

The menu

4. The attachment dimension to the somatisation diagnoses, and «psychosomatics».
5. Psychosomatics and an attachment perspective to personality functioning.
6. What is it about health services and health professionals which make it easier for patients to remain ill? System errors anchored in the attachment strategies of health professionals.
7. **Getting healthy, keeping healthy: the DMM in action.**

MAKING SENSE OF THE LANGUAGE OF DIS-EASE

To maximise health

Depends on understanding attachment

“If a community values its children/patients it must cherish their parents/nurses”.

with apologies to Bowlby, 1951

”Ora na azu nwa.” Igbo kultur, Nigeria

It takes a community to raise a child.

It needs a community of integrated health service to care for these patients.

Problems vs Difficulties

- Problems need action
- Difficulties have to be lived with
- Treating a difficulty as a problem leads to an unresolvable crisis
- Treating a problem as a difficulty can lead to death

Have these patients problems or difficulties?

Living with predicaments

Care is first priority

What is the problem in psychosomatics?

- Information processing
- Identifying temporal sequences and context factors
 - Describe behaviour in its social ecology
- Identifying affects
- Discriminating meaningful information from erroneous information

- Changing self-protective strategies involves changing the mental processing of information.
- Alternative problem solving and new behaviour

Functional formulation

- How does the attachment strategy protect from what sort of danger in which context?
- What role do the somatic consequences of the strategy early in life play currently? (the body keeps the score)
- How do the strategies of the family members interact between them to function protectively?

- AND how do the strategies of health professionals maintain current self-protective strategies in the patient and local social ecology where the symptoms are functional?
- Or could they aid resolution?

Dialogue

- What you mean to say.
- What you actually say.
- What the other hears.
- What the other thinks he hears.
- What the other says.
- What you think the other says.

Usefulness of language of dis-ease

To be alive with as little discomfort as possible.

To make others aware of of your discomfort in such a way that there is the greatest chance that they will respond in such a way that you are comforted.

We use the language without reflection when need is pressing.

Language

- Form
 - *how* discomfort is presented
- Content
 - *what*: the value of specific symptoms
- Structural coupling between 'patient' and 'healer'
 - Sickness and illness
 - Parent and child
 - Illness and disorder
 - Doctor and patient

Application of language of dis-ease

- B – honest and open communication
 - Illness in focus in a reliable way
- A – borrow others' perspectives which they then apply to themselves when they communicate about their own condition – usually after they are over the worst
 - Sickness in focus as if it was illness
 - Content – others' attributions as if own
 - Form - withholding

- C – play out their predicaments: the content is only partially appropriate with exaggeration and/or minimalisation/denial of affects determined by the functional effect.
 - Content – functionality
 - Form - florid

Explaining own dis-ease complaints

- Semantically acceptable to VIP
- Consistent with your known personality/illness history
- 'Truth' – secondary importance
 - Depends on ability and costs of telling the truth
- Tell doctor what wants to hear and relation improves
- A picture of self coherent with somatic vulnerability and personal motivation is continuously reconstructed.
- Dispositions to respond according to each memory system may all differ.

- Whilst the VIP needs to consider FORM to the complaining as well as the complaint.
- The «moral order» whilst evaluating a complaint – focus on right/wrong – emphasises the potentials for deceit.

Deception

- Av. adult lies/deceives self x 200/day
Trivers
- Patient and parents – and doctor – focus on what can be talked about
- This is deceptive for all parts
- **IMPORTANT: note what cannot be talked about without making demands to talk about it**

Many doctors do not talk about affects, but if they do symptoms improve. Salmon et al 2004 & 2007

Understanding the language

Investigate in order to understand the connection between the identified problem and its wider systemic context.

Microsystems

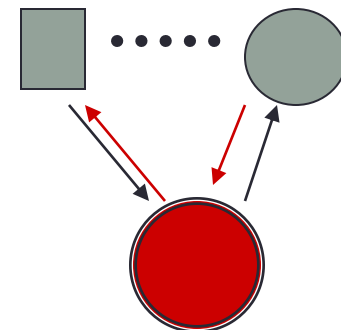
Mesosystems

Macrosystem

= First MultiSystemicTherapy (MST) principle

A microsystem or mesosystem process: Triangulation and either/or

- Triangulation in families with **Type C**
- Parallell processes
 - family members
 - physician-C/L-patient
- Triangulation assoc. with vagal activation and bronchial constriction
- The quality of the relationship between physicians and nurses and the C/L staff



Is this a cooperative joint venture or will one part of the team have the blame if things do not work out?

Triangulation and either/or

- How do doctors driven by performance and need not to make mistakes **Type A**
 - handle risk?
 - use their colleagues?
 - avoid conflict/negative affect?
 - What becomes the moral order of the consultation around these patients?
- And with a preoccupation with affect and less focus on precipitating events **Type C**
 - identify causal mechanisms?
- **Give priority to form > content**

Treatment based on DMM understanding of attachment strategies

unites:

- Biological approaches with psychological,
 - Behavioural with psychodynamic,
 - Individual with family,
 - Genetic with environmental factors.
-
- Treatment should be just as good for the children as their parents
 - and ideally their grandparents!

Modifying Bowlby's 5 treatment tasks

1. **Ensure safe from danger**
2. Focus on the establishment and maintenance of relationships with identification of the repeating interaction patterns
3. What is repeated in the relationship to the therapist – **and other parts of the health service?**
4. How are current expectations and experiences a result of the past – the relationship of 2. to 3.?
5. Re-evaluate image of self for current relevance

Treatment

- Health professionals need a range of ways to understand the strategies being used by somatising patients.
- They need to identify the specifics: **As** and **Cs** usually need different intervention strategies.
- Note the form as well as content
 - What kinds of transformation of information are being used?
 - What is not available for reflection? – affect, cognition, trauma/loss
 - Is the primary focus on self or other?
- Health professionals need to know own strategy.

Treatment

- Identify threats at home/hospital – maximise safety.
 - seeing a psychologist can be perceived as threat to strategy (Stockholm syndrome)
- Avoid moral judgment.
- The goal is getting comfortable – feeling ‘healthy’.

Therapeutic stance

- Warmth
- Respect
- Empathy
- Acceptance
- Humility
- Honesty
- Flexibility
- Low investment

Alliance

- In relation to a stranger use their current attachment strategy and language of illness.
- Clinicians need to be flexible in use of their strategy and be 'multi-linguists'
 - But only under first phase
- Alliance with patient on their illness experience
- Alliance with parents on their attribution of sickness
- Alliance with colleagues on their understanding of disorder

Goal corrected partnerships

- Control is shared
 - An enormous challenge for **Type A** and **C**
- Focus on 'patient-hood' – the state of suffering
 - But **Type A** has a limited awareness of their «suffering»
 - And **Type C** has more suffering than is understandable
- Not client centred
 - not coherent with **Type C** premises
- Not clinician centred
 - not coherent with **Type A** premises
- Not goal directed cooperation
 - The crucial issue is how the goals are identified and adjusted 'en route'

**Ideally goals are modified in light of progress
as a joint venture**

Psychological & Strategic Effects: Deception

- Adolescent and family – and therapists? – focus on what *can* be said or talked about (displacement of problems).
- This misleads everyone. It isn't "lying", but it deceives the self and others.

Type A and Type A

- Identify causal events through temporal sequences.
- Give other's affects priority instead of acknowledging and making use of their own.
- Oversee roll played by own and other's hidden negative affect.
- **Pt. will remain unclear about connection between affective somatic images and state of distress.**
- Rely heavily on information from experts
 - Elicit benign paternalistic medical practice.
 - Clinician responds with 'technical medicine'
 - Believe answer lies in psychoeducation.
- Be disposed to believe the other is «better» than she is.

Type A and Type A

- Preoccupied with pleasing/avoiding conflict with each other – nice parents, nice therapists and nice adolescents.
- Appear deceptively psychologically healthy, ie «in affective balance» - but may have somatic complaints.
- Disposed to facilitate a flight into health/accept assurances that all is now well.
 - Treatment ends prematurely but to mutual satisfaction.
- Will be shocked and puzzled by «ina» (intruded negative affect).

Type C and Type C

- More expert at reading their own affects than acknowledging and making use of the other's affects
 - But feel 'in tune' with each other.
- Knowing that they distort their own affective displays, they are aware that the other may also be doing the same.
- Will tend to oversee the meaningfulness of the contingencies associated with the affective displays.
- Be disposed to believe the situation is worse than it is.

Type C and Type C

- Disposed to demand unending services which pay undue attention to how they are feeling, and remain enmeshed in treatment too long.
- Will be not be shocked by marked displays of negative affect.
- Problem likely to escalate on termination of contact.

Type C and Type C

- Preoccupied with escalating affective displays in order to force through their own perspective
 - easy to be provoked by parents and adolescents, or feel unduly sorry for them,
 - therapists may rely more on affective attunement than information on causal factors.
- Appear deceptively unhealthy, ie «out of affective balance», when are robust enough for, and in need of, clear contingencies to their own behaviour.

Type A therapist strategy and Type C adolescent

Often with Type A parent

- Therapist risks allying with parent and failing to identify the affective strategies being employed by the adolescent to maximise closeness with relatively emotionally distant parents.
- Needs to identify the distorted affects, but has a priority to identify the contingencies to the behaviour.
 - Espy. the anger in the even Cs and the fear/need for care in the odd C strategies

Type A therapist strategy and Type C adolescent

- Fails to achieve an affective balance in building the therapeutic alliance.
- Adolescent disposed to drop out of therapy – doesn't feel understood or 'in tune' with therapist.
 - The adolescent's thoughts and feelings are her reality, intolerant of alternative perspectives – psychic equivalence
- Adolescent goes 'doctor shopping'.
- Therapist fails to identify own roll in breakdown of treatment and that this mirrors the parental roll in the family.
- Feel eventual compulsive caregiving strategy (A3) has failed.

Type C therapist strategy and Type A adolescent

Often with Type C parent

- Therapist identifies the hidden and distorted affects
- Therapist risks failing to identify the contingencies associated with the adolescent's behaviour, and instead preoccupied with the hidden affect.
- A language of affects will feel strange and threatening to the adolescent who will be disposed to withdraw and rely on self-sufficiency strategies to cope with the therapist.

Type C therapist strategy and Type A adolescent

- The therapist and parents can be driven to being intrusive, disposed to label the adolescent's affective state on their premises, without being able to achieve accuracy or functionality in their attributions
- The therapist and parents need to acknowledge the reality of the adolescent's reply: «I don't know how I am feeling, just now».

Type C therapist strategy and Type A adolescent

- Fails to achieve a low key cognitive approach in building the therapeutic alliance, with introduction of affect at a later stage.
- Adolescent kept in therapy by powerful others without evidence of therapeutic benefit.
- Therapist fails to identify own roll and that this mirrors the parental roll in the family.

Does this explain why no association between measured patient satisfaction with treatment and outcome?

Affects and Responsibility:

Type A and Type C

- **Type A** children and parents, and staff need focus on their negative affects and how they express them.
- **Type C** children and parents, and staff need to make light of and minimalise their expression of negative affects.
- **Type A** children and parents, and staff need to feel less responsible for their regrettable actions.
- **Type C** children and parents, and staff need to take more responsibility for their regrettable actions

Love and compassion....

- are needed to win over information processing biases.
- Radical acceptance (see DBT literature)
- Living NOW (mindfulness)
 - **Type A** strategy preoccupied with past and what they did wrong and what they can please others with in the future.
 - **Type C** strategy preoccupied with their future and what others did wrong to them in the past.
- **«We have only the world that we bring forth with others, and only love helps us bring it forth».**

Maturana & Varela, 1988

Mistaken treatment....

arises when the patient is not seen as she is...

- but as another needs her to be,
- imagines her to be,
- accuses her of being.

The system validity of symptoms

Adapted from Dialectic behaviour therapy

- Find what is wise, true or valuable in the symptoms – understand their dis-ease language using attachment theory (DMM)
 - Emotional expression
 - Cognitive understanding
 - Associated behaviour
- Analyse the current ecological validity of the symptoms through understanding the attachment strategies across multiple systems.

First Multi systemic therapy principle

Good enough parenting implies enough 'insensitive' parenting

- Regular immediate response to crying does not lead to Type B strategies in the child.
- The secret is knowing when NOT to respond.
- The art of being a good enough 'idiot'.

The art of being both a sensitive and insensitive doctor at the same time!

Course in not-knowing, Utah

Our behaviour is guided most by what we don't know.

- All you know that you do not know
- All that you do not know that you do not know
- All that you think you know, but do not know
- All that you do not know that you know
- All that you do not know because it is too painful
- Taboos, the dangerous and forbidden knowledge

'Not-knowing' groups

- To take up issues about which people do not know,
- With other people who do not know,
- Through investigating how to ask fruitful questions,
- Sharing most productive mistakes.

Children show us what we dare not see
in the mirror.

Anne Grete Preus - Norwegian musician

The secret of being a good parent is in
the enjoyment of being hated.

Carl Whitaker - family therapist

Give me the courage to accept the
things I can't change, courage to
change the things I can, and wisdom
to see the difference.

attributed R.
Niebuhr

Dharma

The 4 noble truths

1. Life is suffering
2. Suffering is caused by craving and aversion
 - Wanting deprives us of contentment and happiness
3. Learn to live each day at a time
4. The Noble 8-fold path leads to the end of suffering

Health service routines

- Joint focus – "It needs a 'healthy' community of service resources".
- Celebrate misunderstandings and get the curious who do not know together – they are the most valuable resource.
- Do not base practice on diagnoses, but be informed by them.
- Know what is safe to ignore.
- Do not be frightened of lawyers.
- The most important thing a doctor can say is "You are well" – but that does not mean the patient is healthy.
- **Learn the DMM!!!!**