Psychotherapeutically informed psychiatry and the patient presenting with medical symptoms

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The problem with the Acute Trust vs Mental Health Trust split
2 cases in more detail- (neither have MUS)

- Mrs C-a 40 y.o. lady with FAP
- Mrs K-scleroderma (progressive systemic sclerosis) in her 50’s
“Please see this lady – unless she has surgery she will probably develop malignancy in her polyps with a terrible prognosis.”
Multiple polyps in polyposis

* Pathology specimen:
Colectomy with ileorectal anastomosis - this spares the rectum
Mrs C

* 40 y.o. woman with FAP (Familial Adenomatous Polyposis).

* Colectomy and ileorectal anastamosis at 17, with conservation of her rectum and continence.

* Multiple polyps now growing in her rectum.

* “We will try to create a ileo -anal pouch , but if this were to fail she would need a permanent ileostomy.”
Ileoanal anastomosis - this does not spare the rectum
Mrs C

* Arrives on time.

* “Are you going to diagnose me as mad?”

* “I hate the idea of a stoma - Mr Smith (surgeon) has promised that if he can’t create a pouch- if I DO need a permanent stoma- he will just sew me back together and not proceed, even if this means me dying.”
Mrs C

- (JS – why is she so opposed to a stoma?)

- She can cope with a temporary stoma for 6/52, but her husband says she can have it “as long as she does not show it to him”.
Mrs C - Personal history

* Only child. Close to her mother, who had FAP.
* Mother has surgery when patient was 3 – parents decide “no more children”.
* Mum’s Stoma was awful - bag was always leaking, embarrassing.
* She would have loved a sibling, especially a sister.
* Bowel screening starts at 11, polyps found at 15, surgery at 17.

* (What is the Impact of all of this on one’s personal development-issues of femininity, children, psychosexual development-experiences of intrusive colonoscopies from 11 onwards?)
Mrs C

* Few boyfriends, first sexual experience with her husband at 21, he 10 years older than she.

* She very anxious about her scars.

* From 18 she decided not to have children.
Mrs C

- Pregnancy at 29 – arranged for a termination of pregnancy.
- Wished someone had dissuaded her.
- She keeps an anniversary of the date the baby would have been born.
Mrs C

* Feels she would have been less lonely with a baby.

* Has to put up with a cat.

* Her parents told her that she could not go ahead with a baby in case it had FAP.

* “Had we known, when mum was pregnant with you, we would have arranged for a TOP.”

* Patient becomes very distressed.
A dream

* I am in the pre-operative room, about to be wheeled into the operating theatre. The anaesthetist says count to 10, but I count up to 29, and do not fall asleep. I do not have the operation.

* Instead they wheel me back to the ward, mum and dad are there at the bedside. I have a cup of hot tea and a chocolate. The doctors ask me: “What are you doing?”

* I tell them “I can’t have the operation….because I have eaten and had a drink.”
Patient interpreted this in the context of her planned surgery.

JS: You were 29 at the time of the Termination Of Pregnancy. You felt pushed into it, and you were not supported in your wish to have a baby, by your parents or your husband.

Your anxieties about the proposed surgery are tied in with feelings of being forced into a previous operation.

Removal of the foetus vs. removal of the rectum.
Mrs C

* She became very moved and started weeping.

* She has never been able to talk about this to anyone.

* She “must see me again”.

* Gratefully accepted an appointment for 10 days later
Mrs C

* Cancels her follow-up, does not want to see me again.

* Letter from the surgeons:
  * “She saw Dr Stern and did not find the appointment helpful.
  * However she has agreed to come in for the removal of her rectum and the creation of a stoma if necessary, and we will organise this immediately.”

* Patient subsequently asks to see a copy of my report.
The dream—where she “aborts” the operation = the fulfilment of a wish that she could have stood up to protect the unborn baby inside her, and for her wish to be a mother.

The horror of a stoma is mixed up with the horror of an abortion.

The usefulness of the consultation is kept outside her conscious awareness.
Mrs C

* She has not requested further appointments.

* If she were to, would she benefit from therapy?

* Prediction: One might predict a worsening of her depression in therapy, as she got in touch with the extent to which she has deprived herself of thinking, mourning and experiencing; anger towards her husband, and parents; shame and guilt.

* (Permission to publish/present her case granted)
Case 2: Mrs K

* 54 year old Educational Psychologist

* Longstanding, aggressive scleroderma.

* Married to a senior scientist.

* 76 kg in 2000, now 57kg (BMI < 17.5).
Mrs K

* Very thorough and complex medical referral letter with a list of 15 diagnoses and regular 14 medications.

* Subsequent personal communication from gastroenterologist.

* Why is she so non-compliant?

* Why is she always arriving late for appointments?

* Nurses complain that Mrs K is always out with her own clients when they visit.
Mrs K- Initial meeting

* 25 minutes late – busy seeing another patient herself.

* Arrives carrying patients’ files, very business-like, “unsure” why she had been referred.

* Calls physician by his first name, name-drops ++. Interrupts me, uses lots of psychological jargon, asks me if I know various well known friends/colleagues of hers

* Cannot be bothered to take this all very seriously (the Home Parenteral Nutrition (HPN), or seeing me), she only uses the intravenous feeding for 8 not 12 hours because, she says, “I am too busy seeing my patients.”
Mrs K

* She is meant to avoid all solid foods, but “cheats” and has plate of hot chips and steak.

* “I know I shouldn’t” – smiles at me like a little girl flirting with her father.

* Then develops obstructions, and then suffers “explosions” of the ileostomy - “like a Volcano.”
Mrs K – Background

* Adored older child – my younger sister was “much less talented than me.”

* Handsome wealthy father; depressed mother.

* Boarding school at 11 (¿Why) - “I loved it.”

* Father died suddenly when she was 16 – missed funeral.
Mrs K – Background

* “Life and soul” of any gathering.

* Lots of boyfriends, lots of fun, now happily married from age 21.

Mrs K – personal history

* She and her husband have adopted 5 children – all are “wonderful”. (Two with learning difficulties, one alcoholic, only one of the five has a job.)

* No previous psychiatric/psychological input.

* Works as freelance – can’t say no - “I get exhausted.”

* No time for herself, very generous to others.
Mrs K – Follow-up appointment

- Rushes in, needs blood test, keeps me waiting.


- JS: You are very intolerant of that part of you that needs proper looking after. You won’t allow me to do so. You don’t properly look after your broken down bowel and body.
Mrs K – Follow-up

* Becomes sad, and describes how she learnt from early age to deny all vulnerability, all needs and all sadness.

* Her husband despairs at her poor self-care.

* JS: I describe to her how she relies on him to police her “delinquent” self.

* No sense of an internal policewoman.

* How she rushes around, but gives herself no space or time for mourning.
Mrs K – 4 Subsequent monthly appointments

* More able to get sad and angry.

* Looks after herself better, fewer obstructions.

* Arrives on time (almost).

* Cuts down on her work (doesn’t need the money).

* Loves the notion of developing an internal police officer, and now “splits this duty with her husband 50/50.”
Mrs K – After 4 Subsequent monthly appointments

- Positive feedback from her GI physician – more compliant, less sabotaging of her own care
- Stoma much better behaved
- No hospitalisations for the year following her last appointment with me
Psychoanalysis and the 21st Century: Its ongoing contribution to patients in medical settings

* What makes this work psychoanalytic?

* What makes this work different from CBT/standard psychiatry?
Psychoanalysis and the 21st Century: Its ongoing contribution to patients in medical settings

What makes this work psychoanalytic?

* The attitude of the practitioner-a focus on:
* Unconscious processes
* Dreams
* Defence mechanisms
* The relationship between patient and therapist (Transference)
* The emotions and feelings in the therapist (Counter-transference)
Psychoanalysis, Psychoanalytic psychotherapy, and psychoanalytically informed psychiatry?

* Is it psychoanalysis?
  * (NO!)

* No one lay on a couch
* One patient seen for one session only
* One for 6 sessions
* This is my version of a modern applied psychoanalytic psychotherapy, and psychoanalytically informed psychiatry applied to the NHS, to these specific patients, whilst still maintaining the boundaries, abstinence, curiosity, interpretative stance I would with any more “traditional” patient group and setting.
Long history of thinking and clinical practice

Many of our patients have gastroenterological symptoms, issues to do with taking food /drink in, passing it out, control at both ends

There are close links with sexuality, body image, attachment, in fact almost all key elements of Psycho Analysis

It is crucial to maintain both an interest in the physical symptoms, and also not to be overwhelmed by them, maintain “a binocular vision”
Significant number of patients in Acute trusts and Primary care present with MUS

These are the patients who vex our medical colleagues, drive them mad, they often evoke negative countertransference with the doctor reaching for the SSRI, or the repeat (negative) S/I

Tavistock designed a primary care project in Hackney-award winning, evidence based, offering Brief dynamic therapy, and consultations for GP staff
As with the previous patients, significant benefit both to the patients and their professional teams when issues of staff dynamics, transference and countertransference are brought into the thinking.
Conclusion

- Synergy between a psychotherapeutic view of the world and our patients and psychiatry
- Our patients often require both types of intervention
- Medication may not be in opposition to therapy-often only a medicated patient can benefit from the therapeutic input
- The split between “us” and “them” is as unhelpful as the split between body and mind
Thank you-and some references


Stern J (2003a) “Psychiatry, Psychotherapy and Gastroenterology – bringing it all together.” Alimentary Pharmacology and Therapeutics 17,2:175-184

Stern J (2003b) “30 Years of Abdominal Pain.” Psychoanalytic Psychotherapy 17,4:300-311
