

**Training Psychosomatic Integrative Psychoanalytic Therapy
Leadership:**

Xu, Yong M.D.

**Deputy Director, Department of Training and Education
Shanghai Mental Health Center
Medical School of Jiaotong University**

**Jue Chen, M.D.& Ph D.
Chief Psychiatrist
Chief of Psychosomatic Unit
Vice-director of Clinical Psychology Department
Shanghai Mental Health Center
Shanghai Jiao Tong University School of Medicine
Shanghai 200030**

**Dr. W. Merkle
Director Psychosomatic Clinic
Hospital zum heiligen Geist GmbH
Teaching Hospital of the Goethe-Universität Frankfurt
Lange Strasse 4-6
60311 Frankfurt am Main
Phone: 069/2196-2101
Fax: 069/2196-2103**

The following curriculum will explain the training in integrative psychosomatic therapy in Shanghai march 2015

The Program has three parts:

- 1. Psychosomatic Nurse**
- 2. Concentrative Movement Therapy (CMT)**
- 3. Psychosomatic psychoanalytic individual and group therapy**

Participants:

All members of a psychosomatic or psychotherapeutic inpatient treatment team in psychosomatic or psychiatric institution are invited

Special focus of the course

The duration of the treatment in psychosomatic clinics is often determined not only by therapeutic aims, but also by the influence and the limitations of insurance cover. Sometimes, the goals that can be set are limited by human resource constraints. There is a further influence from the groups of diagnoses that are defined and treated in each department.

The decisive framework for the specification of the treatment is the result of the multi-personal field of relationships in the hospital. This framework is fundamentally different in the inpatient setting and the outpatient setting.

While the treatment processes in the outpatient setting are referred to one therapist (trans-ference-countertransference, therapeutic alliance), there are different therapists present who offer different therapies in the inpatient setting. Furthermore, usually the patient in the outpatient setting has a job that structures his day, which is not the case in the regressive status of a ward. The therapist in the outpatient setting can only be contacted during business hours; within the hospital, one of the therapists can be contacted day and night (standby duty).

The consideration of this framework has to lead to modifications of the treatment according to the paradigm of relationship. Particularly, the psychoanalytic psychotherapist has to take into account that with admission to hospital, the patients are included in different systems of relationships and, with that, in unconscious aspects of interaction: for example, reactivated infantile patterns of object relationships and unconscious fantasies in different personal relationships. Every relationship in the hospital is, therefore, not to be considered in isolation, but in a multi-personal group context.

Because of the reality of the relationship, inpatient psychotherapy is multi-methodical (individual therapy, group therapy, art therapy, music therapy, movement therapy, sociotherapy) as well as multi-personal. This means that the re-enactments lead to multi-dimensional transference processes, which have to be reintegrated into an individual transference shape. The concept that can fulfil the multi-methodical and multi-personal therapeutic field of relationship is that of group and team treatment on the ward.

Integrative models want to grasp the patterns of relationships developing within the multipersonal field of relationship as completely as possible, and including infantile parts of object relation or parts of transference besides the work and the real relationship. The patients externalise their internalised object relations in interactional re-enactments even in their behaviour in the here and now of the ward, and use the whole field of relationship. The work in this multidimensional transference context with the corresponding countertransferences in the team represents the core of the inpatient integrative psychodynamic psychotherapy.

The interactional re-enactment in the here and now, therefore, is characteristic of inpatient psychodynamic psychotherapy. The transference is, thus, largely understood according to the concept of the reactivation and externalisation of internalised object relations. They can be found in the multi-personal field of relationship of the hospital situation in different relationships and almost never show themselves only in the relationship with each therapist.

Hence, the basic rule for the team: communicate freely and openly about observations, experiences, feelings, and affects in the different fields of therapy and relationships.

Within the outpatient treatment, the therapist has to deal mostly with successive developing patterns of transference. In contrast, different shapes of transferences can show themselves simultaneously and side by side in the inpatient setting. The characteristic pattern of transference for patients in inpatient therapy is always a multi-dimensional one.

Other patients have a one-dimensional transference that shows itself as a wish for an orally giving mother in the transference to the institution or in the relationship with different therapists. Such transference can also manifest itself in the group therapy as a common fantasy of all patients. For some patients, such as those with borderline personality disorder, the splitting transference is characteristic. Each figure of multi-dimensional transference cannot be considered as split transference - only those that occur in patients with borderline personality disorder.

The splitting transference of unintegrated bad and good object representations are projected to different therapists.

Finally, there are patterns of relationships in inpatient psychodynamic therapy besides the working and real relationships that can also be called transferences: for example, with psychotic or somatically decompensated patients. These, however, cannot be interpreted, but need acting and structuring measures.

For some severely disturbed patients, the dimension of the relationship of caring nursing and the diatrophic level of the ward has the effect of supportive therapy.

Integrating teamwork

The concept of teamwork in inpatient psychodynamic therapy is derived from the basic position of the integrative model (see above). The essential rules for the teams are:

- each participant in the team has to understand himself as a part of the whole. He has to use the team to understand and treat individual patients or the group of patients adequately;
- he has to be aware of the fact that he will not be able to recognise the unconscious processes of patients without including the multi-personal field of relationships in his therapeutic considerations.

There are different ways the task is defined that each person in the team fulfils (cf. different models: Janssen, 2004). The concept of the team as a whole is very important for the atmosphere and the milieu of a department and, thereby, also very important for the treatment of the patients.

As a whole, the team in the integrative model has the following function:

1. The creation and maintenance of the framework (setting), a limiting and holding function that is essential for the therapeutic working alliance: the therapists have to care about creating a facilitating environment, even if they are not always responsible for failure. It is very important for the treatment that the team tries continuously to understand how to facilitate developments and to what extent the offerings of the setting are facilitating. The disclosure of hidden team conflicts, the detachment of the patient, or the adherence of the patient, according to the phase of treatment, springs from this understanding
2. Maintenance of the boundaries of the therapeutic space: pathological patterns of object relationships can only be re-enacted in a space that is protected and safe. Normally, the patients are in a strongly regressive state during their inpatient period. Therefore, it is the task of the teams to create this space in a way that provides the opportunity to separate the therapeutic from the non-therapeutic space.
3. Regulation of closeness and distance: the team members have to develop the capacity to be close to the patients and also to be able to keep a distance. The team has to be separated from the group of patients in order to survive attacks on them and the setting and to react appropriately.

It has to be a perceptive and reflecting team. The perceptive team is a team that can - as in therapeutic ego-splitting in individual therapy - experience and reflect on themselves in their interaction with patients from a certain distance. This modus corresponds with the position of neutrality (abstinence) and of the reflection of the countertransference in the ambulant psychodynamic psychotherapy. However, the distance must not be so great that the empathetic recording of the patient suffers and the containing function of the team is challenged.

4. Maintenance of personal equivalence: even if there are different tasks concerning the therapeutic work, the therapeutic relationships should be considered equivalent. The value of the relationship as equivalent creates a basis of confidence and avoids narcissistic conflicts of self-esteem within the team. The head of the team especially has to assure a clear separation of the different tasks of the various professional groups to facilitate a productive exchange in a protected space for all participants of the team. In particular, the team of nurses must be protected and valued in their function because they are more frequently attacked by the patients because they have no clearly limited contact time with the patients (unlike the therapists, who have the fixed duration of the individual therapy hour, or the defined duration of a group session) and share the reality space partially with the patients. Furthermore, they have to defend the rules of living together on the ward and confront patients in the reality space.

These fundamental tasks for the whole team, the members of which have a different allocation of tasks, makes it necessary to give special attention to the structure of the team and to the kind of guidance needed. Teamwork is like a continuous affective group

dynamic process, which has to be limited to the tasks. The maintenance of this "primary task" (Rice, 1969), the referentiality, is a task of leadership and must be ensured in each session.

So, it is not surprising that there is an obligatory need for external supervision to "clear the container" and to provide a good functional level of the team as a group that should always be a model of vivid communication for the patients.

The re-enactment of the pathological object relation, the transference figure, is worked out through the communication of the members of the team with regard to the relationships with the patient and by the behaviour of the patient. The leader has an integrative function in this process. As he performs an integrative ego function for the team, he provides maintenance of the framework and maintenance for the functions of each member of the team.

On the background of this theoretical framework the course want to show some pillars and principles of inpatient treatment with low mentalized patients who are mainly using the defense mechanism of somatization or developing of psychosomatic symptom.

The basic interest and idea of the curriculum is to emphasize the importance of integrative team work therefore a man emphasis is layed on the session that are with the differnt professional groups together.

Moreover there are also specific parts for the different professional groups.

The workshop is established for different teams with psychotherapeutic and psychosomatic inpatient treatment and clinic centers.

In the center of the topics of symptoms there are the most often diagnosis we found in German psychosomatic clinics to exemplify the work more in detail.

The German teachers of this educational program



Dr.med. Merkle, Wolfgang, MD, Director Psychosomatic clinic, Hospital zum Heiligen Geist, Teaching Hospital of the University of Frankfurt, Lange Strasse 4-6, 60311 Frankfurt.

(30 inpatient, 50 dayclinic patients, 8 pain complex therapy patients, outpatient clinic), since 1996 Psychoanalyst (IPA), Specialist of psychosomatic medicine and psychotherapy, Specialist of psychiatry. Specialist for special pain therapy. Study of medicine in Ulm (Prof. Th. Von Uexküll), Intern in the Psychiatry department University Ulm, Dissertation in 1982: Therapy in chronic cancer pain patients, Education in psychoanalysis in Ulm (Prof Thomä, Prof. Kächele) and Stuttgart-Tübingen (Prof, Henseler), Senior physician in the psychosomatic department in Esslingen. Publications about psychosomatic treatment of psychogenic pain, family therapy of patients with psychogenic pain.

w.merkle@em.uni-frankfurt.de



Mrs Schopf, Gudrun:

Psychosomatic Nurse Manager, since 1999 at Hospital zum heiligen Geist, Frankfurt.

Advanced training in 1990-1992 concerning Behavioural Therapy for nurses.

Co-organizing psychosomatic congress for nurses in Bavaria, Kloster Irsee for 19 years.

Publication: Borderline - Was tun? (Personality disorder, how to deal with?)

On the job training for nurses about psychosomatic treatment and relationship.



Mrs Andrea Wolf-Aslan

Movement therapist at the Hospital zum Heiligen Geist

Working as Concentrative movement therapist since 1987 in psychosomatic institutions

Music and movement studies at the music college of Detmold and Boston

Qualifications in different movement therapy methods:

Integrative movement therapy

Feldenkrais method

Creative body and dance therapy