The Psychotherapeutic Management of Functional Disease

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INTRODUCTION

As we survey the problems that come to the physician every day, we cannot overlook the fact that a majority of them are the result of or related to nervous or emotional factors. For example, headache is often of nervous or emotional origin. Many disorders of the gastro-intestinal tract, from peptic ulcer to colitis, have their emotional components. Various problems of the skin, including urticaria and the neuro-dermatoses, are of emotional origin. One could go on relating one malady after another which involves the emotional aspect of life, often as a basic factor, such as hypertension, functional disorders of the heart, or fatigue. Since this is the case, it is clear that every physician needs to be better oriented from the psychological standpoint in the broad field of medicine. Unless he is so oriented he is not equipped to handle the large part of the problems that he will see.

With the increase in scientific knowledge in recent decades, it became common practice to explain symptoms on the basis of specific organ disease. Certainly in some instances this is true, but often symptoms relating to certain organ systems are a part of a broad personality disturbance, and nothing is wrong with the organ itself in a structural sense. As scientific medicine advanced, the individual as a whole became lost in the effort to understand and to treat the part. No one would decry scientific advance, but our understanding of man's total problems, his adjustments, and his frustrations, has not kept pace.

William Alanson White*, one of America's great psychiatrists, summed up this problem in his autobiography. He reflects: As I "travelled with the country doctor along the roads on the way to and from his patients he talked to me confidentially about his work and as we passed houses and people he would often note that here was where so-and-so lived and there was such-and-such a person. He knew them and he knew about their families because he had lived with them or as their neighbor for years. He brought many of this group into the world; he closed the eyes of many of them in death. He knew that if one of the members of such-and-such a family sustained a fracture there would probably be a delayed union. He knew that in another family a moderate temperature usually resulted in a delirium."

"Since these days medicine has evolved in the direction of specialization and instead of these general practitioners who took care of their patients, no matter what ailed them, we have the age of specialists who deal with some organ or organ system—the cardiologist, the urologist—or who deal with people at certain ages—the pediatrician—or with certain sorts of diseases, such as contagious or infectious, or with certain public and social questions, such as preventive medicine, public health, etc.
"In this process of specialization he [the physician] has lost something. The John Smith that the country doctor used to know has disappeared from the picture in some subtle fashion and in his place we have a host of detailed information about this, that, or the other organ.

"Now after a half century or more of this sort of thing, psychiatry appears upon the scene and emphasizes the psychological aspect of illness, the personality components that are involved, the mental symptoms that go along with the bodily symptoms; in other words, emphasizes the consideration of the organism-as-a-whole, and we see coming back into the picture those things that have been so long forgotten. John Smith again begins to appear in his proper person and with his proper personality and psychological attributes as an individual."

We are becoming more aware that there has been too much surgery and too much non-specific medication to relieve various complaints. Doctors are realizing that the patient and his problems—past, present, and future—must be considered if anything is to be done for him in so many instances. Yet, with this increased realization of the functional aspects of disease, more perplexity has arisen in the minds of many physicians. It is not easy to deal with intangibles, such as feelings, attitudes, and interpersonal problems. Most practicing physicians have been trained to do something tangible, like giving a pill or an injection, or perhaps operating. To complicate the situation further, most patients still retain a mystical attitude toward a practical act, such as an injection or bottle of medicine, and they will too often feel untreated even though an hour has been spent going into the problem and explaining some of the dynamics of their condition. But the situation is changing, particularly on the part of the layman, and many are now coming with a request for definite psychotherapeutic help. The physician needs to be better prepared to deal with the various emotional problems that come to his office. This paper is an attempt to give some help in understanding the treatment of these trying problems.

**BASIC REQUIREMENTS IN TREATING FUNCTIONAL DISORDERS**

There are several basic requirements for the physician who would attempt to treat functional disorders. The first that I would place on the list is the importance of the physician's attitude toward the patient. Menninger points out that "even more important than technical training and knowledge is the cultivation of the proper attitude toward the patient. Without this, psychotherapy is impossible. One must really be interested in the sufferer—one must, in a way, really love one's patients. To be bored or annoyed or disgusted by the fancies and failures and queerness of 'nervous people' is to be foredoomed to failure. One has to be infinitely patient and genuinely interested, and yet detached enough—'cold blooded enough'—to be objective in the handling of the sufferer. The same attitude must be preserved as that of the surgeon, intent upon the operation which interests him, fatigues him, concerns him, but moves him not a bit."

A basic attitude is that of faith that a patient suffering from a functional disorder can be helped, and in some instances cured, through the proper application of psychotherapy. Many physicians have had a pessimistic and almost a hopeless attitude toward the therapy of the psychoneurotic patient. This is tragic for the patient, and doubly so because it is not according to the facts, for it is well known that much can be done of a lasting nature in many cases, and, in the more chronic and difficult problems, relief can often be
given. White states that on one occasion, after an hour and a half of talking with a patient, symptoms of thirty years' duration disappeared. Although many of us could not, perhaps, duplicate this feat, it does emphasize what a strong personality, deeply versed in psychiatry and skilled in the application of his knowledge, can do. To treat and cure any functional problem requires time—maybe one hour or maybe many hours; but to spend this time demands, of necessity, a belief on the physician's part that some good will come from his efforts and that through psychotherapy he can favorably influence the patient.

Besides these attitudes—embodifying the treatability of, and a genuine interest in, the the neurotic patient—one also needs to consider the attitude of respect for the nervous patient. Symptoms are often bizarre and may be contrary to our own standards and ideals. It is easy for us to be critical, to look down upon such individuals as being inferior, as being basically bad. Patients may bluster, may complain, may criticize, or show extreme timidity, but we should always remember that symptoms are the individual's defense against his anxieties, they are protective devices against insoluble conflicts, and they do not express fundamental qualities of the patient as a human being. Levine has pointed out that there can be no constructive relationship between the doctor and the patient except it be based on a feeling of respect for the patient as a person—a feeling that the patient is basically worth while.

When we consider the doctor's attitudes toward the neurotic patient, the problem of the doctor's personal anxieties enters the picture and may easily influence his attitudes one way or another. A doctor who is anxious, who has underlying feelings of inadequacy, may have trouble in being objective. He may over-treat and over-reassure the patient. In his desire to do something to relieve his own unconscious anxiety he will carry out treatment measures that are unwise, either operatively or medicinally. If after various treatment measures the patient still complains or criticizes, the doctor's anxieties and feelings of inadequacy may be stimulated. He will react with irritation or outright anger because the patient has not rewarded his efforts by getting well for him. When this occurs, failure in treatment is inevitable. Objectivity, with a primary desire to help the patient and not oneself, is an essential attitude on the physician's part.

A basic requirement, besides the cultivation of a proper attitude, is a knowledge of certain psychodynamic concepts of mental function. Osler has said, "To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all." This applies especially to psychotherapy, for in no other medical discipline is it so common for prejudices, misconceptions, and preconceived ideas to develop. There is an accepted body of knowledge, tested now over a period of many years, and to approach psychotherapy without some knowledge of it is surely "to sail an uncharted sea."

It is absolutely essential that a doctor have some idea of the unconscious part of the mind. Much of what is known about the dynamics of mental symptoms is built on the concept of conflict between repressed, unconscious tendencies and the more conscious, prohibitive, restraining elements in the personality. Neurotic symptoms, whatever their nature may be, ultimately find an explanation in the underlying conflict, which will vary in different individuals. Neurotic symptoms cannot be explained or understood until the underlying conflict is revealed, and this is the aim of most psychotherapy of any depth at all.

To illustrate the role of unconscious tendencies in symptom formation, the following
case abstract would perhaps be helpful. A married woman, the mother of a five-month-old child, developed obsessive fears that she might harm her child, whom she consciously loved. She was almost frantic when alone with the child for fear she would choke the child or drop the child when holding her. To the mother such ideas were abhorrent and filled her with guilt feelings. After many hours of psychotherapy it was gradually shown that unconsciously she did not love the child—she resented and even hated the child. The child’s birth had reactivated an intense feeling of rivalry that the patient had had years ago with a younger brother. As she once resented and was in rivalry with her brother for parental approval and affection, so was she now hating and was in rivalry with her child for her husband’s and her friends’ affection and approval. Her obsessive fears were the conscious reflection of this struggle. As she began to recognize her hostility and her underlying needs for affection and approval, her fears subsided and ultimately left entirely.

Another psychodynamic concept of importance is that of anxiety. Early fears brought about through threats, deprivation, or insecurity become incorporated within the individual and are associated with various instinctive feelings or drives. Anxiety is the psychosomatic response to an impulse or feeling that once was associated with a dangerous or threatening environment. For example, if a child is intimidated or if he is threatened with punishment whenever he attempts to assert or express himself, then the normal aggressive, self-assertive impulses later on in life are going to cause anxiety, because unconsciously the earlier threats and fears associated with such impulses remain. This concept of anxiety and what it means to the patient in terms of earlier overwhelming situations is essential if one is to help the patient work through his protective devices against anxiety and thus learn to express himself freely. Anxiety blocks him in recognizing underlying feelings and impulses; anxiety blocks mature adjustment. The concept of anxiety makes it possible for us, as physicians, to understand the peculiar behavior of our patients and to anticipate their needs in terms of reassurance, explanation, and permissibility in letting the patient discuss heretofore forbidden feelings and impulses without censorship or criticism. By and large, most patients want to discuss their problems, to reveal their conflicts, and they are waiting only until they can feel secure with their doctor and be sure he is not going to criticize or condemn before they reveal what to them is something terrible. It is very common for a patient to reveal some feeling or desire or experience, and then to say, “I suppose you will never like me now that you know that about me.”

If the physician can visualize what is happening in a dynamic sense whenever a patient presents neurotic symptomatology, he is in a much better position to be helpful. If he can conceive of his patient as being beleaguered or partially overwhelmed by impulses or feelings that are forbidden because of previous threats and intimidations, then it is possible for the physician to step in and give support in helping the patient to meet his conflict.

MANAGEMENT OF THE FUNCTIONAL PROBLEM

With concepts in mind of unconscious forces striving for expression but being blocked by anxiety, our first step in treatment is to facilitate a release of the tension through the patient’s expressing and gaining an understanding of the underlying conflicts. This is accomplished in part by obtaining a history of the problem. There are two types of historical data: (1) The cross-section history, which deals with the onset of the symptoms and the precipitating or life circumstances that existed
at that time, and (2) the longitudinal history, which deals with personality development.

The former gives insight into situational problems that may be worked out with the physician’s help, on a fairly simple, superficial plane, giving fairly prompt relief. For example, a woman patient, married and the mother of two children, had enjoyed good health until about two years prior to the time that she was first seen. She was referred because of tension, insomnia, and various pains migrating from one part of the body to another. She had previously been operated for a herniated disc, but her pains did not subside. They, rather, increased and became diffuse, indicating a strong functional element. It was learned that she had an intolerable home situation because of a dominating, nagging mother-in-law. Her relationship with her husband and children was essentially sound. However, her husband was an outspoken, direct person, whereas the patient was more passive and reluctant to express her feelings. With great hesitancy she finally disclosed this difficult situation, and then only upon the promise that we would not reveal her dilemma to her husband, because she feared what he would think. Upon a full discussion of her problem she obtained some relief, and with this knowledge of her problem it was possible to work out a better arrangement in her situation at home. We finally obtained her consent to discuss the matter fully with the husband, who was understanding and cooperative. She was in the sanitarium for about four weeks, during which time she was given hydrotherapy, a well-regulated activity program, and an opportunity to discuss her problems with her doctor. She left the sanitarium feeling nearly her normal self.

The longitudinal history gives insight into the individual’s development, what he has had to meet throughout life in his parental, social, and educational contacts. Relationships to parents and to siblings are especially important, because fears, hatreds, dependencies, and rivalries are revealed. We know, for example, that soldiers who failed early in combat almost invariably came from a bad home situation. An alcoholic father, a nervous and apprehensive mother, or a broken home were common findings. Insecurity in childhood gave no inner confidence to meet the ordeals of battle. In life, generally, we know that a psychic trauma has left many persons crippled in adjusting to the difficulties they have to meet. In many patients with neurotic upheavals the situational or precipitating factors are minimal, and it is only through a careful, longitudinal study that some clue can be gained as to what the conflict is.

The history is valuable, from the standpoint of securing information, and it is a therapeutic measure of great importance. While relating his life story the patient can verbalize conflicts and feelings and thereby often obtain much relief. Doctors, by and large, do not take adequate histories, and do not give the patient sufficient time to talk. Weiss points out that there is no substitute for adequate history taking, and he insists that the patient must be given time to tell his story. He feels it would be well if patients were allowed to talk more and were examined less. Certainly, too often laboratory procedures are substituted for a careful story of the problem, and not only does the doctor fail to get a picture of the problem but the patient is denied an important therapeutic outlet.

Recently I had occasion to see a young married woman who has an anxiety reaction of several months’ duration. She normally is a fairly well adjusted person, enjoys normal social outlets, likes people, and has been happy with her husband. But since the onset of her illness she has had attacks of faintness, has felt tense, and is very uncomfortable in crowds. She has started to protect herself by
staying home and avoiding any contact with people, because whenever she is around people she becomes more tense and anxious. She has been treating with a local physician, who was giving her "shots," but he had never bothered to sit down and get a history of the problem. He really did not know what he was treating, although it is possible he recognized that she was "nervous" or perhaps "neurotic," but concluded "shots" and a "pat on the back" were all that was indicated.

How far from the truth this is! Her husband was understanding and urged her to talk, because she at first was reluctant to do so for fear she would say something that would be wrong or that would get her into trouble. As the story unfolded, it was learned that her mother had died when the patient was young. The father was good to the patient and never left anything undone as far as doing things for her. When she was 13, the father remarried. The stepmother was nice but was dominating; she always knew best, and in a kindly but firm way directed the patient's life. The father did not interfere because he did not wish to cause trouble. The patient was forced to submit in every way; her wishes, her desires, were always subordinated to those of her parents. In such a passive role the patient got along without too much difficulty until after her marriage. Then she got into a situation that to her was insoluble. Her husband had a mind of his own. He felt they were adults and should be left to make up their own minds about things. He would express one desire for them and the parents would express another. Of course, the patient, in her submissive, passive pattern, wished to please both her husband and her parents. She believed her husband was right, but she lacked courage to rebel and stand up against her parents' kindly and helpful, but nonetheless dominating, role. Resentments developing out of this frustrating situation caused tension and ultimately the neurotic anxiety symptoms.

A solution to the situation was imperative, yet none would be possible until something was known about it. The problem needed to be reviewed by an outsider in order to make possible freedom for the patient. After this step was taken, the patient needed to review more fully her passivity and her repression of all normal aggression and hostility. She needed to learn to express herself and become more independent. But this could be worked out only when the long-term view of the patient was fairly clear. Freedom for the patient in cases like this is not accomplished simply by making the parents stop being so dominating. The patient's needs for dependent support, for reassurance, and her fear of her own aggressiveness need to be understood before she can really be independent and emotionally emancipated.

After a careful history is obtained, the physician has a number of technical treatment measures which can be employed as they are indicated. A careful physical examination with pertinent laboratory procedures is a helpful therapeutic measure where there is concern about one's physical well-being. The reassurance that nothing serious organically has been found may bring relief to some anxious patients.

Quiet, firm reassurance where guilt exists over certain past experiences is often helpful. One should be cautious in giving glib reassurance, for the patient may construe it as being insincere; but a firm, friendly, approving manner gives many guilt-laden patients a great deal of relief.

Some patients whose lives have been narrow and unrewarding can be relieved through helping them to find certain hobby outlets. If it can be pointed out to them that they have been overly conscientious and have demanded too much of themselves and have not per-
mitted sufficient play and recreation in their lives, with the authoritative approval of the physician, changes in the patient's life programs can be made. Such patients often need to be told by someone whom they respect, that play and hobbies are all right, before they can permit themselves such pleasures.

Guidance and advice in practical life situations should be given whenever possible. With the physician's experienced background, helpful instruction can often be given to those who do not have adequate information. But the giving of advice is often fraught with danger and the physician needs to be wary in giving it. It is much better to help the patient to see his problem clearly and then encourage him to make his own decision. Turning to a doctor for advice may be a neurotic, dependent reaction and not really a sincere desire for counsel to be weighed and followed.

There are other measures that one could probably mention, but I would like to conclude this discussion by pointing out the ideal goal in psychotherapy. This is giving insight to the patient relative to his attitudes and underlying conflicts. Giving insight which involves some interpretation must be handled with great care. For example, the patient who had a fear of harming her baby could not be told outright that she hated the child, although in a sense this was true. She first needed to see that she felt frustrated, that the increased responsibilities in the home had cut down on her satisfaction-gaining outlets, and that her relationship with her husband and friends had changed since the baby's arrival. This would lead to a realization that she felt resentful, and gradually she could permit herself to accept her feelings of hostility toward and rivalry with the child. We know that, as conflicting emotions are identified and understood by the patient, the conflict subsides, and new and better solutions are possible for the patient.

In this connection Menninger makes the following significant statement: "It was a practical axiom of one of my psychoanalytic teachers that if the subtle and veiled aggressive intents of the patient were identified with sufficient clarity, directness and persistency, the development of the erotic life tended to follow and the neurosis to disappear."

A neurosis is motivated by the need on the patient's part to remain ignorant of his real feelings and underlying conflicts. A neurosis serves as a partial solution of the patient's problems in the sense that he is relieved of facing his conflict frankly; but to bring about any lasting help to the patient, one must enable him to see his conflicts. However, "before making an unwelcome interpretation the therapist must estimate whether the patient's trust and confidence in him are sufficient to stand the strain." Interpretation may arouse hostility toward the doctor, which may be difficult to control, or it may precipitate suicidal threats.

As underlying conflictual attitudes are recognized, the patient can then be helped to see the relationships between them and the symptoms he has been experiencing. A person who evinces much hostility can be helped to see that it is related to his tension headaches or gastro-intestinal symptoms. If a person can understand that organs or body structure can serve as substitutive outlets for tensions incident to unconscious conflicts, and if the unconscious conflicts are identified, then one has gone a long way in the treatment of a functional disorder.

**CONCLUSION**

In conclusion I would like to emphasize the fact that the problem of the neuroses does not belong to the psychiatrist alone. Many deep-seated neurotic disorders and, of course, the psychoses should be handled by the psychiatric specialist. But the many problems of
adjustment and the acute situational reactions can often be handled by the general physician just as well as by the psychiatrist. Besides the necessity of meeting more adequately the personal needs of our individual patients, there is the wider and highly significant medico-political problem. If patients in distress do not find adequate help from their physicians, if they are too frequently operated and reoperated, with no real relief from their symptoms because their doctors did not recognize the real cause of their symptoms, then the position of the doctor in the eyes of the public is being jeopardized and we are laying ourselves open to increasing criticism, if not to increasing threat of supervision and socialized medicine. Too many patients cannot stand the financial strain of repeated operations and the numerous detailed laboratory procedures. I believe that by spending more time in talking and listening to our patients we can obviate many unnecessary operations and even many unusual laboratory procedures. This will save the patient’s money, it will give us added importance and respect, and, incidentally, we shall be doing something constructive for many emotionally sick individuals.

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