Extended, Strategic Therapy for Recalcitrant Mind/Body Healing: An Integrative Model

Carol Ginandes
McLean Hospital, Harvard Medical School

The development of the power therapies, behavioral medicine, and short term interventions have reported such success even with trauma cases that it is relevant to question the justification for lengthy psychotherapy. Yet some patients with complex mind/body conditions impervious to medical treatment/hypnosis may require extended, multi-modal, integrative therapy.

This paper details a single complex case of paruresis as a prototype for illustrating a holographic treatment model for recalcitrant conditions: Component features of the proposed model presented include: 1) the sequential utilization of hypnobehavioral and analytic approaches; 2) uncovering work providing access to the somatic ego state associated with the illness condition; 3) the extended treatment time frame required for deep psycho-physiological change; and 4) the stages of counter-transference expectably evoked by such patients (e.g. urgency, exuberant optimism, frustration, discouragement), and the transformation of such reactions to achieve maximum therapeutic efficacy.

Key words: Paruresis, Ego State Therapy, mind/body, behavioral medicine, hypnобehavioral therapy.

Introduction

The development of the popular power therapies, behavioral medicine, and short term interventions mandated by managed care (Brown & Fromm, 1987; Phillips, 2000; Shapiro, 1995; Hollander & Bender, 2001) have reported such success even with trauma cases that it is relevant to question the current justification for lengthy psychotherapy. Yet it appears that some patients, both due to temperament and to the nature of their problems, benefit more, or perhaps exclusively, from a course of extensive treatment that integrates more than one modality. Among these may be patients with complex mind/body conditions that have shown themselves impervious to medical treatment and adjunctive, straightforward medical hypnosis.

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Carol Ginandes, Ph.D.
Department of Psychology
McLean Hospital
Administration Building
114 Mill St.
Belmont, MA 02478
email: carol_ginandes@hms.harvard.edu
Components of the Model

My clinical experience has indicated that certain treatment strategies appear to be successful with a wide spectrum of mind/body conditions that have proven refractory to a unitary therapeutic approach. In this paper, I will discuss a single, complex case as a prototype for presenting a holographic model applicable to such recalcitrant cases. Specifically, the treatment principles to be illustrated include the following: 1) the sequential utilization of an eclectic therapeutic repertoire including hypnobehavioral and analytic approaches; 2) the need for uncovering work to gain access to the somatic ego state associated with the illness condition; 3) the extended treatment time frame required for substantive psycho-physiological change to affect the mind/body configuration; and 4) the sequential stages of counter-transference expected to be evoked by the therapeutic demands of working with such patients: e.g., urgency, exuberant optimism, frustration, and discouragement/determination.

Paruresis: A Social Phobia As Clinical Example

As an increasingly commonly identified but presumably still underreported social phobia, paruresis is thought to affect some 17 million or 7% of the American population. This urinary retention problem is a prime example of a mind/body condition considered to be psychogenic in etiology absent organic causes (Bohn & Sternbach, 1997; Zgourides, Himle, & Pickering, 2001). Whereas 25 years ago it was thought to affect mostly women (Rees & Leach, 1975), it is now estimated that 90% of patients seeking treatment are male (Soifer et al., 2001). Unresolved speculations on possible etiology are wide ranging and include among others: an initial sensitizing trauma precipitating fear or humiliation that generalizes to subsequent triggering situations, social or performance anxieties, injunctions about bodily functions from childhood, biochemical irregularities and/or obsessive compulsive disorder. To date there has been a dearth of research and scant hypnotic (Mozdzierz, 1985; Nicolai, 1960; Knowles, 1964; Chiasson, 1964) or medical literature on treating paruresis despite its prevalence. Relevant literature has reported that cognitive-behavior therapy with systematic desensitization using gradual in-vivo exposure (Zgourides, 1987; Watson & Freeland, 2000; Jaspers 1998; McCracken & Larkin, 1991) has been more successful than pharmacological treatment (Zgourides, 1988; Zgourides & Warren, 1990; Zgourides, 1991).

Clinical Case Example: Presentation and History

The patient, Norm, who will illustrate the several facets of the treatment model presented here, was a pleasant, brilliant and obsessional young biochemist rapidly advancing in his career. He had already diagnosed himself with “bashful bladder syndrome” (paruresis). The issue had started in a mild form around puberty as is typical for the condition (Bohn & Sternbach, 1997), but it had become more problematic as being avoidant of public urinals was interfering with the business travel required by his blossoming career. Medical consultation had ruled out organic bladder disease. Prior to his treatment with me, Norm had not confided in anyone other than a urologist about his difficulties, not even his girlfriend with whom he had been intimate for several
years. The urologist had said that there was no need for medical concern as long as he could urinate in his bathroom at home.

**Complex Symptom Configuration Typical of Recalcitrant Healing**

As is prototypical of complex recalcitrant mind/body cases, Norm suffered from a cluster of other complaints in addition to the bashful bladder problem. These included severe allergies; childhood asthma; intermittent tinnitus (for which objective causes had been ruled out); disturbed sleep patterns with hypersensitivity to noise, temperature and movement; dental phobia; a facial tic; bruxism; and extensive plaque-type psoriasis over most of his body. The latter had been unsuccessfully treated with phototherapy and increasingly strong topical steroids by numerous physicians over a decade. Norm also reported that his girlfriend had noted his reluctance to express feelings, particularly anger or sadness. From this matrix of difficulties, he had identified the paruresis, specifically as it interfered with travel, as his most pressing priority. He did, subsequently however, wish to address both the psoriasis, which was uncomfortable and unsightly, and a sleep disturbance which made overnight visits with his girlfriend difficult.

Norm’s family history (condensed for this paper) was notable for his parents’ prolonged marital discord. His mother was described as critical, unpredictable, and prone to emotional withdrawal if she felt neglected or contradicted. Norm’s father, an engineer, had a longer fuse but would intermittently erupt into angry shouting. Norm felt caught in his parents’ battles serving both as confidant and messenger. He had learned to use a very even tone of voice so as not to trigger parental outbursts and was particularly reticent to express any of his feelings to his mother for fear of retaliation. Norm’s younger brother did battle with the parents more vocally but had nonetheless remained geographically close to them.

Norm reported that when he was in his twenties, he had suffered the traumatic loss of a beloved aunt who had died in a tragic pedestrian car accident. Additional developmental history revealed that he was late to speak but then spoke in paragraphs, that he never went away to summer camp, and that he repeatedly felt humiliated by being picked last for team sports throughout his childhood. This life long sense of being clumsy and unathletic had been somewhat overcome in the last few years by Norm’s taking up ballroom dancing to improve his coordination. He had met his girlfriend of several years at a dance class. They had a calm and consistent relationship, saw each other every weekend, but had not broached the topic of cohabitation or marriage. This was due, according to Norm, to his sleeping difficulties as well as to their different schedules and different tastes in living setting and decor. An additional obstacle he identified was his girlfriend’s cat to which he felt allergic.

**Early Treatment: Flood of Therapeutic Material**

As is often the case with patients who have run the gamut of allopathic treatments without success, Norm showed himself to be a most eager collaborator in the hypnotherapeutic endeavor. He was highly motivated and, with his obsessional temperament, was capable of meticulous inventory of thoughts, feelings and behaviors. In an unsolicited essay, he presented me with a virtual flood of associations to the problem including, among several others: being in discomfort from a full bladder as a young child on family car trips until it was convenient for his parents to stop for a
break; having many “hurry up” kinds of demands on the family bathroom at home; feeling distressed at the age of 10 when his younger brother, pointing toward the fly of Norm’s pajamas, said something embarrassing, as well as a sexual history commencing in early childhood, etc. He also provided me with his own suggested guidelines for our treatment work based on his belief that his condition was also physiologically caused and could be addressed on that level. He wrote:

Possible triggers include noise, motion, expectation of problems on a plane or train, a feeling of time pressure... It’s conceivable that the need to make constant postural/balance corrections is interfering with the muscular adjustments need to initiate urination. I wonder if hypnosis could be used as a biofeedback mechanism to help me gain awareness of these muscular adjustments regardless of other postural or balance corrections.

As Norm’s therapist, I soon became aware of the complex nexus of issues competing with his understandably pressing agenda to resolve the bladder symptoms. Additionally, with the history of clustered hypersensitivities and defenses, both physical and emotional that appeared to be moderating affective expression, I suspected a latent trauma history as well as an unresolved grief reaction. But in an effort to honor Norm’s time frame and for the sake of therapeutic efficacy and parsimony, we decided to start with a cognitive-behavioral interventional approach to the paruresis before all else.

Early Treatment Counter-transference with the Medically Ill

Awareness that working with medically ill patients evokes a range of counter-transference responses in care providers is increasing; among these reactions are a felt need to “rescue” the patient as well as subsequent feelings of frustration and powerlessness when the treatment falls short, and a wish to distance oneself to avoid such feelings (Meier, Back, & Morrison, 2001; Smith & Zimny, 1988; Friedman, 1990). My initial counter-transference feeling in response to Norm’s pressing dilemma was consonant with this emotional sequence beginning with a resonant sense of urgency about accomplishing the therapeutic mission (specifically, in Norm’s case, this pressure may have also metaphorically mirrored his symptoms). In my experience, this initial counter-transference response of urgency is often characteristic of working with mind/body patients with whom the need for intervention may have an exigent time frame.

These feelings were accompanied by an exuberant hopefulness when I became aware of Norm’s abundant access to psychological material and the budding therapeutic alliance as we joined ranks on the crusade to conquer his paruresis. With such access to the material I found myself hoping, even anticipating that our work together might be intensive, highly focused and, with any luck, a brief and “straight shot”. What follows are some condensed, sequential snapshots of the course of treatment that unfolded over time; this will serve as a vehicle to illustrate the components of the proposed treatment model.

Hypnобehavioral Therapy as Initial Treatment Strategy

Cognitive-behavioral therapy is the treatment of choice for a wide range of conditions including social phobias (Heimberg, 2002), and hypnosis has been
increasingly shown to enhance the efficacy of cognitive-behavioral protocols (Schoenberge, 2000; Kirsch, Montgomery, & Sapperstein, 1995; Brown & Fromm, 1987). Given the patient’s scientific bent, as well as the literature on paruresis treatment, the first strategic stage of therapy was the utilization of a cognitive-behavioral approach to systematic desensitization of a self-generated ascending hierarchy of anxiety triggering situations (Jaspers, 1998; Watson & Freeland, 2000). Coupled with this were hypnotic suggestions designed to offset the psycho-physiological triggering of anxiety, paired with suggestions for voiding in a relaxed, comfortable manner. Sessions were at weekly intervals. Between visits the patient carried out practice assignments: Relaxation practice was subsequently paired with mental rehearsal of the hierarchy items followed by systematic in-vivo exposure. Hypnoanalytic uncovering was to be broached after this treatment strategy only if needed.

**Anxiety Hierarchy**

In creating this hierarchy, Norm became aware of how pervasive the symptomatic encroachment on his daily activities was. Although he was able to urinate alone at home without difficulty, he had been unable to void at a urinal for several years. Reporting difficulty both starting, as well as maintaining the urine stream particularly with someone waiting outside the lavatory, the associated thought was that someone would notice he was hesitating too long to start urination. Low-ranked anxiety situations began with urinating in a fully enclosed public stall, and ranged through increasing difficulty with public bathrooms at theater intermission, a group “bathroom break” or worse, being individually escorted at a corporate worksite, on an intercity bus, a moving train, and, at the top of the hierarchy, on an airplane, the very vehicle that he most needed for job-related travel.

**Hypnotic Suggestion Strategies**

Relaxation imagery, tailored to his representational system (Lankton & Lankton, 1983), was elicited from the patient’s own repertoire of comfort situations. These were more kinesthetic than visual (e.g., feet sinking into a padded carpet, breathing pattern shifts, a cool breeze, the warmth of the sun, and water imagery including floating and being in a large tub with water emptying, etc.). These resource images were then paired with kinesthetic and verbal anchors (such as “calm and comfortable” and an inner “comfort meter”) to incrementally adjust, etc. Suggestions using the hypnotic phenomena of time distortion and negative hallucination were used to promote the experience of adequate time and privacy for urination.

**Resource Retrieval and Ego Strengthening**

In addition, ego strengthening was pursued (Frederick & McNeal, 1999) through resource retrieval using an “affect bridge” to a time of mastering a difficult situation (Watkins & Watkins, 1997). This led Norm to several mastery associations; one of them was his decision to take a jitterbug class even though, and precisely because, he lacked a sense of rhythm or coordination. He had practiced doggedly until he felt comfortable on the dance floor. As therapy progressed, Norm dutifully used his hypnotic relaxation techniques and reported that hypnotic absorption facilitated a relaxed urine stream, both at home as well as, increasingly, in several of the previously threatening in-vivo situations from his anxiety hierarchy.
Treatment Impasse Triggers Next Strategy: Analytic Approaches

However, despite these significant treatment gains after several weeks, Norm noted that the blocking, anxiety, and delay around the actual initiation of urination had not diminished entirely, even though once begun, his urine stream flowed more easily than before. In addition, the upper echelons of the anxiety hierarchy were proving resistant to the hypnobehavioral strategies.

Dream Content Corroborating the Impasse

This seemed to confirm my privately held initial impressions that underlying dynamic material was shoring up the maintenance of symptoms. On schedule, Norm corroborated this with the presentation of a veritable analytic bonanza of dreams: The first involved what he called “yo-yo content” in which he experienced himself battling with someone for control of a yo-yo. In a second dream, he was trying to drive but could not reach the brakes; he adjusted his seat and felt himself proceeding along an elaborate road with the sense that he needed to “backtrack”. In the third dream, he felt himself to be in what he thought would be an adult bathroom but he soon discovered that the stalls were, as he said, “teeny-weeny”.

Guarded Optimism as a Counter-transference Reaction

Despite the setback in Norm’s behavioral gains, at this point in the treatment my counter-transference reaction to his spontaneous access to unconscious material was again a sense of optimism albeit somewhat more guarded than before. For in the next phase of treatment, the hidden counterpart to Norm’s zealous conscious collaboration and copious production of material metaphorically signifying symptomatic relief was increasingly revealed. An entrenched reluctance to change began to surface. At this juncture, he began to report the bashful bladder symptoms were vacillating between successful in-vivo and relaxation practice one week and backsliding the next. In order gain access to the underlying impasse to healing, I familiarized Norm with ego state concepts and ideomotor signaling (Watkins & Watkins, 1997).

Hypnoanalytic Encounter with the “Stonewalling Somatic Ego State”

Through our ensuing forays, we soon encountered an ego state that appeared to be a key player in Norm’s intensifying struggle. As has been observed (Frederick, 1994) and confirmed by my experience (Ginandes, 2000) some ego states and, I believe, ones specifically associated with illness conditions, are often more inclined to “speak” through somato-sensory signals than through verbal language. Deciphering their communications may be key to unlocking the deeply suppressed affect and/or resistance toward complete healing (Frederick & Phillips, 1995). In Norm’s case, this core ego state heralded its first overt appearance in treatment by a rather coherent array of uncomfortable sensations that asserted themselves with emphatic somatic consistency. These included forehead tension, ear ringing, headache, and itching sensations migrating through different bodily locations. The ideomotor “no” finger began to raise itself spontaneously and frequently even without questioning. This cluster of sensations and signals was clearly associated with what, I think, could best be called a “stonewalling somatic ego state”. I believe this is a prototypical player that must be contended with in recalcitrant mind/body conditions of all kinds.

When I had invited Norm to access the well-practiced experience of comfort,
he suddenly frowned, saying he was experiencing a sharp feeling of tightness in his forehead. Inquiring directly of the forehead whether it was trying to communicate something (Ginandes, 2000; Watkins & Watkins, 1997; Frederick, 1994), he reported hearing a loud inner retort saying “Hey!” I then asked if there was a feeling. He replied “Sadness”. To the query “What do you want?” there was no reply. But to the question “What do you need?” the reply was “Comfort”. Would it be helpful to understand more about what comfort was needed? The “no” finger rose. I asked, “Is there a reason why you are reluctant to delve into this further?” I was met with stony ideomotor and verbal silence. Reprising this line of exploration in a subsequent session, I asked whether there was a reason not to continue exploring at this time. This time the finger clearly signaled “no”. To test the waters of possible future problem resolution, I queried “By when will you have solved the bashful bladder problem to your satisfaction?” This produced an “I don’t know” reply. “What do you need to do to successfully resolve this issue to your satisfaction?” “Wait.” “Wait for or until what?” “Change.” “Change how?” and the answer was “Hey!”! Recognizing the familiar salutation, Norm then reported a feeling of anxiety and dread he felt specifically in his chest. Invoking a somatic bridge from these feelings to an earlier significant time (Watkins & Watkins, 1997; Phillips, 1996) yielded utter silence. Were the bladder symptoms trying to help him in some way? “Maybe” was the ideomotor reply. Were they trying to express some of his feelings? “Yes.” Would it be all right to begin to explore some of these matters? The reply again was a resounding ideomotor “no!”! Would it be all right to explore why not? “No!” This kind of impasse, condensed here, occurred in some form repeatedly over a period of sessions as this pivotal player which Norm began to call the “Censor” moved center stage, blockading all access to further uncovering of specific content or traumatic etiologies.

Counter-transference Discouragement and the Need for Time

Consciously, Norm became increasingly disappointed with this part of him that refused to reveal anything more specific, and behaviorally, his in-vivo practice gains appeared to be vanishing. Although I knew from experience that this kind of resistance was not only to be expected but also to prove instrumental for further progress, I too, with counter-transference resonance, felt somewhat bogged down and impatient with what seemed to be a long wait at a therapeutic red light. It is at this juncture that the treatment practitioners can understandably become discouraged and frustrated or begin to unconsciously withdraw from the patient (Meier et al., 2001) The challenge is for the therapist to stay patiently engaged. It is noteworthy to underscore and, again I think paradigmatic of work with these kinds of cases, that the “Censor” had revealed that “time” would need to pass before “change” could occur in the stuck inner scenario.

Permission to Heal

I have previously discussed the importance, when treating mind/body conditions, of consulting the core self to ascertain whether there is permission for healing to occur (Ginandes, 2000). In response to such a query in trance, Norm scientifically visualized a pie chart representing the degree to which his inner self was willing to have the bladder condition improve. Tellingly, he reported that at least 35% of
the problem would need to be maintained, a percentage which further corroborated the observed impasse in symptom reduction. The dynamic contrapuntal relationship between the part of Norm that was progressing toward resolution of the problem and the tenacious more primitive ego state associated with its maintenance became increasingly clear. However, it was not until later that we were able to understand why the possibility of greater healing was felt as so threatening.

**Working Through of Psychodynamic Issues**

Yet despite the stasis in symptom reduction, work on Norm’s deeply held psychological themes continued to proceed in our sessions. The therapy material consistently flagged the following themes: a fear of humiliation, a sense of inadequacy, the dread of being overwhelmed by sadness, and the anxiety about angering, disappointing or saying “no” to his mother. Paradoxically, the feelings of disappointment, sadness and anger mobilized in response to the apparent stalling of treatment gains, provided an opportunity to connect with his emotional experience and its expression. I congratulated him on how much more easily he was able to identify his emotions. My hunch was that the ego state that was resisting explorations was also practicing being able to say “no!” in ways which Norm, in order to be a “good boy” and not rock the family boat had never dared to as a child. Dialoguing in trance with the “Censor” and reframing its role allowed for a transformation in which Norm, although initially skeptical, began to welcome its right to self-determination and self-expression. He vividly noted that we had “pulled that part out from the shadows where he was sulking and brooding”. Over time the somatic ego state, in addition to the usual somato-sensory communications, began to respond directly in words. Norm’s negativistic withholding affect, which had been so forbidden, began to be transformed into the delight and exhilaration of a two-year-old who relishes in proclaiming, as he did in trance, “No, no, no, no! No, I don’t wanna!”

**Cracking the Code of the Symptom’s Meaning**

We were subsequently able to shift over to a direct dialogue in trance using a gestalt technique with Norm’s mother. At first he could only do this in a whisper; but over time his tone became louder and clearer as he found his voice. He eventually became able to say no to her emotionally intrusive demands and cyclical withdrawal of approval and attention both in trance and, to a greater degree than ever before, in his actual interactions with her. Through this work we were finally able to decipher what appeared to be the core reason and need for maintaining a portion of his symptoms.

Through dialogue with the somatic ego state, consistently signaled by anxiety and a feeling of dread in his chest, Norm associated to his mother’s anxieties about his exploration of the world too far away from her. She had, as he had finally discovered, “limited and reined me in”. All of his life he had feared she would retaliate with disapproval and withdrawal if he were to venture far away. Since puberty, and particularly with his career advancement, he had taken over the job of reining himself in unconsciously with a bladder condition that literally had made it difficult for him to leave home.

**Abreaction of Grief**

However, there was another significant piece of the puzzle that needed to fall into place: it appeared that the expression of powerful grief feelings was blocked (Brown
& Fromm, 1986). Norm reported that he could not remember ever crying and that even the thought of feeling sad made him worry that he would be overwhelmed with pain. Serendipitously, two external events conspired with his growing internal readiness to feel sadness. One day as he was crossing the street, he saw a squirrel that had been hit by a car and was still, painfully, alive. The other development was that his girlfriend’s aged cat, to which she was deeply devoted, needed to be euthanized.

Although he made no conscious associations to these events for several weeks, eventually, he did. He was then able to feel deep grief about his girlfriend’s loss of her pet and, more importantly, his own loss of his beloved aunt who had been hit by a car. The sobbing that ensued in the session was so powerful that he was truly amazed at his capacity for feeling and his ability to survive it. For Norm, this uncensored emergence of deep feelings was perhaps the biggest ratifier of his treatment progress despite his having identified the bladder problems as his priority.

**Treatment Gains Proceed Again**

This breakthrough apparently signaled a therapeutic green light once again. Norm had a dream that he was in a bathroom with a urinal, and he worried that he would not be able to void. But in the dream he decided to relax, and his urine stream started easily. After this, he began once again to progress through items that were high on his anxiety hierarchy. Subsequently, Norm was even able to challenge successfully his highest ranked fear when he was able to urinate in the lavatory on a transcontinental flight. No longer feeling crippling anxiety, he maintained just a little bit of mild dread in order to appease his defensive need for a remnant of the symptom.

It had taken us two years of treatment, but the gains that had been made were substantial. Behaviorally, Norm was now able for the first time in years, to void at a public urinal. By way of external corroboration of his success and his developmental progress, perhaps unconsciously, he presented me with a therapeutic trophy: When he came to my office for sessions and used the bathroom, he began to leave the seat of the commode in the up position like the man that he had become.

He was also now able to be aware of feeling stressed, sad, frustrated, even angry and to tolerate the feelings without fearing emotional dissolution. And finally, two years into our treatment, after they had been a couple for seven years, he was able to invite his girlfriend to move in with him, feeling optimistic that they would be able to negotiate their differences without, as he had feared, recreating the embattled marital relationship of his parents.

Now that the paruresis had been resolved, Norm requested that we shift our attention to the psoriasis which had worsened significantly in conjunction with a streptococcal infection. Prior to this, there had been periods when the psoriasis had appeared to remit only to reemerge with a vengeance. Although psychological material about the psoriasis had spontaneously surfaced during the first two years of treatment, it clearly was going to require therapeutic time and priority for resolution. By now familiar with his psychological topography, I began gearing up for another extended trek through this complex terrain. Given the extensive literature of hypnotic success with dermatological conditions (Shenefelt, 2000) and a smaller case literature on psoriasis (Frankel & Misch, 1973; Winchell & Watts, 1988), I felt a guarded sense of hopefulness. This time with less ebullience, my counter-transference reaction has settled into a
steady determination to stay the course with as much patience and dedication as I could muster. The treatment journey with Norm continues to proceed at this time.

**Discussion**

This case has afforded an opportunity to clarify what I feel to be important strategic components of a model for treating complex mind/body cases:

1) The sequential utilization of hypnobehavioral and hypnoanalytic approaches;
2) The uncovering and integrative developmental work with the somatic ego states associated with the illness condition;
3) The extended treatment time frame required for significant psychodynamic and psycho-physiological change to occur; and
4) The normative counter-transference reactions (exuberance, urgency, frustration, discouragement) evoked by such demanding casework.

Although initial tangible progress was made in the diminution of Norm’s paruresis, his backpedaling or “yo-yoing”, as his dream so aptly described, was inevitable given the weight of the unconscious need for the symptom maintenance and consequent reluctance to change. The paring of a hypnotic approach integrating the patient’s own representational system with a cognitive behavioral protocol instigated an initial shift in the entrenched psycho-physiological loop of debilitating anxiety and resultant avoidance. Following this with direct hypnoanalytic dialogue with the mind-body, through somatic ego state techniques, allowed for the careful negotiating, reframing, and developmental repair needed to change the underlying dynamic of the symptom. Although content specific trauma material did not fully surface and the problem was clearly multi-determined, it was nonetheless possible to work on the illness condition as it related to Norm’s core developmental struggle with his mother as well as his defensive repression of emotional experience and expression. Staying the course with the patient through the vicissitudes of his exploratory forays and retrenchments, much as one would with a toddler, may have therapeutically repaired the early developmental disturbance caused by his mother’s anxiety about separation and individuation that he had internalized and transformed in his multiple somatic perturbations.

The added ingredient for therapeutic success was the allowance for an adequate, extended treatment time frame in which to pursue the careful course of integrative treatment needed and the willingness to weather the counter-transference vicissitudes which can challenge even a seasoned clinician. Being conscious of the normative nature of these when working with complex recalcitrant mind/body conditions allows the therapist to make a significant choice that may affect the outcome of the treatment itself. This is the choice not to withdraw emotionally from the patient as is the usual psychological reaction in the face of prolonged treatment and setbacks (Meier et al., 2001; Smith & Zimny, 1988; Friedman, 1990). An awareness of this multi-modal, holographic model of treatment of recalcitrant mind/body cases will perhaps enable the therapist to replace the normative counter-transference stage of withdrawal in the face of the treatment impasse with heightened stamina and a determination to go the full distance needed for healing.
References


