aware of the eyes, posture, breathing, color or other relevant physical features. When the breathing becomes shallow, or the eyes appear remote, or the shoulders tense, or colors change, it is a signal that some emotional activity is at work. (*Emotion*: movement is an intrinsic part of the word.) The verbal content is not to be ignored, but it is usually not as important as the feeling behind the physiologic involvement. Each individual body actively engages in the process of expression, or in resistance to expression. Even frozen withdrawal is a condensed physical involvement. At the high points of each person's unique type of physical involvement, a well-timed and well-dosed intervention is most important.

As an example, during one group session Naomi was talking with her characteristic mannerisms fully engaged, but almost no one was listening. She sat on the edge of her seat. Her voice strained and scratched more intensely than usual. The back of her neck was so tight that her chin tilted up and her head tilted back. In that position her glasses magnified her eyes which were focused so deeply within herself that she literally did not see other people. My co-therapist noticed and asked her if she was seeing anyone as she spoke. She paused momentarily, then acknowledged that she was not. She tried with spastic difficulty to go on with her story while attempting to see others. Her struggle for contact added to her agitation as her neck tightened even further and her breathing became severely distressed. She could not continue.

After a tense reflective moment she cried out that she must be frightened just to be with people while she was this open (emotionally). I had sat next to her, so I asked her permission to slightly move her neck and head as she spoke. [I typically have a "no touching" contract. And only with renewable permission where the patient truly has the freedom to refuse do I occasionally intervene in this way.] My aim was to loosen the fear-induced physical contractions in her neck and eyes, hoping to help her eventually become more present to literally see, and to be with others. This physical work, through moments of irregular visual and emotional contact, finally allowed deep direct expressions of fear coupled with tremor and crying along the way. Eventually, her whole physical being and manner softened

as her primitive fear discharged in a safe, reality-based context. Finally the restraining tension in her eyes, neck and vocal cords yielded to allow some real contact with the others, even while she remained somewhat afraid.

Sometimes physical intervention is needed to promote presence of mind, meaningful contact and a beginning physical shift in respiratory and other tensions. But useful interventions do not always require direct physical touching. In fact physical touch can have complex meanings to the patient and, therefore, may be dangerous unless the therapist is very well trained (Bar-Levav, 1993). But useful interventions require at least a knowledge of the body and its emotion-related features, as well as a set of valid techniques (Kelley, 1979, Bar-Levav, 1988, Reich, 1945, Lowen, 1958). Over enough time most of the body's characteristic inhibitions and expressions will surface in the relationship with the therapist. These occasions present continuing opportunities for slight shifts on the physical level. Measuring such changes at the body level will eventually give us our criteria for success.

Chronic physical strain from emotion often leads to real physical illness which then requires the non-physician therapist to establish a relationship with a physician-ally. At this time neither specialty is able enough by itself to assume the entire responsibility for treating the patient's emotionally and physically interrelated system. Finding such an ally for a therapist is often difficult, as is finding a therapist-ally for the physician. Physicians, for valid reasons related to previously disappointing results from psychotherapy, may be reluctant to cooperate. And now that they have powerful new psychotropic medications at their disposal, they may see less reason to. As a result, we therapists have no choice but to become more expert in this area of the physical aspects of emotions and then to make ourselves fully known to potential medical allies. As pioneers on the frontier of emotions within the body, the ideal way to proceed is in such a relationship, when available.

Once allied, we need to work together against the "quick fix" delusion. Business-driven medicine presses for short-term treatment to contain costs. Aiming at symptom alleviation rather than system-cure, it will, over time, prove to be cost-*defective*. At the moment, though, short-sighted economics is king, more so than standards of health. And currently this system supports only a token involvement in psychotherapy. Since some of us now know how to proceed more effectively toward the emotional roots of many illnesses, we must substantiate our position to dispute the short-term trend.

Academic study alone will not bring us the expertise we need to take on this very difficult task. Each of us needs a qualified mentor to guide us through the new depths of this art. Unfortunately, at present there are only a few. Some of the more able have developed and tested new theories which are available for study: the theories of Bar-Levav, Kelley, Lowen and a few others even shape frameworks for practice. They differ somewhat from each other, but one can learn a great deal by studying their similarities and differences. The real learning key, however, is to gain personal experience with them or with one of their more able proteges. And beyond acquiring a valid theory, we need to be trained to become reliable emotional/physical instruments. We are at the same time the observer and the tool of influence on the emotional/physical being of the patient. Only after we work through the blocks in our own personality can we frame a relationship in which the patient can join us on the road toward health.

After all of the above is in place we should be able to see the significant emotional history of each patient, "bred" into the physical structure. The earliest life experiences, "written" nearest the core, profoundly color what developmentally follows, physically and emotionally. If subjective fright was a common condition in the earliest months and years, then later developmental experiences would be perceived with that fright and its resultant restraints already in place as a core experience, distorting the later experience. Therefore, reaching those earliest affective states is fundamental if we mean to influence the entire organism, emotionally and physically.

While there is much more to learn, we are in a position to significantly impact many of these difficulties if a secure therapeutic relationship is in place over a long enough period of time, and if we are competently equipped with knowledge of the body and appropriate interventions. Much more refinement is called for and, while it seems to be a huge job, we all ought to carefully think through the alternatives. The costs of not doing it this way to individuals, their families and our culture are too heavy and far-reaching to ignore.

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Background Point of Theory

Illness, except when it results from normal aging, is often an expression of the continuing wish of individuals to be cared for by others, since such human closeness generally is reassuring. This, more so than genetic determinants, explains why some young and relatively fit bodies are much more susceptible to disease than others.

Thinking in the Shadow of Feelings, p. 73

REALLY, HOW DOES PSYCHOTHERAPY HEAL? AND WHY IT IS NOT FOR PATIENTS WITH CHRONIC PHYSICAL ILLNESS

Reuven Bar-Levav, M.D.

A middle-aged man was referred to a psychiatrist. Upon arriving he gives the doctor a long look: "Are you the psychiatrist"?

"Yes, I am."

"Ok, I'm ready. Psyche me."

Slowly he sits himself down, waiting to be fixed.

I first heard this story as a joke, but over the years it increasingly became clear that it was merely a gross exaggeration of what patients expect from their psychotherapists. Patients come to feel better, to be solaced, to escape their loneliness and pain, to get relief from despair and from hopelessness. They come to be "fed," they want to be seen, to be heard and to be welcomed. This is what they generally want, not therapy.

And this is what all too often they get. Sadly, most of what happens between patients and psychotherapists is not psychotherapy. As a result, most patients feel better after awhile, but very few get well. This is why psychoanalysis and psychotherapy are generally not held in high regard either within medicine or by the public at large, and one reason insurance carriers use to justify their unwillingness to pay for it. "Where's the meat?" they wonder.

Why is this so? Because confusion abounds. So, here are a few clarifications that might help.

In a strict sense, the word "psychotherapy" refers to a process which attempts to heal the psyche, that nebulous and vague non-physical construct invented by psychiatry to give the "soul" or the "spirit" (as distinguished from the body) a more scientific and respectable ring. Defined rigorously, the "psyche" is recognized through the sum total of a person's functioning in the world as reflected in thoughts, feelings and behavior. It has

conscious and unconscious roots, and these determine how one adjusts and relates to his or her social and physical environment.

Because the "psyche" is so hard to see and impossible to touch or to examine directly, it is no wonder that the process of therapizing it is also poorly understood, and that even "experts" have a vast variety of strange definitions for it.

Almost anything that happens between two people which can be described as "helpful" has been defined as therapeutic to the psyche, and therefore as "psychotherapeutic." But merely relating the hardships and problems of daily living to a psychotherapist is not psychotherapy, and even discovering the hidden content of the unconscious is of only limited usefulness. Surely, riding horses or contemplating the beauty of the universe in the yoga position are of no therapeutic value to the psyche at all, though they and others increasingly are promoted as such.

People feel better for a little while by unburdening pain to an accepting, sympathetic and non-critical human being, but the pathologic process itself is not affected by it in any way. Being listened to lessens the sense of isolation, loneliness and despair, but it does not "cure" anything. A listening therapist does not have a greater effect on pathologic tendencies than a kind lover or a friendly barber.

In spite of the fact that, by now, people numbering in the millions have undergone psychoanalysis and traditional psychotherapy, it has never been shown that the internal physiologic balance that shapes the psyche is in any way affected by gaining insight or understanding. Not even theoretically has anyone ever tried to explain how the analysis of the components of anything might change its composition. This obviously is not true in chemistry and in the natural sciences, even if it could be argued that it is sometimes valid in philosophy.

Freud was a brilliant observer but he failed to remember that human beings, like all living things, are first and foremost organisms governed by the rules of the natural sciences, not of the social ones. Although rational at times, the prime inner force that motivates them is the ongoing attempt to avoid and evade anxiety (Bar-Levav, 1988, p. 324). Freud's psychology, including the term "psyche" itself, is derived from Greek mythology and it is rooted in philosophic reasoning. This is why it is so fascinating, and so wrong.

The "mind," the "self" and the "soul" do not reside in the brain. To the extent that they have a physical existence it is within the body. Simply stated, to heal the psyche requires that we change the physiologic adaptations and responses of the body to a sense of danger, to frustration, hurt, and deep disappointment. Intense fear of that which was unknowable is every infant's lot, many times over (Bar-Levav, 1988, pp. 322-323) and so is explosive preverbal rage that attempted to overcome powerlessness and the inability to always prevail. No baby can escape from these.

To survive, everyone's body must adjust to such subjectively terrible experiences in one way or another. And quite naturally, the specific earliest physical adjustments that helped each of us survive become our prototypical, lifelong and characteristic ways of responding to our environment. This is the physiologic basis of character (Bar-Levav, 1988, pp. 88-93). The physiology, not what we think, must be altered if we are to gain the freedom to respond to the environment in a different way that makes more sense, and that is better suited to the realities of adulthood.

The capacity for trusting people increases, and with it the ability to have and maintain intimate relationships, as the physiologic responses of the body to fear, hurt and anger are altered. This is directly helpful in improving one's self-image and self-esteem, which in turn always causes people to be more effective in relating to their physical and social environment. The same is true of the ability to concentrate and to learn new things. It also swells as anxiety is decreased, which makes the mastery of difficult tasks easier and which helps in managing complex and difficult situations.

Taken together, all these enable people to achieve a higher standard of living and to find joy and satisfaction in life. Whether or not a person gets "cured" from depression is best measured by these criteria.

This is what *psycho*therapy can achieve, and this is what it must achieve to deserve its name. Changing the physical responses of the body, those that had their origins in the earliest moments of life and, which are *not under the control of the cortex* (and therefore cannot be reasoned with) is an enormous undertaking still widely believed by many to be impossible. In the absence of a correct theoretical basis it never had a chance of succeeding. And even with it, years of painful confrontations with oneself are still required. But the many courageous patients who have persevered in the effort have discovered that a life essentially free of anxiety is not a mirage (Bar-Levav, 1988, pp. 220-258).

It helps to remember that even a course of psychoanalysis lasts a very long time, and it merely tries to analyze the unconscious by informing the brain. In real *psycho*therapy, on the other hand, the body is the one that must do the "learning," and its various parts are very, very slow learners. After all, they are mere tissues, and not of the cortex. The body already has previous "knowledge" which helped the organism survive while the older, subcortical part of the brain was in charge. Even later, the body does not come under the control of the cortex, and thus it can "refuse" to give up what it already knows, except under consistent pressure over time. That's why New Year's Eve resolutions have so little power.

Still and all, anomie and the hopelessness and despair which manifest themselves in physical and intellectual confusion can be overcome (Bar-Levav, 1988, pp. 72-74), even though no shortcuts exist in this difficult and tedious process whose goal it is to actually cure depression.

For these reasons it generally makes only little sense to recommend that older patients or those with serious physical illnesses begin a course of real psychotherapy. "Physical illness" here does not refer to transient conditions such as a cold or a broken leg, but to chronic and stubborn pathologic processes which not only shorten lives but which also seriously interfere with normal daily living, conditions which Medicine in its current state can only ameliorate, not cure.

Older patients also need and deserve good help, and obviously so do younger ones with a "bad" prognosis. Those who have already suffered irreversible losses from strokes, heart damage, near-terminal cancer or degenerative illnesses (for instance, advanced multiple sclerosis) urgently need emotional support.

They must learn to cope with their losses and pain in order to live for as long as possible as fully as possible, and to help them die with dignity. But strictly speaking, such help is pain management, not psychotherapy. The value of such treatment should not be minimized. These are suffering human beings in desperate need whose pain can and ought to be lessened.

Besides competence, the work of emotional pain management requires even more compassion than is required of psychotherapists. Those who dedicate themselves to merely offering emotional support cannot expect the joyous rewards often obtainable in psychotherapy: seeing dead eyes in a patient light up with a new eagerness to live. Therapists who minister to the physically sick must have especially good ego boundaries in order not to

run out of inner resources from doing such draining work month after month. In this regard, the work of psychotherapists is easier.

Andrew was a physician in his mid-40's who had come to seek my help when he simply could no longer continue living within his family in a state of emotional slavery. He had been able to endure it for a very long time because even such a life was better than anything he had before. But finally he reached a point of burnout. He was starved for warmth, for close human contacts and for a sense of welcome. His options were stark: these or death.

He blossomed in the course of ten years of very hard work. Although nearing 60 he looked much younger, a man so full of life that young and older colleagues alike were inspired by his example. He was given and assumed even greater responsibilities in the hospital with which he was affiliated, and became Chief of the medical staff. Belatedly he tried to father and to befriend his grown children. With his improved self-esteem he literally seemed to stand taller.

But then, just when he was about ready to finally leave therapy, suddenly and unexpectedly as always, he was struck down by an especially malignant form of cancer.

So full of life, Andrew fought the illness valiantly. He really wanted to live, almost lusting for it, and he did not yield until the fast-growing cancer almost literally knocked him off his feet. Just before that point I agreed to let him join me in a professional retreat that was fully booked in the Laurentian mountains, near Quebec. He was no longer able to walk very much in the mountains he loved, but how could *he* be refused? Even near the end he continued to function as an effective person in a wheelchair, pale, cachectic and frail in body, yet a shining example of the power of the human spirit.

We helped him die with dignity. It was extremely important for him to maintain his relationships with members of his psychotherapy group and with me until the very end. But in those last few months our work was no longer psychotherapy but life support and emotional loss-management. His was a song of life about to be cut abruptly, long before it was finished. He had to mourn for himself.

Life to its fullest had only begun for him a few short years before, and his appetite for partaking in whatever it had to offer was imbued with the

vitality of youth. Like a young soldier shot in the heat of battle, so he too was not ready for death. But he was wiser than any young soldier, much more "awake" and much more aware, a man with clear vision and without delusions. He welcomed medications to tolerate the physical pain, but he wanted nothing to lessen his emotional sense of loss. Like a captain on the bridge of his ship, he wanted to go down in full regalia, head high. This we helped him do.

Andrew was fortunate in at least one way: he had started a course of psychotherapy many years before his quick decline, and he had a powerful and well-functioning support system in place when he needed it. I would have had nothing to offer him had he first sought my help near the end of his life, since my practice is limited to *psycho*therapy. It really makes little sense for patients who are chronically and very seriously sick with a disabling physical illness to become so deeply involved. Similarly, no one should ever be encouraged to seek psychotherapy at an age too advanced to set out on major new journeys. But discouraging does not always work.

The sad and touching story of the elderly woman who pleaded, and then demanded, that I make room for her in my practice is a good example. She was in her late sixties, but this did not matter to *her*.

> "Just because I am old I'm supposed to die?" she challenged me without bitterness. "I should give up forever my todays just because I have had no yesterdays? How can you deprive me of life with meaning?"...She had never been aware of the richness of her inner life and obtained tremendous relief from the little unblocking of her hidden hurt and anger that resulted from our [few] encounters. She could not imagine herself going back to her previous existence. She had to better her life. For the first time in years she had begun to read a book, and for the first time ever she visited a museum. (Bar-Levav, 1989, p. 85)

She was not a bit interested in statistical projections and unwilling to accept my recommendation that she leave treatment with me after receiving psychologic first aid. Having belatedly tasted the fruit of the tree of knowledge, she fought to have more of it. Likewise, while normally no responsible surgeon would operate on a patient whose medical condition did not permit it, exceptions are made sometimes. Disabled coronary patients sometimes thoughtfully insist on being operated on, preferring to risk dying on the table over hopelessly lingering on.

Generally, however, the criteria in surgery are clear and the obligations of the surgeon are spelled out in nonambiguous terms. Not so for psychotherapists. Almost anything goes. There is no agreement about the nature of psychotherapy, what its goals are, who needs it, and who should or should not be treated. If they need patients to make a living, psychotherapists in general are glad to accept anyone with some pain in their practices. Their honesty and ethics are not in question, but their judgement is. Since they usually tend to be "do-gooders" they are generally unable to refuse anyone, especially not people in real need. They often overidentify.

Besides, psychotherapists toil in the youngest and the least exact branch of medicine, and as a result their responsibilities and tasks are often poorly understood. Anyone can now define what psychotherapy is in any way that fits with what he or she is able to see, which allows everyone to practice with subjective integrity. But objectively, what psychotherapists do (as reflected in the literature and as reported elsewhere) often does not meet the minimum standards for "psychotherapy" as outlined here.

The emotional support that physically sick people require is often the very opposite of what real psychotherapy must achieve. It is often desirable to help such patients sustain their delusions about better days that may lie ahead, rather than push them to give up dreams that cannot be. The only right and kind thing to sometimes do is to *not* face reality. It is necessary and often justified in such cases to lessen unbearable emotional pain by allowing distortions in conscious awareness to remain uncorrected, and by joining the resistance against being alert.

The "politically correct" push to misname aspects of reality in order to minimize someone's hurt feelings or subjective sense of deprivation is always very damaging because it obscures the outlines of reality.

The level of anxiety quickly rises whenever such confusion reigns. It is easier to remember that "cripples" or "handicapped people" need our assistance and deserve our help than it is to offer these to "physically challenged" people. The same for those who are intellectually slow. It is not only confusing to refer to retarded individuals as "great minds" ("not all great minds think alike"), but it also is cruel and stupid. Sanity and clarity are both assaulted by such deliberately perverse Orwellian double-think, double-speak, which by now is common.

To reverse the truth even with the best of intentions is damaging, but it is unnecessary to insist on pointing out painful realities to those who can do nothing about changing them. Why needlessly lift the veils of self-delusion when nothing better exists? Old people and younger ones with serious and chronic physical illnesses need competent and compassionate emotional support to live more comfortably for as long as they can. But, in general, they should not be involved in real psychotherapy.

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CASE PRESENTATION

Clinical observation and experience have always been the way knowledge in medicine was transmitted to the next generation of practitioners. Physicians were mainly taught by apprenticeship in the past, and even now observing experienced clinicians is still the backbone of medical education. Though many of us are psychologists and social workers and not psychiatrists, this is an effective way to teach psychotherapy, which is one main goal of the Journal.

The clinical case presentation is therefore a regular feature in each of our issues. The primary therapist summarizes his or her diagnostic impressions and major clinical interventions, and this is followed by comments from other experienced psychotherapists, each giving his/her own clinical observations and ideas. We invite and publish responses from all readers, regardless of their theoretical bent, and unless clinically contraindicated also offer the patient an opportunity to anonymously express his or her reactions to the presentation and discussions.

You, the reader, are invited to actively participate in this clinical dialogue by sending in your own clinical observations and plan. Briefly indicate your theoretical assumptions and give a specific rationale for your recommendations. Clearly written presentations will be published essentially without editing, but must be no longer than 250 words. All responses for inclusion in our next issue must be received no later than April 1, 1998.

CLINICAL CASE PRESENTATION
M's Pregnancy

Natan HarPaz, Ph.D.

As a child, it appears that M was neglected by her mother. She recalls coming home from school to a dark house and calling out for her mother. Receiving no response, the little girl would search and finally find her sitting in a room with the blinds drawn, silent in the dark. Mother was eventually hospitalized in a psychiatric ward for more than two months when M was seven years old. When M was nine her mother divorced M's father, remarrying him when she was 11. Three years later the father, a weak, frightened music teacher, was diagnosed with multiple myeloma and died of bone cancer when M was 16. Her mother died of breast cancer when M was 25 years old.

M grew up as a panicky, troubled child who was difficult to get close to. Her parents and others found her "hard to love" because she was physically unattractive with a jerky, unsettled body, partly due to a hypo-thyroid condition which was not diagnosed until the age of eight. At about the same time her poor eyesight was first diagnosed. She has worn thick glasses ever since. At a young age, this troubled girl had already been referred for counseling at a family service agency.

A bright young woman, M enrolled in out-of-town colleges to escape her needy, depressed, suffocating mother. When she was 25, just a few months before her mother's death, M began therapy with me. She was anxious, angry, confused and severely depressed. While in treatment she sporadically dated several men, soon finding each either abusive or too needy and she quickly pushed them away. After several years of therapy, and to the surprise of many who knew her, M married a computer analyst who was a religiously observant Jew. Unlike her parents who were non-observant Jews, she decided, for her marriage to succeed, to follow the modern orthodox way of life--observing the Sabbath, maintaining kosher dietary customs, and attending weekly synagogue services. This helped her by adding structure to her life.

After four years of marriage, M became pregnant. Within six weeks she was having complications and a D&C had to be performed to remove a molar tumor from her uterus. On an emotional level the trauma was excruciatingly painful since instead of a child, an "alien" was growing in her abdomen. After the removal of the tumor, instead of the expected HCG

(pregnancy hormone) level dropping, it increased, indicating that the tumor cells were metastasizing elsewhere in her body. Untreated, this condition (Trophoblastic Disease) could be fatal because the pregnancy hormones act as nourishment to the molar cells which can then grow at other sites in the body. The treatment of choice is several months of low dosage chemotherapy administered daily for a week at a time, followed by a week of no treatment. Blood samples are drawn once a week to measure HCG levels. Two months after having become pregnant, M began her chemotherapy treatment. CT scanning indicated the presence of lesions in her lungs but none were evident in her brain. After seven tedious and difficult months of chemotherapy, M's HCG levels finally dropped, indicating that the Trophoblastic Disease was no longer a threat and M was back to "normal."

Throughout the molar pregnancy and its aftermath, M struggled valiantly in therapy with her great disappointment and pain. Her once brittle and rigid ego boundaries were now, after several years of intensive work with me, palliably intact and able to withstand tremendous storms of affect. She was often angry at everyone--me, therapy, her group members, my co-therapist, her husband, her mother and God--all of whom, it seemed, had contributed to the difficult place she now found herself. At one session she yelled at me that if I had not helped her to become as emotionally healthy and as much of a woman as she now was, she would never have gotten pregnant and would have been spared this horrible ordeal. She blamed her husband for impregnating her, thus "causing" her this "hellish journey" into chemotherapy. She was angry at her parents for giving her bad genes and at God for not seeing that she had suffered enough in her life. When she was finally ready to have a baby, He had not smiled upon her and given her the child she wanted so much. M's life had always been overcast with a sense that if something good happened to her it would soon be taken away or destroyed. Therefore, she could never be openly happy and embrace life to its fullest.

Soon after the course of chemotherapy ended M began complaining about an increasing variety of strange symptoms including pressure in her mouth and around her teeth, headaches, heart palpitations, pain in her knees, vertebrae and chest, strange sensations of pricking and stabbing in her throat, and a burning feeling in her fingertips. Her internist referred her to several specialists, none of whom was able to diagnose her condition. Understandably, M was frightened and angry. Some doctors believed that her symptoms were residuals of chemotherapy. Recommended treatments varied from changes in diet and exercise to psychotropic drugs for anxiety

and/or depression. M consulted internists, neurologists, infectious disease specialists, lung specialists, cardiologists, a rheumatologist, and an endocrinologist. Without discussing it in any therapy sessions, she extended her vacation by a week to get a team diagnostic workup at the National Jewish Hospital in Denver. The varied diagnoses and opposing recommendations for treatment left M confused, distrustful and angry. She couldn't trust her doctors and finally resorted to her own intuition in an attempt to find the proper diagnosis for her symptoms.

During the past two difficult years, working in both group and individual sessions, I have been able to hold onto M in spite of my own conflicted feelings and her repeated "kicking" and pushing away. I have had to pay close and focused attention to my understanding of M's character and personality makeup and have had to force myself to carefully monitor my reactions, searching out countertransferential distortions. Sometimes I felt hurt and angry when I was "dismissed" by M. On several occasions I discovered, after the fact, that in a desperate attempt to contain her panic, M had impulsively sought the help of yet another specialist. At those times I felt that I was not in charge of her therapy and that in spite of all my efforts, which at times seemed far "above and beyond the call of duty," M easily rejected me for someone else. Didn't she know how much I worried about her and how many consultations I had with colleagues to help me treat her properly? Did she forget that, even before all these physical trials, I had been to "hell and back" with her many times over more than a decade of our lives? What about the real-relationship that had existed between us for so long and that is fundamental to our work together? What happened to that essential adult part of our relationship which is based on mutual respect and on a commitment to a non-acting-out process? The adult M too often ignored this crucial aspect of therapy. In addition, her illness rendered us both helpless, powerless and, consequently, scared.

To help me evaluate my own emotional reaction and to address my difficulties with M, I presented her at numerous peer supervision sessions and I used her case as an example of my work at an advanced psychotherapy workshop. I examined the origin of my hurt and angry feelings and endeavored not to act them out with M. I explored my difficulty in "loving" M even when she was angry for so many months. I entertained many suggestions from colleagues, among them the idea that my disappointment and anger were related to M and I having "made a baby together" but she could not carry it to term and instead produced a molar pregnancy. My struggles with feelings of helplessness, ineffectiveness,

and anger--particularly when M would dismiss me out of her panic, anger, or deep hurt--were the focus of many supervisory sessions.

At the same time I had to remain thoughtful and remind myself that, while genuinely needy and understandably hungry for mothering, M had not been a somatizing patient in the past. She had enjoyed physical activity and the outdoors. Even though she was dependent, awkward and often sorrowful in her demeanor, her fear of abandonment was still too deep for her to allow herself to become physically and chronically dependent.

In group sessions, I often helped M express her rage directly by using me as a target. In addition, she often cried with deep hurt about the unfair changes and terrible losses in her life and about my inability to cure her. After each group session in which I had invited her to stand facing and railing against me, I expected a significant change and a reduction in symptoms and complaints. My clinical rationale was that since M was not characterologically a somatizing person, her symptoms were physiologic manifestations of unexpressed rage against me for not curing her, against her mother for not loving her, and against God for giving her a tumor instead of a baby and making her sick. I hypothesized that direct, open expressions of rage at a specific, transferential target--me--would release her primitive preverbal rage and make room for the expression of intense, lifelong pain. M felt deep hurt about not having been adequately mothered and for having been taken from instead of given to. For so long she had forced herself to bury her dreams and yearnings because "they could never happen to me." She couldn't allow them to emerge and almost become a reality because they would then crash and shatter, bringing bitterness, rage, and pain.

But when M's strange symptoms persisted and did not yield to such intensive expressive work and the anticipated changes did not materialize, I, too, became convinced that she was suffering from an as yet undiagnosed physical condition. I eventually told her that in the past I had suspected that her emotions had precipitated her symptoms. But now, like her, I believed that her complaints were about real physical symptoms and not, as other doctors claimed, "all in her head." Furthermore, I would stand by her while she continued her search to find out what was wrong with her. M was both angry at me for not "believing her" sooner and touched by my commitment to work with her in her future struggles.

I was relieved and satisfied when several months ago M was finally properly diagnosed with Lyme Disease and a prolonged antibiotic course

of treatment was begun. Lyme Disease is an infection caused by the bacterium Borrelia burgdorferi which is usually transmitted by the bite of certain species of ticks. M suspects that she was infected during the first few weeks of her pregnancy when she was hiking in the mountains. Thus, unbeknownst to anyone, while on chemotherapy she had also been suffering from symptoms of Lyme Disease. Since her diagnosis, M's physical condition has worsened. She now suffers from severe pain in her head, joints, ribs and other unexplained sensations of burning, stabbing, nausea, fainting, and dizziness which finally necessitated her leaving her job and going on disability. M continues her therapy in both individual and group sessions, but she has had to miss sessions from time to time because she is occasionally bedridden. I continue my own struggles with my feelings of occasional hurt and anger.

Natan HarPaz is a psychotherapist in private practice in Southfield, Michigan. He is a Fellow of the American Group Psychotherapy Association and a past president of the Michigan Group Psychotherapy Society. He is the Dean of the Bar-Levav Educational Association.

"M's PREGNANCY"
An Object Relations Perspective

J. Scott Rutan, Ph.D.

Introduction

All theoretical positions represent leaps of faith. From the psychodynamic position, we *assume* the reality of the unconscious even though it cannot be proven (Rutan, 1992). Once we make that assumption, we are committed to trying to understand all that we see on the basis of unconscious operations. If we vary from that position we risk missing important opportunities to help our patients learn from and about their unconscious.

Object relations theory goes farther and *assumes* that the driving force in personality is the need to be in relationship (Kernberg, 1976). This means that we understand all behavior as object-seeking, even though at the manifest level it may appear to be object-repelling.

The case so clearly presented by Dr. HarPaz represents a wonderful example of how our basic assumptions might be both helpful and incorrect in working with patients. From the dynamic perspective, physical symptoms represent possible communications concerning the unconscious world of our patients. We make the assumption that physical maladies are outward manifestations of inner conflicts. This can be a dangerous assumption if we neglect to also note that the reverse can also be true--namely, that physical illnesses can result in psychological symptoms. Nonetheless, if we are to be true to our quest to seek manifestations of unconscious processes we must be diligent in our stance.

The Case

M had a very troubled childhood. Dr. HarPaz begins, "As a child, it appears that M was neglected by her mother." An object relations theorist would not have used that language since he/she would *assume* that the mother was doing the very best she could to mother her child. The notion would not be that the mother *neglected* her daughter, but rather that the mother likely envisioned herself as toxic and therefore unconsciously

determined that her best "mothering" would be to stay away from her daughter.

Meanwhile, M, like all children, was learning about the world and herself by observing all that was happening around her. Some lessons she may have learned would be:

"I am awful--neither my mother nor my father wants to be around me."

"To depend on others is dangerous because they either leave or die."

"I am defective. My body (notably my eyes and my thyroid) have let me down."

With these perceptions of herself and the world, she developed an interpersonal style that kept people away. Dr. HarPaz suggests that she was "hard to love." Given her expectation that relationships meant pain and loss, any other response would have been maladaptive.

Nonetheless, she evidenced sufficient strength to continue in the quest for intimacy. Indeed, she was successful in finding a loving, kind husband and therapist.

We could have predicted that pregnancy would be a crisis for M. With the all-encompassing narcissism of children, all the ills of the family are presumed to be the results of the child's entrance into the world. The prospect of a child coming into her marriage must have been terrifying for M. In addition, she had little in her history to help her feel confident in her ability to be a good-enough mother. Taken to a logical extreme, the dynamic position could posit that the cancer in her uterus was an apt communication about her conviction that what came out of her body would be "cancerous" or awful.

It should not surprise us that she used anger to fend people off--especially those she loved the most. Like her mother before her, it was the most effective protection against harming them. Indeed, the fury at Dr. HarPaz for helping her improve enough to become pregnant is completely understandable. Now a child must depend on her! Her conviction that "if something good happened to her, it would soon be taken away or destroyed" was honestly earned in her childhood when that precise scenario occurred repeatedly.

When her physical symptoms began to manifest themselves more powerfully, the dynamic interpretations also increased. The pressure in her mouth might indicate a powerful urge to "speak the unspeakable." The pain in her knees might speak of a fear that she "hasn't a leg to stand on." Her heart palpitations may predict a "broken heart." The interface between the physical and the emotional is complex and not well understood. Though we now know there were good biological reasons for these symptoms, this does not preclude their also offering important windows into M's unconscious.

Dr. HarPaz spent a great deal of time assessing his "countertransference" to M. This is admirable for any therapist. However, it is important to distinguish between countertransference and projective identification. In this case Dr. HarPaz seems to have been containing the projections from his patient. He found her "hard to love," just as her parents had before him. The unlovable aspects of herself had been projected onto caring others, which certainly makes more sense than bearing them oneself. This, from an object relations point of view, accomplishes several things. First, it relieves the patient from having to feel awful about herself--she can let her therapist do that for her! Second, it sets the scenario where others can respond to her in familiar ways (distancing, anger, etc.) Third, it protects others from getting too close so that neither they nor M will be hurt.

Technical Implications

There are no *right* ways to approach our task. Rather, the goal is to find a theoretical position that fits the personality of the therapist. We need to find a theory that feels "right" to us and one that does not protect us or the patient unduly. Some classical analysts can sit mutely because they truly believe that the most important gift they can offer their patients is the opportunity to gain full access to their inner life and transferences. Other individuals take that position because they fear a more visible role in the therapy. Obviously, the former therapist will be more helpful to his/her patients than the latter. Likewise, some therapists can be highly active in the therapy because they are committed to the belief that the here-and-now interactions are where change occurs. Others are highly active because they narcissistically need to be central in the exchange.

Object relations theory is always concerned with the *attachment* rather than the *separation* side of relationships. From this vantage point, the therapy would have focused on helping M begin to own her yearning for intimacy

and her loving feelings. When she raged at the therapist, the therapist might have commented, "I can understand your wish to push me away. Who knows if I will die, or become hospitalized, or leave?"

A self psychologist, on the other hand, would be much more concerned with accurate mirroring in order to help the patient gain a more mature self (Kohut, 1971). This therapist might respond, "It must feel terrible to rage at one who has tried so hard to help."

A classical analyst, determined to help the patient learn more through transference, might respond, "What kind of individual would treat you as I have?"

Conclusion

The alarming part of this case is that the physical symptoms were, indeed, the result of an undiagnosed illness. Dr. HarPaz not only did fine psychotherapy, he was able to move from his commitment to the dynamic position to allow for another world view to be considered. In our rigor to remain "in role," it is best to remember that "both and" can sometimes be better than "either or" in understanding our patients.

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DISCUSSION OF M's PREGNANCY

Leonard Horwitz, Ph.D.

Although this patient does not readily fit into one of the ten personality disorders described in DSM-IV, she closely resembles Kohut's description of a narcissistic personality disorder. He describes such individuals as prone to periods of "break-up, enfeeblement, or serious distortion of the self" and whose symptoms are primarily autoplastic, i.e., internalized and self-contained as opposed to the overtly behavioral characteristic of the narcissistic *behavior* disorder. The typical symptoms shown by these patients are hypochondria, depression, hypersensitivity to slights, and lack of zest. With the possible exception of hypochondria, the patient was certainly characterized by a chronic depressive outlook and the expectation that anything good in her life would quickly disappear and go up in smoke.

Kohut (1978) makes a further differentiation of various syndromes of self-pathology which are relevant to this case. He describes the under-stimulated self, the fragmenting self, the over-stimulated self, and the overburdened self. M clearly fits into the category of the under-stimulated self who suffered from "prolonged lack of stimulating responsiveness from the side of the self-objects in childhood" (p. 418). M had the misfortune of growing up in a family with a depressed and unhappy mother who was markedly unresponsive to the needs of her developing daughter and a weak and inadequate father who was incapable of meeting the needs of mother or child. Deficient parenting was compounded by physical unattractiveness and awkwardness associated with a hypothyroid condition as well as myopia which led to her wearing thick eyeglasses. Thus, she grew up with a chronic sense of being unlovable and unable to elicit the interest and concern of others.

Although Kohut regards many of these patients as treatable, my own clinical experience leads me to some reservation about the extent to which a therapist is able to reverse the early damages to the self that such patients have endured. Although it is clear that M has profited greatly from her psychotherapy, she seems to this clinician like an excellent candidate for becoming a "lifer." The deep-seated, ingrained sense of defect associated with the failure to elicit loving responses from her self-objects in the critical first years of life leads to scars that are difficult to overcome. As such, these patients frequently require an ongoing relationship with a

soothing, accepting therapist as a way of counteracting their chronic sense of unacceptableness.

Another issue of interest in this case is the optimal general therapeutic approach to this patient, in particular the choice of supportive or expressive strategies. Most psychotherapies are neither primarily one modality nor the other, but rather fall into a mixed supportive-expressive range as described by Luborsky (1984) and it appears that this approach was used by Dr. HarPaz. Based on the patient's early sense of deprivation, her expectation of not having her needs met, and her readiness to accuse caretakers of not having sufficient interest in her, I would expect the emphasis in this treatment to come down on the side of supportive interventions. Horwitz et al (1996), in their study of the psychotherapy of borderline patients (not her diagnosis) have shown that patients with self-organizations that are easily fragmented require a predominantly supportive approach in order to benefit from treatment.

This long, difficult treatment placed a considerable burden upon the therapist. Not only did he have to bear the transference-based reproaches of the patient who blamed the mother-therapist for her misfortunes in life, but he also had to deal with a patient's chronically undiagnosed physical condition. It is quite clear in this write-up that the therapist's dedication and commitment to the patient over a long period of time had helped the patient deal more openly with her pent-up anger, to be able to form a reasonably good relationship with her husband, and to continue working with her therapist in pursuit of greater self-fulfillment.

The most interesting and instructive aspect of this case was the therapist's difficulty in dealing with the patient's somatic symptoms following the remission of the trophoblastic disease: headaches, heart palpitations, generalized bodily pain, etc. The patient sought the help of many specialists for a period of two years before the correct diagnosis of Lyme's Disease was made. To her credit she sensed, before any of her doctors did, that her physical symptoms were not psychologically based and she persisted in finding the cause. The countertransference reactions to this patient were based on several factors but at this period of the treatment the therapist was mainly offended that the patient was seeking help on her own initiative, frequently not discussing her consultations with the therapist until after the fact. Thus, the therapist felt excluded from an important aspect of the patient's life problems.

In retrospect one can not understand why this patient decided single-mindedly to pursue the course she did. After multiple physical examinations and consultations, no physical problems were found and the therapist, as he described it, decided that the somatic symptoms were an expression of the patient's repressed anger at the depriving, neglectful mother. I believe that most therapists would have made that assumption given the negative results of the physical exams and the emotional problems and life history presented by the patient. Since the therapist viewed the symptoms as psychosomatic, and the patient had the conviction that they were physical, it was only natural that she began to withhold her intention to pursue her quest for further medical investigation.

To his credit, Dr. HarPaz was able to revise his views of the patient's physical symptoms on the basis of two factors. One, he made a concerted effort to focus on the patient's aggression, mainly via the transference. When that process did not produce any change, he began to question his hypothesis. A second factor was the important observation that this patient was not a somatizer. Her history, including her prior work with the therapist in which anger at significant figures in her life loomed large, did not include somatic symptoms as an expression of her psychic conflicts. My guess is that the therapist's puzzlement and frustration in understanding this development was exacerbated by the fact that she showed no previous evidence of somatic reactions.

With regard to the technical approaches to dealing with this patient, I have one question to raise. Dr. HarPaz states that he "invited her to stand facing and railing against me" in an effort to uncover the patient's unexpressed rage. My problem with this technique is that it introduces an element of artificiality and lack of spontaneity in the patient's reactions. I believe it is preferable to work with the patient's spontaneously arising affects or with the defenses against them. By inviting her to rail against him, the therapist may be implicitly conveying that neither of them should take the feelings seriously since they are only engaged in an "as-if" kind of role playing. Also, the patient may enact these feelings in a compliant manner and not experience them with much conviction because they are being expressed on demand. My own preference is to encourage the expression of latent feelings by establishing an atmosphere of trust and safety in addition to offering transference interpretations which convey permission and acceptance of negative (or positive) transferences.

Finally, I was impressed with Dr. HarPaz's efforts to deal with his own feelings of frustration in working with a patient who not only presented

perplexing somatic symptoms but who also had difficulty in expressing gratitude or appreciation for the efforts of the therapist. Despite his long experience as a therapist and supervisor and his obvious competence, he was able to recognize the fact that his own countertransference anger at being made to feel peripheral after all of his long effort to help was likely to interfere with the process. His use of various forms of consultation, including peer group supervision, was laudable and presents a model for all therapists, no matter how experienced, to emulate.

Dr. HarPaz should be congratulated for his skillful work and his perseverance with this difficult case.

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M's RESPONSE

Betsy Leib-Feldman, M.S.W.

I cried for a long time after reading the article about M's pregnancy. I experienced overwhelming sadness, followed by anger, disappointment and guilt. As a therapist, I often empathize with the struggles and pain of the patients whose case histories I read. But I am also able to put them out of my mind after a while, and walk away. The article about M's pregnancy, however, was very different, for I could no longer detach myself. Why the strong emotional reaction? Because I am M. It is my life that I am reading about and not someone else's. And that reality is powerful for me.

Dr. HarPaz invited me to respond to his article. I view this as a unique and rare opportunity and thus I gladly accepted his invitation. In our long relationship, my therapist had never before discussed so openly his many feelings and struggles while working with me and the impact that my illness and way of being has had on him. I realized that due to my own self-absorption, I hadn't paid much attention to our real relationship. I missed and neglected the importance of its meaning along the way. And for that I felt guilty.

I also know that my own sense of betrayal and powerlessness interfered with my ability to see the person of my therapist, with his own set of reactions to being with me. This resulted in my pushing away and dismissing him further. To be able to continue to treat me, Dr. HarPaz needed and had intact ego boundaries, a strong sense of self, and support from his colleagues. If he had not possessed this, and had been unable to place himself in my shoes, he might have more readily acted out his anger and feelings of powerlessness. The fact that he had a history with me prior to the illness also contributed to his ability to hold on to me. For all of this, I am fortunate.

I would like to make a few additional comments about my therapy. At first, it sounded plausible that my physical symptoms were due to the trauma of the pregnancy, and I wanted to believe Dr. HarPaz's theory about this. However, my body seemed to be screaming out, "Physical Illness!" in a way it had never done before. I was convinced that I had some type of infection invading my body, becoming worse by the day. After all, my body had always worked for me the way I wanted it to, and now I could not just will the symptoms away. Prior to the chemotherapy I had been

physically healthy and, like so many others, had taken my good health for granted.

But now my own therapist, who knew me better than anyone else and had worked with me for many years, suspected that my problems were emotional in etiology. This increased my sense of betrayal, panic and resolve to take matters into my own hands since the man I trusted didn't believe me. I wondered at the time whether he really saw who I was.

I then started my journey to many different doctors. They couldn't find out what was wrong with me, and I thought that they didn't take the time to dig deeper. After a total of ten minutes at most, one neurologist concluded that I had suffered from panic attacks, prescribed Xanax, and sent me on my way without any follow up. This infuriated me even more, and rightly so. Yet another told me that if I had a serious illness I'd have only one or two symptoms, not fifteen or twenty. Out came the prescription pad for the anti-anxiety drugs. For the record, I refused to take any of their anti-depressants since I didn't believe their conclusions. Finally, I went to a top medical facility for a comprehensive evaluation and nothing remarkable showed up. I reported this in a group session after which my therapist asked whether I was now done going to doctors.

But my body continued to betray me with difficult-to-describe symptoms. And then they kept waxing and waning, and changing. I could not control them! I would see patients each day, and all of a sudden the person would be swirling before me, as if upside-down! One day on the way to work I went into a public place, stood in line, and all of a sudden collapsed when my legs could no longer support me. Why was this happening, I wondered. The more difficulty I had articulating some of these troublesome symptoms, the more powerless and enraged I felt. And when others who knew me the longest did not believe me, I pushed them away even more. I felt very much alone and terrified. I seriously considered leaving therapy at that point. Yet I was also determined to find out what was wrong with me, and after many attempts to work with me, Dr. HarPaz eventually agreed that I had a physical problem and he would support me while I searched for the cause. This proved to be a tremendous relief for me since I then felt freer to talk about my experiences and gain the support and validation I needed. Through the help of the Internet, I was able to finally diagnose myself, gain medical confirmation for it, and begin a long and difficult treatment process.

I have learned that it is very important for the clinician to know the patient's character. Unfortunately, many clinicians fail to see the patient as a whole person as I have observed again and again during my many visits to many doctors. Even the most seasoned clinician can err on the side of attributing the patient's symptomatology to solely physical or emotional etiology. For instance, one could err in the direction of sending a patient who is already in a tailspin to many different specialists when the cause is indeed emotional.

In my case, Dr. HarPaz, given his knowledge of my character and the absence of somatization in my past, could have worked with me differently. He might have encouraged me more strongly earlier on to pursue seeking a diagnosis for my increasing symptoms, once I had informed him that my oncologist believed my symptoms were unrelated to the chemotherapy. In the meantime, he could have continued to work with my rage since that was present no matter what the cause. Once I was ultimately diagnosed, I became more convinced that Dr. HarPaz had demonstrated remarkable sensitivity and empathy in helping me with my struggles. This resulted in my being more open and trusting in our relationship.

I have learned that physicians and healers who have suffered from their own physical illness at one time in their life have greater capacity to empathize. In order for those of us who have not experienced illness to be exquisitely sensitive toward those who have suffered, we must already have a sense of who we are, and have accepted our own vulnerability and mortality. I continue to struggle with my Lyme disease and the many painful physical and emotional issues surrounding it. I believe that when I am able to work with patients again, I will come away with a greater degree of sensitivity and empathy to those who are suffering with both physical and emotional illnesses.

RESPONSE TO RUTAN AND HORWITZ

Natan HarPaz, Ph.D.

Every open discussion of a clinical case can be a constructive learning experience because it reveals more than a kernel of truth about at least two people--the patient and the therapist. Both Dr. Rutan's and Dr. Horwitz's responses to my presentation of "M's Pregnancy" came from their own unique perspectives and made a contribution to my understanding of my patient and of my work with her. In addition, it was very interesting and beneficial for me to read M's own response to my article about her. I thank all three for their contributions. Such clinical discussions among clinicians and patients are relatively rare in the literature and may bring us closer to what really works in psychotherapy.

I agree with Dr. Rutan that "the interface between the physical and the emotional is complex and not well understood." However, the physiological state of my patient, as Dr. Rutan said, may in fact offer us "important windows into the patient's unconscious." The type of physical problems or ailments which afflict our patients may provide us with clues which will help to isolate the weak link in their psychological/physical life.

Dr. Rutan suggested that my difficulties with M resulted from a third factor: projective identification. In my discussion of M's pregnancy, I was trying to discern how much of my reaction to M was my countertransference, and how much was a realistic response to a very difficult situation (Blum, 1992; Gill, 1982). My fundamental operative assumption when I practice psychotherapy is that in every clinical situation the person of the therapist is at the center of the therapeutic process (HarPaz, 1994a). When a therapist is deeply involved in a long-term therapeutic relationship there are many chances for countertransference to interfere with the therapeutic process. Necessary safeguards should be employed when doing intensive long-term psychotherapy to help diminish the effects of the therapist's countertransference. I have already elucidated several of them (HarPaz, 1994b) within the context of Crisis Mobilization Therapy (CMT)--a system of combined therapy in which patients are seen in one individual and two group sessions a week with a co-therapist in the groups. The likelihood of the therapist's acting out his or her countertransferential distortions is lessened in this model. It was the fact that these safeguards were in place over many years, combined with the real physical problems in M's life, that led me to conclude that some of my

difficulties were more due to reality than to countertransference or projective identification.

I do not agree with Dr. Rutan's point that "there are no right ways to approach our task" and that "the goal is to find a theoretical position that fits the personality of the therapist." While there may be many ways to skin a cat, as the old saying goes, if we view psychotherapy from a medical/surgical perspective, there are not many ways to treat M just as there are not many ways to perform an appendectomy. In fact, the purpose of publishing "M's Pregnancy" and its respective responses was in part to help us find the right way to approach our task. The fact that many therapists use different approaches to try to accomplish their task does not validate Dr. Rutan's point. It may actually demonstrate the opposite: psychotherapy is only in its infancy, and many practicing therapists do not really know how to treat such conditions and are still searching for the right way to treat their patients. It is important for us professionals not to give up the scientific search for the right way to treat our patients' illnesses. At the same time I agree with and accept Dr. Rutan's point of view that the therapist must be able to be flexible in order to allow for "another world view to be considered." It is in this spirit of open consideration that this discussion took place.

In his discussion of "M's Pregnancy," Dr. Horwitz raised an important question regarding M standing and railing against me. He claimed that such a technique introduced "an element of artificiality and lack of spontaneity in the patient's reactions." Anger exercises have been used by therapists for many years to help patients express deep feelings (Casriel, 1972). Many of the body therapies such as Bioenergetics (Lowen, 1967) and Radix (Kelley, 1992) use exercises to help patients access real feelings which have been buried by fear. Utilizing exercises in psychotherapy is often necessary for patients who are afraid to powerfully express their own anger and who cannot work through it without a therapist to help them experience and express it fully in a safe place. At a later phase in therapy exercises can also be used to help patients whose anger serves as a defense against hurt and fear. Obviously, such exercises should be used carefully and judiciously. It is critical that the therapist know whether an exercise serves the patient's resistance rather than the intended goal. If an exercise yields an "as if" reaction by the patient it obviously should be stopped (HarPaz, 1995).

Speaking *about* one's feelings, common in psychoanalysis and psychodynamic psychotherapy, is at least once removed from the patient's

actual experience and all too often involves only the person's cognition and not the physiology. Direct work with the body and the use of verbal or non-verbal exercises which help the patient experience and express feelings can reach the physiology, a necessary step for character change to occur (Bar-Levav, 1988). Therefore, it was important to help M access her repressed rage which might have otherwise compounded her problem. In my relationship with M over many years she had spoken about her anger and rage and even acted it out. But as I stated in my paper, I hypothesized that "the direct open expression of rage at a specific transferential target--me--would release her primitive preverbal rage and make room for the expression of deep and lifelong pain." Only after a real-relationship has been established between the therapist and the patient can such an exercise yield the desired result (HarPaz, 1994a). It was within the context of a real-relationship of many years that this technique was used with M. If the patient's expression of rage is directed at a therapist within an established viable real-relationship, inaccessible feelings which lie beneath the anger may be stimulated and become available to the patient. A patient who is compliant may also find such exercises helpful because unexpected spontaneous feelings other than anger may be released and expressed and propel the patient beyond his/her characterologic compliant stance.

I appreciate Dr. Rutan's and Dr. Horwitz's compliments and I thank them both for their comments and discussion of "M's Pregnancy." I invite Drs. Rutan and Horwitz, if they are so inclined, to further discuss this case or any other theoretical or clinical matter raised in this issue. Their comments will be published in the next issue of this journal. In order for psychotherapists to find the best way to treat a patient we need to discuss openly in all available forums and venues our varied theoretical formulations and clinical experiences. We should all function as a community of colleagues seeking the truth (HarPaz, 1994b). We should never leave ourselves as therapists out of our clinical discussions about our patients. Open clinical discussion as presented in this issue may teach us more about ourselves, help us heal our patients and bring us closer to the truth.

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Background Point of Theory

The tendency to be sickly is another aspect of the physiologic basis of character. Some people typically respond to subjectively unbearable stress by developing physical symptoms, the direct bodily equivalents of emotions. Asthma and various skin disorders commonly develop when such overflow occurs early in life; gastrointestinal difficulties, high blood pressure, and rheumatic disorders are more typical later on. But increased susceptibility to anything, including the common cold, infections, and injuries, is often a sign of intensified stress and anxiety. Symptoms bring attention, first aid, and helpful healers — in short, relief from empty loneliness. Besides, they provide relief from adult responsibilities and freedom to regress without loss of face.

Thinking in the Shadow of Feelings, p. 89

WHAT IS THE BLEA TUESDAY SEMINAR?

A BLEA postgraduate clinical psychotherapy seminar has been held in Detroit every week for over 20 years, always from 12:00 Noon to 2:00 P.M. Practical issues of patient management have been supplemented with theoretical examinations of the nature of psychotherapy and human behavior in general. The Socratic method of teaching has usually been used. Seminar participants have been challenged to think critically and to examine afresh our own and each others' opinions and statements. We have grown together in our expertise and our ability to understand and to enunciate the rationale, techniques and methods of our clinical work.

The BLEA Tuesday Seminar has thus been and continues to be a laboratory in which new ideas are tested. The choice of topics and teaching of seminars is rotated among the BLEA faculty, fellows and graduates. Carefully prepared assignments are presented by seminar participants from questions distributed the previous week. The answers are read aloud, discussed, critiqued and sometimes heatedly debated.

There is now a chance for you, the reader, to also benefit from this stimulating experience. Each issue of the Journal, devoted to one Tuesday Seminar topic, brings to you questions posed and some of the responses. What follows is one of the assignments and some of the answers which were presented during a two-week period in September, 1996. Your thoughtful response in 250 words or less is welcome and, if suitable, will be published. The deadline for inclusion in our next issue is April 1, 1998.

BLEA TUESDAY SEMINAR

Serious Illness in the Therapist

Assignment for September 3, 1996

You have just learned that you have a serious physical illness which has cumulative debilitating effects and which threatens to take your life within the next three years. Please respond to the following points:

Tuesday Seminar Responses

1. **Describe your emotional reaction to this finding--your illness and its irreversible course.**

I am scared and angry. How unfair it is after all the work I've done with myself to have this happen now. My life is stable and I'm often content. There is so much I still want to do. There can't be a decent god who would allow this to happen! Even if I'm not dead in three years I'll have to live with "cumulative debilitating effects" which will surely affect the quality of my life.

Pamela Torraco, M.S.W.

I feel anger, fear, hurt and anger again.

Leora Bar-Levav, M.D.

With some embarrassment I find that I have a sense of relief about my condition. I am tired and find that the will to fight is not immediately present.

Joseph Froslie, M.S.W.

My initial reaction is fear. I have thought many times before about what I would do if I were to develop such a terrible illness. I believe that during the latter phase of such an illness I would take my life.

Natan HarPaz, Ph.D.

I feel extreme sadness and fear with some anger in-between. The feelings are so strong that I am preoccupied and able to focus on little else.

Ronald J. Hook, M.S.W.

At first I am numb to my feelings, perhaps denying reality. Next, I alternate between my fear of being helpless and my anger at the "enemy" who "did" this to me. As I write, I fear ultimately feeling so sorry for myself that I will withdraw and push others away.

Paul P. Shultz, M.S.W.

I am scared. What will I do with the life that I have left? There is suddenly so little time when I assumed I had plenty. And I have been feeling so healthy! Surges of panic seem to bubble just below the surface as I come to grips with my irreversible deterioration. It is too hard to grasp, and I lapse into numb resignation. But as the thoughts spin in my head, I begin to get angry. Damn! Why me? The world really is not fair.

David A. Baker, M.S.W.

2. Having been told of your illness, what feelings and thoughts does this knowledge stimulate in you regarding your work with your patients?

I expect I would be far more impatient and intolerant of the ways in which I and my patients waste time and life. I think I would also be hungrier than I already am for evidence of my effectiveness with patients, at times even desperate to see that I've made an impact on others. Overall, I believe I would be more openly expressive and less guarded in showing myself, as if to say finally, "Here I am: If you don't like it, then complain or leave but I will only live what I have left as I really am." Writing these words brings tears to my eyes. I am sad and pained that I do not live more this way now.

Leora Bar-Levav, M.D.

I am aware of the preciousness of time. I sense some bitterness in myself since my patients will likely live longer than I. I start to worry about them. Will they have enough? Perhaps we should have a crash course of treatment.

Ronald J. Hook, M.S.W.

My work with patients is the most important and helpful activity I can find to counteract the sense of helplessness I have inside. I know that my work now will be of great importance to me and that I will continue to practice as long as it makes sense.

Joseph Froslie, M.S.W.

This will be difficult for my patients. Therapy for many of them will be disrupted and they'll have to live through this loss. How will I keep my balance throughout this time and treat them properly by neither withdrawing nor being too open? I know that particularly for some this could be valuable, but at this point I am scared and angry that we both have to go through this.

David A. Baker, M.S.W.

I will share my fate with my patients at the right time. Since we are involved in a *real* relationship, it is appropriate to discuss with them the nature and irreversibility of my illness so that they have a chance to work through some of the issues regarding my impending death and other losses in their life. As I think about losing them, I already miss them.

Natan HarPaz, Ph.D.

I immediately feel hope that I could be for my patients at least as good an example of dignity, self-respect and determination in my decline as my father was in his. He seemed to hold onto and fight for life not out of fear of death but out of love for what life had to offer. He sought and often found heroism and joy in even small things.

Paul P. Shultz, M.S.W.

My work is one of the things that has made my life stable and enjoyable. Now it feels like an additional burden. I want to *be* one of my patients now, not treat them. I don't want to have to put my

patients' needs first when I need so much myself. They are such good people--I want to cry out to them and have them hold me, not the other way around. I am thankful to have such good colleagues who can help me with myself and with my patients.

Pamela Torraco, M.S.W.

3. How would you handle the issue of disclosure or non-disclosure with your patients? Explain.

I would work without disclosing until such time as it was evident that I could work only for another 6 months or so. Some debilitation may show prior to that, but it could be workable without complete disclosure. I would worry that early disclosure might promote a mass exodus from my practice.

Ronald J. Hook, M.S.W.

I would disclose in titrated doses, carefully considering with my supervisor what would be best for each patient. Given my experience with the death of my father when I was ten and the denial that shrouded that event, I must pay close attention to my tendency to say either too much or too little. The process should be respectful to all involved. Once I bring my illness into the therapy, it becomes part of the therapy and must be worked with as such.

Elaine Minkin, M.S.W.

Each patient's status will be reviewed carefully before disclosure. Each patient will be told individually by me the specific diagnosis, prognosis and typical course of the illness as reported to me by my physician. The uncertainty regarding rate of deterioration and time of death will be emphasized. I will make clear that the illness will eventually preclude my treating them. I will propose that each patient continue working with me until such time as referral to another competent therapist is called for by reality.

Paul P. Shultz, M.S.W.

4. Do you think about your own mortality in your work with patients? How realistic are you? (Really examine your internal process as you respond.)

I live with my own mortality every day. Perhaps this has been enhanced for me since I suffered so many losses early in my life. Numerous relatives perished during the war. My younger brother died of a serious illness when we were both children and my father succumbed to kidney disease while I was still in my teens. Being Jewish also adds to my undeniable sense of the vulnerability and impermanence of my life. The daily morning prayer of thanking God for "returning my life to me" serves as a personal reflection of the fragility and preciousness of life. I think of this every day as I involve myself with the lives of my patients.

Natan HarPaz, Ph.D.

Typically, I only think about my mortality in my work with patients after someone I or they know dies or has a "close call" with dying. At such times I jar myself with the realization that I am a few years short of fifty, I need bifocals, and there are many things I will not do in my remaining years. I also jar my patients when they are grossly delusional about their mortality as demonstrated in poor self-care. But generally I deny my mortality rather than living calmly alert to that fact each day, each session.

David A. Baker, M.S.W.

As I age I find myself more involved with assessing my own mortality and being more thoughtfully aware of it. I no longer view life as never-ending. Hopefully I will be able to help my patients accept the fact that life is a series of decisions that have far-reaching consequences to the individual and those nearby. I have in some ways lost (thankfully) my innocence regarding life, my vulnerability and my mortality. Never one to see myself as invincible, I lived for many years as if there was always another tomorrow and another chance. This has changed.

Joseph Froslie, M.S.W.

I thought yes, but it's really no. I am unrealistic. I delusionally expect indefinite time still. This has damaging effects.

Ronald J. Hook, M.S.W.

Assignment for September 10, 1996

Think of a patient with whom you have a solid real-relationship--one that has withstood the test of some rough times. Five years into therapy the patient tells you in an individual session about the results of a physical checkup. The symptoms that you have been addressing over the last six months as manifestations of emotional conflict have been diagnosed as symptoms of a serious physical illness with cumulative and debilitating effects which threatens to take your patient's life within the next three years. With this in mind please answer the following questions.

Tuesday Seminar Responses

1. **Describe your emotional reaction to this finding--your patient's illness and its irreversible course.**

I feel shocked, then a rush of guilt. What did I miss? How much harm has been caused all this time while I treated the illness solely as emotionally-based? I feel scared--scared for my patient's health and life and for my responsibility and powerlessness. I feel the urge to rage at the heavens for throwing this at us.

David A. Baker, M.S.W.

I am heartsick. I know how debilitating, disruptive and discouraging serious illness is to the individual as well as to those who are a part of that person's daily life. I am also frightened since it evokes my own fears of pain, suffering and dependency. I fear that I will overidentify with my patient's fears and/or denial.

Sharon Banks, M.S.W.

The vignette suggests that my patient's illness was discovered on a routine check-up rather than as part of an ongoing search to rule out any and all physical bases for my patient's symptoms. This is implied not only by the absence of an explicit statement about my judgement that he/she pursue physical work-ups but also by the

suggestion that I addressed the symptoms as manifestations of emotional illness. As such, the vignette suggests that I was grossly incompetent. I would have made a direct and significant contribution to his/her deterioration and possible demise and I would certainly be extremely pained and very scared, even mortified by my behavior and its consequences.

Leora Bar-Levav, M.D.

When I imagined my patient telling me she had leukemia, I immediately felt deep sadness and then a moment of denial. Maybe the lab reports are wrong. But as she confirmed the reality, I felt anxious about the uncertainties that lie ahead for both of us and I doubt my ability to help her as her illness progresses.

Joann Coleman, M.S.W.

My initial emotional reaction to this finding is fear, similar to my reaction if this finding was about myself. Because hearing such news is so terrible, I am not sure whether my emotional response is an overidentification with my patient or "normal" identification. My awareness of the reality of my own fragility and frailty is heightened: "There but by the grace of God go I."

Natan HarPaz, Ph.D.

I believe that initially I would be unaware of my reaction, not wanting to let myself really take in what the patient was telling me. Next, I would become aware of fear of not being in control alternating with sadness at the certainty of the impending loss. If I erred in not sending him to a physician sooner, I would feel guilty also.

Paul P. Shultz, M.S.W.

I am shocked and sad, scared and helpless. I've spent five years with this patient, hoping to make an impact on one life that will last for many years. Now I feel like a powerless pawn in some large and insensitive scheme of nature. I realize I am also angry.

Pamela Torraco, M.S.W.

2. Having been told of your patient's illness, what feelings and thoughts does this knowledge stimulate in you regarding your work with this patient?

I feel guilty because I have addressed the patient's symptoms only as expressions of emotional conflict. In spite of telling myself that I should have continued to work with the emotional components, I realize that I did not see or hear the whole person. Even if the symptoms were unclear and difficult to diagnose, such a discovery taps my feelings of insecurity and impotence. Hopefully, with supervision I will not now act out with my patient in an attempt to allay my guilt.

Natan HarPaz, Ph.D.

How much new material do I open up in the patient? How do I help him or her live a full life as long as possible without distorting the fact that he is on a rapid course toward death? Some fear exists in me regarding how to prioritize interventions. Opening him too far might make the balance of his life more difficult. Not opening him enough may deprive him of some life he *could* have had.

Ronald J. Hook, M.S.W.

I am saddened and sobered. I am somewhat embarrassed as I recognize that I am also relieved that this new turn of events will take the tedium out of the therapy. Strange as it sounds, I am honored to walk with my patient through his deterioration and maybe his death. I also dread facing my patient's and my own mortality. I will search out steady help to stay present with the patient, to not withdraw or get busy, to not carry this load alone.

David A. Baker, M.S.W.

I have already had more than my share of experience as a caregiver to acute and chronically ill relatives and close friends with life-threatening and terminal illnesses. I fear I will lose objectivity and attempt to deny or predetermine the outcome. Either would be an injustice to my patient. Conversely, my experience may serve my patient well. I recognize my impotence, but know also that I can be

involved, committed, sensitive, and present under the most adverse conditions and face death squarely and honestly when it is inevitable.

Sharon Banks, M.S.W.

Knowing how I erred, I know the patient cannot and should not trust me. While it is human to err, my capacity to disregard the possibility of physical illness for half a year suggests I never truly identified with him/her nor took his/her life very seriously. Were this patient to wish to continue treatment with me, it is clear that the proper direction the work ought to take is to focus on the dangers of blind trust and perhaps the legitimate place for a malpractice suit.

Leora Bar-Levav, M.D.

Upon learning my patient is seriously ill, I focus on how my own difficulty to properly care for myself when I am ill hinders my work. Rarely do I consider a serious underlying physical cause when I am sick. I focus too much on the emotional component. I am aware of my resistance to live with another person in my life who is dying.

Joann Coleman, M.S.W.

I am aware of sensing some resignation on my part and worry that this will lead me to give up and not help my patient fight the necessary battles. I might subtly support my patient's unwarranted giving in to his or her own resignation or wish to withdraw.

Joseph Froslie, M.S.W.

3. Would you help your patient plan for the future? If yes, how?

I would do my best to help my patient plan for the future and would be careful to help assess whether the plans were realistic. I am glad that my colleagues and co-therapist can help me with this delicate process. It is conceivable that in such a difficult situation the patient and therapist can engage in wishful thinking or resignation. The patient's therapy group will also be helpful in assessing the reality of the plans the patient makes for the future.

Joseph Froslie, M.S.W.

I would help the patient plan for the future by staying as realistic as possible. I would help him to evaluate the effects of his life, his illness and his death on his surroundings and relationships so that he can plan and manage it in the best way possible. I picture myself on these occasions like a lawyer who steadies his client while the client is under siege.

Ronald J. Hook, M.S.W.

I will try to help my patient plan for the future by maintaining a consistent push to evaluate and accept reality. Although this is what I normally do, it will be more difficult because I will want to deny the reality of the "cumulative and debilitating effects" of the illness. I will try to help my patient live as fully as possible, making whatever adjustments the reality of the illness calls for, and to die with dignity. I will encourage him or her to plan financial and other business affairs thoughtfully and to attend sensitively to close relationships, particularly if there are children involved.

Pamela Torraco, M.S.W.

4. How do you imagine the end of your relationship with this patient to be? How realistic are you?

What kind of contacts I will have with him, be they therapy sessions or visits to his sick bed, will be issues that will have to be reality-tested as they present themselves. If effective psychotherapy will help my patient fight the disease process and live more fully as he slowly deteriorates, I will aim toward keeping him in formal therapy as long as realistically possible. When his treatment is finally terminated, I imagine I will maintain regular telephone contact, and will visit him at bedside perhaps once every week or two.

Paul P. Shultz, M.S.W.

I am fortunate that I haven't had to face this issue in recent years with any of my long-term patients. Obviously, should such misfortune happen, I will continue my work with my patient till the end of his/her life. Their place in the group will be secure until such time as attending sessions becomes physically impossible. I and their fellow group members will be closely involved in their dying process.

Natan HarPaz, Ph.D.

I imagine the end of my relationship with this patient to be a gradual withdrawal on their part, and on mine. I hope that it wouldn't be too soon on either of our parts. But some of these withdrawals are merciful. This is a hard road to walk sanely. I would be at risk of becoming cranial during such a time--an old, characteristic method of withdrawal of mine.

Ronald J. Hook, M.S.W.

I imagine that at the end there would be fewer drastic swings in emotion and few surprises in the patient's life. I envision a relationship that would include more quiet moments, times of deep joy and sadness, and an acute sense of the value of a pain-free hour. I would certainly feel the tendency to withdraw emotionally, but would be able to counter this for the most part.

I believe I am mostly realistic, but I cannot really know the intensity and difficulty ahead for myself and my patient since I have not had such an experience.

David A. Baker, M.S.W.

LETTERS TO THE EDITOR

I read your Spring, 1997 issue with great interest. As a patient in my sixth year of therapy, I am writing to express my thoughts on the real-relationship from a patient's perspective. I have been in treatment with other therapists unsuccessfully in the past and I now recognize that one factor that was always lacking was the real-relationship.

The real-relationship I share with my therapist has been my anchor. Her steadfast belief in the effectiveness of therapy and her confidence in my ability to make real changes in myself have given me the motivation to keep coming back, even on the most difficult days. When I was able to accept that she was a human being who genuinely cared about me, I was able to begin loving myself. I know, too, that the real-relationship we have developed together will be the touchstone that will guide me in other relationships in my life.

Christine Doan
Rochester Hills, Michigan

As indicated in your Statement of Purpose, one main goal of the *Journal* is to teach psychotherapy through the sharing of clinical observation and experience. Clearly the *Journal* is meeting this objective. Every article and section is grounded in individual observation and experience.

My core criticism of the *Journal* is its lack of diverse comments and viewpoints. Your title suggests broadness, yet all of the participants hold the same opinion. This publication lacks the diversity it appears to advocate in its title, and the interaction it encourages in published statements which invite thoughtful responses and participation from your audience.

If the *Journal* is to be more than the validation of the book, *Thinking in the Shadow of Feelings*, the editorial team must strategize on how to get your audience involved and how to spur them into participation. Only then will the *Journal* become the *fully* interactive, diverse and thought-provoking tool it could be.

Suzanne L. Crane
Royal Oak, Michigan

Thank you for your comments and your compliments. Like you, we are eager to have diverse viewpoints in the Journal and we encourage them and publish them when they fit. As you have noticed, in each issue we include responses to the clinical case from various theoretical perspectives.
Ours is a relatively new journal and we hope that with time it will indeed become a forum for critical thought, as we planned it.

The Editors

The *International Journal of Psychotherapy & Critical Thought* is published by the Bar-Levav Educational Association two times per year -- Spring and Fall. Subscription rates are $20.00 for one year, $35.00 for two years, and $11.00 per individual copy.

The *Journal* encourages a dialogue between readers and the authors of published articles. Readers are also invited to respond to Tuesday Seminar discussions and the Case Presentation. We assume your response is for publication with your name unless you tell us otherwise. If you request it, we'll omit your real name. We cannot print all the material we receive, and we reserve the right to edit material you submit for publication. All material printed becomes our property. All responses should be 250 words or less, typed and double-spaced.

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The Bar-Levav Educational Association (BLEA) is a non-profit educational and research association incorporated in Michigan in 1977 and governed by a public Board of Trustees. It sponsors intensive individual and group psychotherapy training for postgraduate and postdoctoral psychiatrists, psychologists and social workers. BLEA also sponsors small, high-level, public seminars devoted mainly to the effects of emotions and character on our value systems, public policy and child rearing practices.

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Please direct your inquires regarding the training program or conferences to Natan HarPaz, Ph.D., Dean, The Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075.

Coming in the Next Issue

The Co-therapy Team