Psychodynamics in Medically Ill Patients

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This article explores the role of psychodynamics as it applies to the understanding and treatment of medically ill patients in the consultation-liaison psychiatry setting. It provides historical background that spans the eras from Antiquity (Hippocrates and Galen) to nineteenth-century studies of hysteria (Charcot, Janet, and Freud) and into the twentieth century (Flanders Dunbar, Alexander, Engle, and the DSM). The article then discusses the effects of personality on medical illness, treatment, and patients’ ability to cope by reviewing the works of Bibring, Kahana, and others. The important contribution of attachment theory is reviewed as it pertains the patient-physician relationship and the health behavior of physically ill patients. A discussion of conversion disorder is offered as an example of psychodynamics in action. This article highlights the important impact of countertransference, especially in terms of how it relates to patients who are extremely difficult and “hateful,” and explores the dynamics surrounding the topic of physician-assisted suicide, as it pertains to the understanding of a patient’s request to die. Some attention is also given to the challenges surrounding the unique experience of residents learning how to treat medically ill patients on the consultation-liaison service. Ultimately, this article concludes that the use and understanding of psychodynamics and psychodynamic theory allows consultation-liaison psychiatrists the opportunity to interpret the life narratives of medically ill patients in a meaningful way that contributes importantly to treatment. (Harv Rev Psychiatry 2009;17:389–397.)

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Psychiatry and the rest of medicine may appear at times to have little in common; however, like the body and mind, they are part of one whole. The integral connection is most obvious when a psychiatrist responds to a colleague’s request to consult upon a patient with a medical/surgical problem. This professional interaction has its roots in centuries of thought about the connection between the body and the mind—from ideas about psychologically derived physical complaints to an understanding of how psychological-mindedness can be used to facilitate treatment. This article reviews significant aspects of the literature on psychodynamics in medical illness.

Psychodynamics refers to the interaction of the emotional and motivational forces that affect behavior and mental states. It is a “way of thinking about both patients and clinicians that includes unconscious conflict, deficits and distortions of intrapsychic structures, and internal object relations that integrates these elements with contemporary findings from the neurosciences.” In this article, we will place psychodynamics in its historical perspective, explore the effects of personality on medical illness and treatment, outline the psychodynamics of physically ill patients in terms of attachment theory, and look at conversion disorder as an example of psychodynamics in action. In addition,
we will evaluate the effects of countertransference, including how it relates to the most difficult of patients—namely, those experienced as “hateful.” We will then explore the dynamics involved in the challenging example of physician-assisted suicide. Finally, we will take a step back and look at these issues in the context of psychiatric residency training.

HISTORICAL BACKGROUND

The connection between psychological thought and illness, as well as the perceived connection between personality and disease, dates back as far as the practice of medicine itself. Thousands of years before the term psychosomatic medicine came into existence, ancient physicians recognized that the mind and body were interconnected. Hippocrates and Galen understood health to be the balance of four humors (yellow bile, black bile, blood, and phlegm), and disease to be the result of imbalance between them. Each humor corresponded to a temperament—namely, choleric (yellow bile), melancholic (black bile), sanguine (blood), and phlegmatic. By the time of the scientific revolution in the seventeenth century, the specific associations between emotion and disease were becoming apparent in the study of hysteria. Thomas Sydenham described the phenomenon as “some great commotion of the mind, occasioned by some sudden fit, either of anger, grief, terror or like passions.” Thomas Willis (known as the father of modern clinical neuroscience) made the connection between hysterical behavior and irregularities in the nervous system.

A causative relationship between psychodynamic principles and somatic symptoms emerged in Europe during the late nineteenth century. Jean-Martin Charcot attempted to understand the cause and course of hysteria by observing patients. Pierre Janet and Sigmund Freud studied under Charcot and applied psychodynamic principles to explain somatic illness. Janet postulated ideas about dissociation, understanding early life events as important antecedents of adult traumatic dysfunction. He believed in a process of mental dissociation, termed the “splitting of consciousness,” and thought that subconscious ideas transformed into hysterical symptoms. Freud was aware of Janet but disagreed with Janet’s ideas about the origin of dissociation. Freud hypothesized, instead, that unconscious conflict manifested itself in debilitating physical symptoms. This revolutionary concept paved the way for modern psychosomatic medicine.

In the 1930s, psychoanalysts seeking to understand the ways in which the mind influences the body developed the modern-day field of psychosomatic medicine. Psychoanalysis brought together psychological, biological, and social realms of thought, elements required by psychiatric consultants to illuminate the vagaries of somatic illness. Helen Flanders Dunbar pioneered the concept of psychosomatic medicine, describing linkages between personality types and specific symptoms in the 1940s. In the following decade, Franz Alexander developed a model in which he postulated a direct connection between illness and psychodynamics, suggesting that unconscious conflict was a primary source of symptom formation and disease. He provided a compromise between Charcot’s emphasis on physiology and Freud’s analytic theories. Alexander postulated that there are psychologic mechanisms of emotional expression, and identified unconscious conflict as the basis of seven “psychosomatic” illnesses: bronchial asthma, duodenal-peptic ulcer, essential hypertension, neurodermatitis, rheumatoid arthritis, thyrotoxicosis, and ulcerative colitis. The “biopsychosocial” model of illness was introduced in the 1970s by George Engel, an internist. This model integrated aspects of personality, environment, and physiology to explain the causative and protective factors of disease. In the 1980 (third) edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), “psychophysiological disorders” became “psychological factors affecting medical conditions,” indicating that all illness, including physical illness, is influenced by both the mind and the brain.

Not everyone agreed with this conceptual framework, and some have argued against the connection between disease and mental states. For example, the discovery of H. pylori in 1983 was viewed by some as proof of the lack of a role for intrapsychic processes in medical illness. Interestingly, although H. pylori is a common infection, few infected individuals develop ulcers. Psychological stress appears to be one mediating factor impairing mucosal defense in the stomach, thus leading to ulcer formation.

DIMENSIONS OF PSYCHODYNAMICS

Personality

Grete Bibring drew upon Freudian principles in identifying a patient’s behavior as “the result of conflicts between his deep strivings and his defensive methods against these strivings.” Writing for a general medical audience in 1956, Bibring explained the role of personality in understanding how patients react to illness. She ultimately described four types of patients (the overconcerned, worrying patient; the self-willed, independent patient; the dependent, demanding patient; and the hostile, querulous patient), who might suffer from the same medical disease but would respond differently and interact differently with their physicians. Bibring suggested that attention to patients’ behavioral patterns (e.g., personality) and their concomitant anxieties would allow physicians to approach their patients in ways to promote greater likelihood for cure. With the overconcerned,
worrying patient, for example, the doctor can more facilely take on the role of omniscient parent who protects the patient and discusses plainly the facts of illness and treatment. This approach stands in contrast to how a doctor would respond to the self-willed, independent patient—for example, by highlighting the person’s strengths, lest his or her disabling fears of weakness be exposed.\(^1\)

Patients (indeed, people in general) have certain distinctive personality characteristics, grounded in their nascent temperaments, attachment styles, childhood experiences, and traumas. Early life interactions and events lay the foundation for subsequent unconscious conflict and for healthy or pathological future object relations. Illness, like other forms of stress, intensifies conflict and leads to psychological (though not necessarily pathological) regression. In turn, regression can bring to the surface issues related to trust, dependency, and self-control.\(^1\) Familiarity with key personality styles is thus critical to understanding patients, facilitating the doctor-patient relationship, and helping patients cope adaptively with stress.

In 1964, Kahana and Bibring\(^1\) defined seven archetypical personality styles. These styles, exacerbated under stress but distinctive from disorders, have been studied and modified to illuminate the intrapsychic meaning of illness to patients, including their fears and desires:\(^1\),\(^1\),\(^1\),\(^1\),\(^1\),\(^1\) dependent and overdemanding (oral) people, threatened by abandonment, have a need for care; (2) orderly and controlled (compulsive) people fear a loss of control and desire self-control above all else; (3) dramatizing and captivating (hysterical) people require admiration, with the consequence that anything resulting in reduction of masculinity or femininity is a serious threat; (4) long-suffering and self-sacrificing (masochistic) people feel that they are worthless and deserve punishment, with the consequence that they are often help-rejecting as they take on the martyr’s role; (5) guarded, querulous (paranoid) people both invite and fear attack; (6) people with feelings of superiority (narcissistic) fear loss of autonomy and thus need to be perfect and invulnerable; and (7) aloof, uninvolved (schizoid) people feel threatened by intrusion and desire privacy. Understanding these styles and needs is crucial, and affords the consultant the opportunity to tailor interventions in ways that are not merely tolerable, but also therapeutic, to the patient. For example, setting limits with demanding, dependent patients by arranging daily appointments can alleviate their anxiety. Allowing individuals with compulsive tendencies to participate in their own care—from deciding with their doctors about carefully described treatment options to selecting their dining choices on a menu—may also have beneficial effects. The psychiatric consultant can help the medical team frame treatment for a masochistic patient in terms of self-sacrifice, and for a narcissistic patient in a way that helps him retain a sense of importance and integrity. Unambiguous language is useful in setting paranoid patients at ease. Appropriate acknowledgement of the importance of privacy can assist the schizoid patient.

Perry and Viederman\(^1\) outlined three tasks that patients facing illness must experience, and acknowledged the frequent overlap between these phases. First, patients must accept and admit to others that they are ill; second, they must regress, depending on others for care; and third, they must reintegrate into lives of normal functioning following their recovery. Successful negotiation of these phases is no simple task. Acceptance of the “sick role” can create narcissistic injury by destroying fantasies of invulnerability and control.\(^1\) Moreover, illness exacerbates stress, and the hospital itself can be an inherently stressful environment.\(^1\),\(^1\),\(^1\)

Strain and Grossman\(^1\) point out how well most people do when hospitalized, especially given the scope of the stresses. The authors identify seven broad categories of psychological stress faced by hospitalized patients:

1. The basic threat to narcissistic integrity
2. Fear of strangers
3. Separation anxiety
4. Fear of the loss of love and approval
5. Fear of the loss of control of developmentally achieved functions
6. Fear of loss of, or injury to, body parts
7. Reactivation of feelings of guilt and shame, and fears of retaliation for previous transgressions

Reactions to stress may vary based on patients’ underlying personality type and ego functions. According to Strain and Grossman,\(^1\) the “nature and magnitude of the patient’s response to . . . stresses will depend on what illness and hospitalization mean to him in terms of his past experiences and development, and in terms of his current psychological resources.” The authors indicate that most patients are capable of coping with the sick role, hospitalization, and challenges of medical illness, and point out that “this is extraordinary in itself when one considers the magnitude of these stressors.”

Attachment

Patients’ reactions to medical illness derive not only from their underlying character, but also, in part, from their history of attachment. In the 1970s Bowlby\(^2\),\(^2\)–\(^4\) and Ainsworth\(^5\) described attachment theory, but it would not be until decades later that attachment would be considered within a biopsychosocial model to help describe patients’ responses to being ill. Attachment theory proposes that the ability to develop adult interpersonal connections is driven by the texture of patterns formed between the infant and caregiver during the first two years of life. As De Rick\(^6\)
states, “securely-attached individuals create internal working models of the self as lovable and of the other as trustworthy.” Strain and Grossman\textsuperscript{21} nicely frame attachment theory as it applies to hospitalized patients: “Children who were not neglected, hurt or exposed to extreme emotional or physical traumas, whose relationship with their parents was built on trust, are less likely to be threatened by a recurrence in adulthood of these stresses in the hospital setting.” In addition to their hypothesis that attachment insecurity contributes to physical illness, Mauder and Hunter\textsuperscript{27} propose that “illness events are near-perfect triggers for the mobilization of attachment behavior.”

There are three types of attachment: secure attachment, which is thought to generate trust leading to the development of reciprocally meaningful relationships in adulthood; avoidant attachment, where individuals tend to avoid distressing situations and overregulate affect; and anxious/ambivalent attachment, where individuals tend to underregulate affect, enhancing their expression of distress to produce reactions in their object or partner.\textsuperscript{28} Since the 1970s, there has been increasing interest in attachment theory as it relates to adult hospitalized patients and their course, care, and coping defenses.

One example of this interest is Tacon’s consideration of attachment theory in cancer patients,\textsuperscript{29} particularly the relationship between “Type C” individuals (who are cooperative, overly patient, unassertive, and appeasing),\textsuperscript{30} avoidant attachment, and the interaction of these factors on medical illness. Other authors have also commented on decreased immunological function and the association to loneliness, divorce, and bereavement.\textsuperscript{31–33} Coronary artery bypass patients who perceived their primary support relationships as “good” and who received more postoperative attention from their attachment figures fared better than their less-supported counterparts. They required less pain medication and recovered more quickly.\textsuperscript{34} Feeney and Ryan\textsuperscript{35} studied compliance and found that visits for health care were inversely proportional to avoidant attachment. This finding suggests that the avoidant person is less likely to seek medical care—which creates more complex adherence issues, and as Tacon\textsuperscript{29} points out, is especially important when considering that avoidant cancer patients, for example, may delay diagnosis, attention, and treatment.

Conversion Disorder

Psychodynamic considerations in medically ill patients take into account conscious, semiconscious, and unconscious information. Conversion disorder is perhaps the best example of psychodynamics in action as the unconscious plays out a conflict in the form of physical symptoms. Conversion-like disorders have been described since antiquity. The Kahun Papyrus, an ancient Egyptian medical text dating from 1900 BC, introduced the concept of the “wandering uterus.” Papyrus Ebers, from 1600 BC, has a section devoted to “Diseases of Women” and suggested that improper positioning of the womb was responsible for hysterical symptoms.\textsuperscript{36} Conversion disorders comprise a unique constellation of symptoms in DSM-IV, including neurological symptoms that can be sensory, voluntary motor, or both. Patients may present with paralysis, pseudoseizures, amnesia, ataxia, blindness, or deafness. It remains controversial whether conversion disorder should be a classification of its own or belongs in the dissociative domain. In addition, and less controversial, is the necessity that the cardinal symptom be out of the realm of consciousness.\textsuperscript{37} In Freud and Breuer's examination of hysterical phenomena,\textsuperscript{38} they asserted that such symptoms were due to the “conversion of psychological distress into physical symptoms.” They described the mechanism as the unconscious repressing stressful negative affect, with the result that the distress is placed onto a part of the body—a process that leaves the mind without psychological symptoms, so much so that the patient may display prominently “la belle indifférence.”\textsuperscript{38} This particular manifestation is not present in all patients, some of whom are quite distressed by the sudden appearance of physical symptoms.

Toone\textsuperscript{39} reviewed conversion disorder in 1990 and noted that it was more prevalent in hospitalized patients than in the general population (1%–4.5% vs. 0.3%, respectively). This finding suggests that the cause of conversion disorder—be it stress, regression, or some other mechanism—may present more prominently in hospitalized patients. Symptoms typically appear suddenly and can resolve quickly, though symptoms may also recur or even last for years.\textsuperscript{37} Severe social stressors have been implicated as seminal events. Triggering symptoms include bereavement, rape, incest, warfare, and, presumably, severe medical illness or hospitalization. The differential includes multiple sclerosis, complex partial seizures, myasthenia gravis, stroke, and catatonia. The disorder differs from factitious disorder or malingering in that the symptoms are derived from the unconscious.

Treatment for conversion disorder includes a careful evaluation to rule out a physical disorder. After a physical cause has been eliminated, reassurance and relaxation should be the focus.\textsuperscript{1} It is crucial to avoid embarrassing the patient. Telling the patient that there is “nothing wrong” is less successful than reassuring the patient that he or she will recover but may require physical therapy to regain full function. Opening up discussion of current stressors that might be contributing to the symptoms is preferable to an interpretation of the patient’s unconscious. If symptoms persist, an attempt can be made to understand and bring to the surface the suppressed unconscious affect that might have caused the symptoms. Since the duration of symptoms has
been tied to the chronicity of disease, treatment should focus on rapidly resolving the symptoms. Spontaneous rapid resolution is the norm. In one analysis, Folks and colleagues determined that 25 of 50 hospitalized patients with conversion disorder had resolution of symptoms before hospital discharge. If symptoms are serious and need urgent resolution, narcoanalysis with amobarbital may be considered in an inpatient setting with the proper safety precautions. Hypnosis is a safer approach, and it may allow the patient to experience the conflict causing the symptoms in a setting of psychological safety. Anecdotal reports suggest that lithium, phenothiazines, or electroconvulsive therapy may be effective. Interestingly, even in the absence of mood symptoms, antidepressants are thought to be helpful.

**Countertransference**

The field of psychosomatic medicine, which took its initial shape through the work of Freud, Flanders Dunbar, Alexander, and Engle, continued to develop through the twentieth century into a field sensitive to, and compatible with, an increasingly sophisticated scientific understanding of disease. By the end of the century, psychiatrists began to appreciate how neurobiological processes, from genetic expression to protein production, contribute and respond to individual life experiences.

Though the logistics of working in the medical hospital make a traditional psychoanalytic approach unfeasible, dynamically informed psychotherapy, derived from the principles of analysis, is directly applicable to treating the medically ill. Forming a therapeutic alliance and understanding patients' experiences requires a psychologically minded perspective. Patients are not composites of symptoms described as facts in the history of the present illness. Knowledge of dynamic principles also allows the psychiatric consultant to reflect upon the ways in which members of the medical team react and respond to a given patient and to each other.

Psychiatrists, like all physicians, are not immune from the challenging feelings engendered by their medical patients. Mendelson and Meyer defined the experience of countertransference as “those responses on the part of the psychiatrist that result in undue and unnecessary interference with his clinical effectiveness.” They examined how, especially in the context of working with patients who are chronically ill, a consultant's countertransference reaction had the potential to lead to “pessimism, hopelessness, and despair.” They cited four situations inspiring such reactions:

1. Psychiatrists working in a medical setting endure “physical and psychological inconveniences”; (2) psychiatrists, more than their physician colleagues (who lack the time or training to fully explore their chronically ill or dying patients’ psychological distress), bear the brunt of the patients’ despair; (3) psychiatrists can experience frustration and irritation at working with patients whose character pathology contributes to their physical illness; and (4) psychiatrists can respond pessimistically to the overwhelming litany of psychosocial stressors that appear to cripple a patient and that contribute to the inability to comply with the medical regimen. The authors concluded that, when recognized, countertransference reactions could be explored and overcome, and would not lead to a reduction in the value of the psychiatric consultation.

**CLINICAL CHALLENGES**

The Hateful Patient

No one can inspire a more powerful countertransference reaction than the “hateful patient,” and nothing can interfere more in the care of a medical patient than the interplay of psychodynamics that renders the patient “hateful” to the rest of the care team. In a seminal article in the *New England Journal of Medicine*, Groves outlines the care of the “hateful patient.” After describing four different types of patients that typically cause significant distress amongst medical care teams, the article presents various techniques for dealing with patients who evoke negative countertransference.

Groves's four types of hateful patients are the “dependent clingers,” “entitled demanders,” “manipulative rejecters,” and “self-destructive deniers.” He points out that these four descriptions are stereotypes and that any given patient-team dynamic presents with numerous nuanced complexities.

Initially, dependent clingers are usually polite and appropriate in their requests to their physicians. Their requests progress to what the physician experiences as an overwhelming “self perception of bottomless need” that is projected onto the physician as an insatiable, unachievable hunger for care. The physician cannot possibly meet all the demands of the patient and frequently becomes exasperated at the situation, grows angry, and flees from the caretaking role. Groves suggests that intervention is therapeutic at any point during the escalation of demands. The key to repairing the alliance is to set meaningful boundaries that respect both the needs of the patient and the limitations of the physician. Describing in detail how, when, and for what reasons the patient may appropriately reach the physician can be helpful. Empathy should be expressed throughout the interaction, but firm limit-setting within an empathic context is critical for both patient and physician.

Groves describes entitled demanders as similar to “dependent clingers” in their sense of neediness, but as far more
aware of their effect on their physicians and more likely to threaten retaliation if rejected. Groves describes the dynamics as follows: “The patient is unaware of the deep dependency that underlies these attacks on the doctor. The physician, in turn, does not recognize that the hostility is born of terror of abandonment.” Typically, in the moment of hearing the patient’s entitlement-laced demands, the physician will feel angry and will wish immediately to prove to the patient that the patient does not deserve his entitlement. The physician’s reaction is natural and expected, but if it is communicated to the patient, it will escalate the standoff and undermine the patient’s prime defense in the setting of an illness that he cannot control. A far more successful approach, given the dynamics in these patients, is to validate their sense of entitlement, allowing them to relax with the caregiver and to feel heard and understood. Once a modicum of trust is established, the physician can start to redirect the entitlement toward the therapeutic goal, emphasizing that the patient deserves the very best care but that he needs to work with the team in order to help the team provide it.

The hallmark of manipulative help-rejecters is that they seek care, come to the hospital, or arrive in the outpatient office, but will not improve despite numerous workups and treatments. This type of patient should be approached with great care and not be identified in the physician’s mind as a manipulative help-rejecter until medical causes of the distress are ruled out. The patient, as Groves says, will appear “almost smugly satisfied; they return again and again to the office or clinic to report that, once again, the regimen did not work.” Groves points out that on the surface the patient wishes relief of his or her symptoms, but dynamically what is in play is a wish for an “undivorcible marriage with an inexhaustible caregiver.” To the patient, persistence of symptoms means continuation of the relationship. The key to managing these psychodynamics is to reassure the patient of an ongoing, committed relationship by making frequent “check-in” appointments regardless of symptoms, which often frees up such patients to separate their medical complaints from the concept that without those complaints, they are unlovable. In this context, the patients feel cared for and often start to feel better. Groves also points out that psychiatric referral can often be interpreted as abandonment, despite the reality that the recurring tenacious symptoms often are surrogates for depression. To avoid this potential problem, he suggests that a medical appointment be made soon after the psychiatric appointment so that the intervention is seen as consultative and not construed by the patient as abandonment.

Self-destructive deniers breed overwhelming frustration in physicians, who watch such patients continue to smoke after being admitted for emphysema, continue to binge eat when knee arthritis has become crippling, and so forth. Groves uses the example of the alcoholic who continues to drink in the setting of liver failure. He divides patients into “major deniers” and other deniers. The “major deniers,” based on the writings of Hackett in 1970, are people who use denial to their advantage. Since they perceive themselves as healthy, any significant illness or the knowledge of the consequences of self-harmful behavior is suppressed. These patients are not intentionally self-destructive. By contrast, “other” deniers have severe dependency needs and “have given up hope of ever having needs met”; they “represent a chronic form of suicidal behavior.” On the one hand, the physician may want to rescue the patient, but on the other hand, the physician may wish for the patient to die, which can create significant anxiety in the physician. As Groves puts it, “the doctor who begins to wish that the patient would die should begin to grasp the possibility that the patient wishes to die.” Sometimes the team can feel relieved when a patient like this does pass away. Groves recommends in this setting a psychiatric consultation to rule out depression, along with vigilance on the part of the physician not to abandon the patient.

With difficult patients, it is virtually impossible to provide a meaningful, effective, and comprehensive plan of care without considering the psychodynamics in play and determining, given the context of those psychodynamics, how to best approach the patient.50

Physician-Assisted Suicide

The request to hasten one’s death in medically ill patients raises profound psychodynamic, ethical, legal, and political questions. It is also more common than one might initially think. Physician-assisted suicide has been considered as an option in 55% of patients with HIV. In a survey of oncology patients, 25% of the patients thought about asking for euthanasia. Depression or intractable pain increases the likelihood of patients considering physician-assisted suicide. Consideration of the psychodynamic motivation for the request to die can reveal a perspective that can lead to a deeper understanding of the patient’s experience and pre-conscious intentions. For example, the request to die might be a request for communication with the physician; however, it might be an attempt by the patient to find a reason to live. Wishing to control one’s death can also be an attempt to maintain control over one’s life. As Nietzsche put it, “It is always consoling to think of suicide: in that way one gets through many a bad night.” Sometimes the desire to die is a wish to discard the physically sick part of the self. Other patients have fantasies that their deaths will exact revenge upon their doctors, which motivates the request for hastened death. In still other patients, their hopelessness—a common reason for patients to contemplate wanting to die—may be a signal to look for depression. The psychodynamic understanding of a patient’s request to die may play an

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RESIDENTS AND PSYCHOSOMATIC MEDICINE

The challenges of recognizing the psychodynamic features described above and applying them to the medical setting is a key feature of psychosomatic medicine, and one to which psychiatrists in training must become accustomed. The transition from inpatient or outpatient psychiatric to consultation-liaison (C-L) psychiatrist can be a complicated, but transforming, experience for a psychiatric resident. From the ordered hours of the outpatient psychotherapy setting, and from the scheduled meetings, therapy sessions, and supervision of an inpatient unit, the C-L service can be unpredictably busy. Comfortable with taking confidential notes, making decisions about medications, and managing the care of their patients, psychiatric residents may experience the role of a consultant as frustrating. After conducting therapy in a setting of predictable quiet and privacy, residents may find themselves interviewing patients, often who are critically ill, with only the “privacy” of a curtain, or writing notes in a nursing station in a medical record that can be read by anyone on the team.

Perry and Viederman57,58 describe several pitfalls to which residents are susceptible when beginning to consult in the hospital. They identify three “maladaptive” approaches to working with the medically ill patient: “the pseudoanalytic, the rigidly biological, and the overly sympathetic.” The “pseudoanalytic” approach describes a resident who “becomes excessively identified with the patient’s predicament, projects his own feelings into the patient, and loses perspective on the clinical situation.”

The approach is based on certain assumptions. As Viederman and Perry state,47 “Depression, unlike grief, is a maladaptive response to the crisis of illness; this crisis has certain characteristics: (a) psychic disequilibrium with confusion and uncertainty, (b) regression with intensified transferences, and (c) a tendency to examine the trajectory of one’s life.” They also propose that, “when in this situation, the patient is not only more vulnerable to depression, but also more responsive to intervention.” The intervention is as follows. All patients have a life narrative that underlies their current mental state, response to illness, and receptiveness to treatment. Through empathic, detailed interviewing and discussion, the psychiatrist comes to understand the underlying dynamics that have formed the trajectory of the patient’s life, his personality type, his ego strengths and weaknesses, and his core conflicts. By formulating and describing to the patient a psychodynamic narrative of his life—highlighting those characteristics that may have been vitally important to his sense of identity (e.g., physical strength, control) but that may be
compromised by medical illness—the psychiatrist is able to reflect back to the patient an understanding of the patient’s experience and to bring to the patient’s consciousness an understanding of how his illness fits into the narrative of his life. This understanding enables the patient to adopt better coping mechanisms and to relieve depression. Viederman and Perry caution that this technique may not work for every patient. The masochist, for example, may “respond to the ‘benevolent’ aspects of the intervention with an exacerbation of self-punitive, depressive trends,” but for the appropriate patient this technique can have a powerful therapeutic effect. An excellent review of coping in patients with medical illness can be found in the chapter by Schlozman, Groves, and Perry. The masochist, for example, may “respond to the ‘benevolent’ aspects of the intervention with an exacerbation of self-punitive, depressive trends,” but for the appropriate patient this technique can have a powerful therapeutic effect. An excellent review of coping in patients with medical illness can be found in the chapter by Schlozman, Groves, and Perry. 59 The tables on vulnerability and coping are especially useful.

CONCLUSION

The literature and tradition concerning psychodynamics in medical illness is long and storied, the continuing product of an interplay of diverse factors, including medicine, psychoanalysis, neurology, and more traditional psychodynamic sources. All of this must be understood against the backdrop of increasingly complex and diverse medical interventions, situated within complex health care systems that create pressures and stresses of their own.

Understanding and addressing the psychodynamic issues that arise in inpatient settings can be useful in managing multiple aspects of the inpatient experience, including in helping to explain personality types in the setting of medical illness and in identifying reaction patterns to predictable stressors in the medically ill. In addition, the implementation of psychodynamic principles can improve our conceptualization of the doctor-patient relationship (via attachment theory), bolster the therapeutic alliance (including with the “hateful patient”), and provide a framework for treating conversion disorder.

As the historical pendulum between psychoanalytic and biological psychiatry continues to swing back and forth, and as scientific advancements further unravel the etiologic mysteries of disease and uncover new therapeutic alternatives, it is critical that psychiatrists and psychiatric residents do not surrender their knowledge of, and training in, psychodynamics to pursue exclusively psychopharmacologic treatments. Building on past theoretical models, consultation-liaison psychiatrists can interpret the narratives of medically sick patients’ lives through a psychodynamic lens, and consequently place illness into context, while providing a unique opportunity for meaningful intervention.

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