Psychotherapy in psychosomatic diseases
Preconditions

- competence of the therapist (+ perception of the patient);
- regular meetings;
- agreement on purpose;
- shared responsibility (oral / written contract).
Keywords

Active listening
Empathy
Hope
Respect
Patience
Learning
Awareness
Personal development
Change
Autonomy
Favorable circumstances vs. limits

1. The authentic need for a change

Intrinsic motivation > extrinsic.

The therapist should pay attention to intrinsic, however dysfunctional motivation (e.g., secondary benefits from symptoms).
Favorable circumstances vs. limits

2. **Insight** (e.g., CBT)

vs.

**Suggestibility**
(e.g., hypnosis).
Favorable circumstances vs. limits

3. Integrity of one's personality
(symptoms are perceived as undesirable, other areas of personal and social functioning are conserved)

vs.

Higher destructuration of one's personality
(symptoms are part of a more substantial psychiatric illness or a personality disorder)
Favorable circumstances vs. limits

4. Short duration of symptoms = more favorable prognosis

PT has more radical objectives
Trust in therapy is higher
Tolerance of symptoms is lower
Compliance, both for medication and psychotherapy, is higher
Secondary benefits, sick role = less probable
Challenges

1. Necessity of a **combined approach**
   (e.g. relaxation, art-therapy, group therapy, ...)

   + collaboration to other specialists

   + case manager
Challenges

2. **Cost-benefit** from the perspective of the patient vs. the perspective of the therapist (HBM)

Consequences for addressability and adherence
3. **Resistance**

   e.g. 1: stemmed from suffering itself

   e.g. 2: stemmed from the incapacity to analyze/understand
Challenges

4. Congruence / discrepancy between the abilities developed within psychotherapy and the particularities of the social environment (e.g., attachment to the "sick role").
Challenges

5. **Control** within therapy – how directive is the approach

**Dependence on the therapist** - dual effect (accelerates building of trust / creates problems in building autonomy)

**Codependence**
Challenges

6. **Attachment to the old routines**, even if this is self-destructive / painful

the tendency to keep intact thoughts, behaviors, routines, memories, even if they are associated with suffering („postpone cleaning“)
Kinds of psychotherapy
1. **Psychoanalytical (psychodynamic)**

(Freud, Adler, Jung, ....)

- 3 compartments of Psyche - Self, Ego, Superego;
- Self - instincts, basic needs;
- Superego - norms, rules, values;
- Ego - adjustment to reality;
- Symptoms stem from the imbalance between these compartments;
- Efficient when symptoms have a long, complicated history;
- Profound type of therapy;
- Keywords: transference, countertransference, resistance, insight, awareness.

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No tree, it is said, can grow to heaven unless its roots reach down to hell

—C.G. Jung
2. Relaxation / Hypnosis
(Mesmer, Erickson, Ferenczi,...)

- easy access to Self;
- more directive than psychoanalysis;
- based on inducing a modified state of conscience = trance and on administering therapeutic suggestions;
- a key element = suggestibility / suggestive predisposition);
- the therapist needs a thorough specialization;
- duration typically shorter than psychoanalysis;
- disadvantages: can be difficult / impossible to run in certain conditions (psychoses, personality disorders,...)
3. Behavioral / Cognitive-behavioral
(Watson, Skinner, Pavlov, Ellis, Beck, Festinger,...)

- behavior is learned / modeled;
- a symptom serves to a purpose and can be conditioned;
- therapy is equivalent to deconditioning;
- the therapist should pay attention to the gains-losses balance, as seen by the patient;
- theoretical bases: the ABC model (Ellis), the theory of cognitive dissonance (Festinger);
- “here and now” type of therapy;
- can be useful in psychosomatic disorders and diseases.

"If people are good only because they fear punishment, and hope for reward, then we are a sorry lot indeed."
Albert Einstein
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Cognition</th>
<th>Emotion</th>
<th>Physical</th>
<th>Behaviour</th>
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</thead>
<tbody>
<tr>
<td>Fatigue</td>
<td>Effort will make fatigue worse</td>
<td>Depression</td>
<td>Physically unfit</td>
<td>Avoids activity</td>
</tr>
<tr>
<td>Headache</td>
<td>Tumour, stroke I won’t cope</td>
<td>Anxiety</td>
<td>Muscular tension</td>
<td>Focus attention</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Worries about consequences of insomnia</td>
<td>Anxiety</td>
<td>Arousals</td>
<td>Avoidance</td>
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<td>Focus attention</td>
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<td>Analgesics</td>
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<td>Focus attention on not sleeping</td>
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<td>Hypnotics</td>
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<tr>
<td>Breathlessness</td>
<td>Suffocate</td>
<td>Anxiety</td>
<td>Hyperventilation</td>
<td>Avoidance</td>
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<tr>
<td></td>
<td>Asthma attack</td>
<td></td>
<td></td>
<td>Focus attention</td>
</tr>
<tr>
<td>Chronic pain</td>
<td>Damage</td>
<td>Depression</td>
<td>Physical basis of varying significance</td>
<td>Avoidance ++</td>
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<tr>
<td>Atypical chest pain</td>
<td>Heart attack</td>
<td>Anxiety</td>
<td>Hyperventilation</td>
<td>Focus attention</td>
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<td></td>
<td>Musculoskeletal</td>
<td>Seeks reassurance</td>
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<td></td>
<td>Avoids exertion</td>
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<td></td>
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<td></td>
<td>Attention reassurance</td>
</tr>
</tbody>
</table>
Social situation

Erroneous assumption

Exaggerated perception of danger

Defensive behavior

Psychological and somatic symptoms

Distorted (negative) assessment of own resources to cope

CBT

CBT

CBT
4. Biofeedback (Shearn, Schultz, Sargent, …)  
(direct influence on symptoms, via the real-time feedback received about the abilities to control a body function)

- feedback mostly visual;
- success is more probable if the patient is motivated;
- can enable the control of normally unconscious body functions (e.g., muscle tone, temperature);
- useful in a series of psychosomatic disorders (e.g., migraine);
- does not address the profound causes of symptoms;
- still, can be learned and practiced alone, offering a certain autonomy to the patient.
5. Humanistic
(Fromm, Frankl, Rogers, Maslow, Perls,....)

- human beings are capable of choices and responsibilities;
- an essential contribution in finding personal happiness is looking and identifying a personal sense of life;
- suffering can be a good opportunity for reflection;
- suffering belongs to the whole body and not to a single organ;
- aims the increase of awareness and creative abilities.
6. Group therapy

Benefits:
- providing hope;
- perception of solidarity;
- providing information;
- discouraging self-centeredness;
- catharsis;
- role of substitutive family, cohesion;
- modeling, interpersonal learning;
- improvement of social abilities (can indirectly lead to an increase of compliance);
- finding meaning.

Risks:
- gratification of neurotic needs;
- unrealistic objectives;
- the onset of new symptoms.
CLINICAL CASE

HISTORY
- a 56-year-old male referred by his orthopedic surgeon to the pain-management center;
- injured his back while on the job as a technician and had already two spine operations in the last two years;
- returned to work, but stopped after a year when he hurt himself again;
- he had not worked since;
- got worker compensation claims and later qualified for Social Security disability benefits;
- medical diagnosis: post-laminectomy syndrome with radicular pain (residual pain from his spine after corrective surgeries) and myofascial pain (muscular pain with spasm, tender spots, or muscle knotting);
- psychological evaluation: discouraged and depressed;
- two months earlier, he had made a suicidal gesture (cut himself lightly with a knife) and sought help from the psychiatrist; he was prescribed Prozac, which elevated his mood, but he still reports feeling depressed averagely two days a week;
- he did not attend psychotherapy, nor was prescribed it;
- currently, he has recurrent thoughts of being "a professional pain patient";
- reports difficulties in the relationship to his wife, because of his illness;
- insomnia, even with sleep medication;
- smokes a pack and a half of cigarettes a day and has a history of alcohol abuse (managed through individual counseling and group therapy - AA).
CASE FORMULATION

- this case displays several psychosocial risk factors that can play a role in chronic pain;
- long-term problems in coping are illustrated by heavy smoking and previous alcoholism, getting and staying into the role of being disabled;
- marital difficulties deprive him of social support and add greatly to his current stress;
- depression reduces further his motivation and ability to cope;
- chronic sleep problems contribute, along to the somatic symptoms, to his gradual demoralization.

Positive factors:

- openness to psychosocial interventions (including PT);
- familiarity to the concept of personal growth;
- not willing to seek further material benefits or compensation;
- willing to repair the relationship to his wife;
- motivated to change, in the sense of expressing the desire to return to work, get rid of depression.
POSSIBLE INTERVENTIONS

1. CBT:

- making him familiar with the ABC model (with a focus on B and C) (e.g., the accident, the quarrels with his wife; alcoholism and smoking);
- making him familiar with the model of cognitive dissonance (to understand why to focus on thoughts and behaviors);
- working with unrealistic / catastrophic thoughts (e.g., "I wish everything could be as before", "I will never get better");
- address the thoughts re: limitations imposed by the injury or illness (do no perceive acceptance as a surrender);
- address the thoughts re: social support (need of consistent prosocial approach);
- defining the characteristics of the Optimal Functioning Zone (thinking through and planning activities to stay in the Zone);
CBT (cont'd):

- after stabilizing of more realistic and adaptive thoughts, focus on behaviors;
- begin with behaviors with lower importance (e.g., try to get into small shopping, stroll in the park) and end up with those with higher importance (find an appropriate job, provide support in the family);
- focus more on planning and, consequently, on problem-solving behaviors.

2. Biofeedback:

- supplement for CBT;
- has a direct and relatively fast impact on perceived pain;
- should be preceded by learning and doing relaxation;
- strengthens the relationship between cause - effect (thoughts - behavior), which is useful for running CBT.
3. Relaxation

- contributes to pain reduction, by reducing sympathetic arousal;
- it can be learned (e.g., home-use tapes), thereby promoting autonomy;
- is an additional way of staying in the Optimal Functioning Zone;
- addresses insomnia;
- facilitates the understanding of the connection between cognition, emotion and outcome;
- facilitates the knowledge and acceptance of the concept of "stress management";
- is independent of patient's intelligence or social support;
- offers a potential easy to implement to daily hassles and stressors, including the challenges brought by accepting the new health status and finding a new way in life.
4. Hypnosis:

- direct positive effect on pain;
- increases self-efficacy, internal locus of control, coherence, optimism;
- additional benefits on smoking;
- positive effect on sleep;
- improves social functioning (family, friends, work);
- should be preceded by learning and doing a few sessions of relaxation;
- useful for doing self-hypnosis, meditation when confronting with subsequent pain episodes;
5. Group / family therapy

Can be an option, considering the characteristics of this case:
- the difficulties in the relationships inside the patient's family;
- the chronic condition of this patient, without the immediate perspective of a significant change in his abilities to work and perform social roles;
- the willingness of the patient to integrate in society, from the new position of acceptance;
- the good previous experience with a therapy group (AA).

6. Humanistic approach

Can address aspects such as patient's
- choices (e.g., to accept vs. to refuse the current health status);
- responsibilities (e.g., to reintegrate in society, to escape from the sick role);
- sense of suffering (e.g., to accept suffering as a part of one's life);
- sense of meaning (e.g., opportunity of personal growth).