

Running head: INTEGRATED CMT AND TMS TREATMENT

AN INTEGRATION OF CONTROL MASTERY THEORY AND THE THEORY OF
TENSION MYOSITIS SYNDROME FOR THE TREATMENT OF CHRONIC PAIN: THE
CASE OF “JAMES”

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INTEGRATED CMT AND TMS TREATMENT

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ABSTRACT

Chronic pain is a national health epidemic and chronic back pain is one of the most common pain symptoms. Research suggests it is insufficient to explain chronic back pain as being predominantly due to structural issues of the spine. The theory of Tension Myositis Syndrome (TMS) offers an alternative explanation for the etiology of back and other somatic pain, namely, that pain serves a distracting function against repressed, negative emotions. Anecdotally, hundreds if not thousands of individuals have experienced a significant reduction in pain following the principles of TMS treatment as outlined by the medical doctor John Sarno. However, there is a dearth of high-quality research on the treatment of TMS and using a TMS-informed approach in psychotherapy. The purpose of this study is to examine the potential efficacy of a psychotherapy integrating the theory and treatment of TMS with Control Mastery Theory, a psychodynamically-influenced and empirically supported psychotherapy model. The study analyzes the 44-session treatment of “James”, who, was experiencing significant chronic back and other somatic pain and had been told by medical doctors that structural issues were not the cause of his pain. A battery of self-report quantitative pain measurements was used. James’ quantitative results and qualitative self-report indicated his pain did not decrease throughout the course of treatment, despite evidence suggesting a strong therapeutic alliance and James fitting almost all of the personality characteristics common among TMS patients. A psychodynamic explanation of the results is offered, incorporating the results of the Shedler-Westen Assessment Procedure. Recommendations are made for future chronic pain psychotherapy treatment and research.

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CHAPTER I

Case Context and Method

The Rationale for Selecting this Particular Client for Study

The present study sought to integrate the theory of Tension Myositis Syndrome (TMS) with a psychodynamically-informed psychotherapy model (Control Mastery Theory; CMT). The theory of TMS provides an explanation for the etiology of, and treatment for, various psychosomatic phenomena or *mindbody disorders*. The theory is most commonly associated with the treatment of chronic back pain. The present research was designed and intended for use with an adult individual experiencing chronic pain (i.e., pain lasting longer than three months), and preferably chronic back pain, that could not be solely explained by a medical cause. Operationally, I was seeking a client that was either (a) willing to receive medical consultation to rule out medical causes as explaining the chronic pain (there were two different local medical doctors trained in the theory of TMS that could have provided such a consultation), or (b) had already received medical consultation ruling out medical causes for the chronic pain (e.g., was told by a medical doctor that the pain was not solely attributable to physical/structural issues). (For inclusion/exclusion criteria, see Table 1.)

The subject of this study, “James”¹ met the inclusionary/exclusionary criteria in Table 1. A 60-year-old man, James was seeking treatment for widespread chronic pain, most severely in the lower back but also occurring in the groin, hips, stomach, shoulders, buttocks, and feet. James had been to numerous medical specialists and undergone multiple surgeries but continued to suffer with daily, debilitating chronic pain. James was referred to me by Dr. Jeffrey Axelbank, a psychologist specializing in the treatment of chronic pain using a TMS-informed

¹ A pseudonym.

approach. (Dr. Axelbank also served as clinical supervisor on this case and was a member of my dissertation committee.) James had already received medical consultation in which he was told that his back pain was not due to the structure of his spine, nor was it due to any other known medical cause. Medical doctors had also not found any structural issues responsible for the other areas of pain.

The Clinical Setting in Which the Case Took Place

The treatment occurred in a teaching clinic affiliated with a university-based doctoral-level psychology graduate school. The fee was set based on the sliding scale fee structure of the clinic. At the time of treatment, I was an advanced-standing graduate student pursuing my doctoral degree in clinical psychology. I had completed a course in short-term psychodynamic therapy in which I learned about CMT. As mentioned, I was supervised on the case by Dr. Axelbank, who had expertise in both the treatment of TMS and psychodynamic psychotherapy. After each therapy session, Dr. Axelbank and I watched video of the session and subsequently met to discuss the therapy. I provided therapy to James as part of my doctoral dissertation. The Institutional Review Board of Rutgers University approved the research design of the study. James provided oral and written consent to participate in the case study and was aware the case would be used for my dissertation research. Throughout the treatment, James and I met weekly, twice-weekly, or did a “double” session once weekly lasting one hour and 40 minutes. In total, there were 44 sessions, of which 14 were double sessions.

The Methodological Strategies Employed for Enhancing the Rigor of the Study

All sessions were video-recorded and reviewed by both therapist and clinical supervisor. As mentioned, weekly supervision occurred to discuss the case and develop appropriate interventions. Additionally, the subject was administered a battery of psychological and pain-

specific quantitative measures at intake, before session 22 (at which point 22 therapy hours had occurred), before session 36 (at which point 44 therapy hours had occurred), and after termination (for a detailed discussion of measurements and outcome, see Chapter IV on assessment and Chapter VIII on treatment outcomes).

Sources of Data Available Concerning the Client

Prior to the therapy beginning, I had spoken to James' daughter, who was evaluating psychological treatment options for her father. The daughter described how James could be "stubborn." Prior to our first meeting, I also spoke with James once on the phone to introduce myself and schedule the initial consultation.

Confidentiality

All client information in this study has been de-identified and, in some cases, disguised to further protect the client's confidentiality. I have attempted to change information in a way that still accurately portrays the client and the therapy process.

CHAPTER II

The Client

James was a 60-year-old, married, Caucasian male, who sought out psychotherapy due to severe chronic pain in his lower back, and less severe but still significant pain in his groin, stomach, buttocks, shoulders, feet, and hips. James saw therapy as a “last ditch effort” to heal his chronic pain, because he was starting to believe that he had exhausted the plausible physical explanations and treatments for his pain. James had previously pursued back surgery, physical therapy, specialty pain clinics, and various medical injections (e.g., cortisone) to reduce his pain levels. James had a history of somatic ailments dating back to his childhood (e.g., back pain while playing youth soccer and gastrointestinal distress). However, in the past, James felt like he had always been able to find a satisfactory physical explanation and corresponding treatment for his ailments. James’ most recent incidence of chronic pain began five years ago, shortly before retiring.

James was diagnosed with Somatic Symptom Disorder, with predominant pain, persistent, severe, as described in the American Psychiatric Association’s (2013) Diagnostic Statistical Manual 5. James’ pain was both hindering him from engaging in pleasurable activities (e.g., he was hesitant to do any form of physical exercise or physical recreation because of the pain; he was hesitant to go on vacations for fear the pain would become too limiting of his activities) and was a cause of significant distress during daily activities, including sitting, walking, and bending over. James was consumed by thoughts of his pain, was worried that he would never get better and end up bed-ridden because of his pain, and spent most of his day thinking about the pain, pain treatments, and possible explanations for his pain.

After treatment concluded, my clinical supervisor and I completed a Shedler-Westen Assessment Procedure (SWAP; Shedler, 2015) assessment for James. The SWAP is an empirically-supported assessment tool, completed by clinicians, that provides information regarding a client's personality and offers potential insights into case formulation. According to James' SWAP, he likely met criterion for a diagnosis of Obsessive Personality Disorder.

James lived with his wife and had two adult children residing in different states. He was retired. James had a conflictual relationship with his wife. He felt like she was a "good mother" and was "loving" towards James, but he did not find their sexual relationship satisfying and sought out prostitutes to pursue sexual gratification. James' family had grown tired of his seemingly endless search for a cure to his pain and his constant complaining of physical discomfort.

James had no documented mental health history and had never sought mental health treatment. He remarked early on that was it not for his feelings of desperation, he never would have sought out psychotherapy. Prior to therapy beginning, James had been researching TMS online but had not read any of John Sarno's books on the subject. James knew from the beginning of treatment that I would be using an approach informed by the theory of TMS.

CHAPTER III

Guiding Conception, with Research and Clinical Experience Support

The Pain Epidemic

According to the National Research Council (2011), there are many current challenges to gathering accurate data on pain prevalence and “there is no standardization of methods, definitions, and survey questions regarding pain used in population-based studies across and within agencies” (p. 60). As an example, Johannes et al. (2010) state, “published point-prevalence estimates of chronic pain from population-based surveys vary widely...within the United States (US), from 14.6 to 64%” (p. 1230). Nonetheless, it is clear that chronic pain is a health epidemic in America. According to the Institute of Medicine’s 2011 report, chronic pain affects about 100 million American Adults (National Research Council, 2011). Using 2012 data from the National Health Interview Survey, Nahin (2015) estimates that 25.5 million adults experienced chronic pain in a three-month period. Chronic pain is associated with a myriad of health problems, including poorer overall health, depression, exhaustion, increased disability days, increased health care visits, emergency room visits, and health care usage (Nahin, 2015).

Within chronic pain, chronic back pain (most commonly of the lower back) is one of, if not the largest, represented pain symptom. It is estimated that as many as 70 percent of adults are affected by low back pain at some point in their lives (Anderson, 1997). In a 2009 study, 28.1 percent of adults age 18 and over reported experiencing low back pain (Centers for Disease Control and National Center for Health Statistics, 2010). In a nationally representative internet-based survey, the point-prevalence of chronic pain was 30.7 percent and chronic lower back pain was 8.1 percent (Johannes et al., 2010). In another nationally representative study, Hardt et al. (2008) estimated chronic back pain point prevalence to be 10.1 percent. Moreover, the presence

of chronic low back pain is increasing. Freburger et al. (2009) found the prevalence of chronic low back pain went from 3.9 percent in 1992 to 10.2 percent in 2006. Given the scope of chronic pain and back pain and considering that somatic symptoms are the leading cause of outpatient medical visits (Kroenke, 2003), developing effective treatments for chronic pain and chronic back pain is of considerable importance. Although the current research was not designed with consideration for the current opioid epidemic (e.g., The Council of Economic Advisers, 2017), this only bolsters the importance of developing non-drug treatments for pain.

The Insufficiency of Structural Models of Back Pain

It is beyond the scope of this paper to comprehensively review different models and explanations for chronic pain. A brief review will illustrate the insufficiency of what Sarno (1991) calls the “structural model” of back pain. Sarno describes how conventional medical training teaches the structural model of back pain:

Conventional medical training had taught me that these pains [of the neck, shoulder, back, and buttock] were primarily due to a variety of structural abnormalities of the spine, most commonly arthritic and disc disorders, or to a vague group of muscle conditions attributed to poor posture, under exercise, overexertion, and the like. Pain in the legs or arms was presumed due to compression (pinching) of nerves. However, it was not at all clear how these abnormalities actually produced the pain (p. vii).

The structural model of back pain assumes structural abnormalities are the main cause of chronic pain. Following this assumption, the treatment of back pain targets the structure of the back. Physical therapy and surgery are common treatment approaches focusing on a structural model.

There is a large body of research related to structural abnormalities of the spine and back pain. In 1994, the *New England Journal of Medicine* published a seminal study titled *Magnetic*

Resonance Imaging of the Lumbar Spine in People Without Back Pain (Jensen et al., 1994). The purpose of the study was to examine the spinal structure of asymptomatic people (i.e., people that were not reporting any symptoms of back pain). The results showed of 98 people without pain, only 36 had no structural abnormalities. The results further found “64 percent of these people without back pain had an intervertebral disk abnormality, and 38 percent had an abnormality at more than one level” (pp. 70-71). The authors concluded MRI’s showing “bulges or protrusions in people with low back pain *may frequently be coincidental*” (p. 69, italics added).

More recently, Brinjikji et al. (2015) conducted a systematic literature review examining spinal degeneration in asymptomatic populations. The authors found, “Disk degeneration prevalence ranged from 37% of asymptomatic individuals 20 years of age to 96% of those 80 years of age...Our study suggests that imaging findings of degenerative changes such as disk degeneration, disk signal loss, disk height loss, disk protrusion, and facet arthropathy are *generally part of the normal aging process rather than pathologic processes requiring intervention*” (pp. 812-813, italics added). In the same systematic literature review, the authors reviewed research examining structural abnormalities in individuals *with pain*, stating structural abnormalities are:

... not necessarily associated with the degree or the presence of low back pain...A systematic review of 12 studies found no consistent association between low back pain and MR imaging findings of Modic changes, disk degeneration, and disk herniation...Systematic reviews on the prognostic role of MR imaging findings for outcomes of conservative back pain therapies have failed to find an association between imaging findings and clinical outcomes. Perhaps most important, the relationship

between imaging findings and surgical outcomes has not been well established (pp. 813-814).

There is no consistent association between low back pain and structural abnormalities in the back. When magnetic resonance imaging detects a structural abnormality, this has not proven to be an effective predictor of surgical outcome. The structural model of back pain is not well established as it relates to both asymptomatic and symptomatic people.

Other Evidence Suggesting the Insufficiency of the Structural Model

There is evidence that suggests emotions and beliefs influence pain, and also that pain is contagious. For example, in Lithuania and in Greece, chronic whiplash injury is extremely rare (Ferrari, 2002). Ferrari argues that whiplash is a “social disorder” and that depending on the culture, there can be a hypervigilance regarding potential whiplash symptoms (and a subsequent amplification of symptoms due to symptom expectancies). As another example, 1988 data found that Carpel Tunnel Syndrome (CTS) “was the second most likely of 13 chronic conditions to be attributed to work” (Luckhaupt et al., 2013; p. 2). People commonly associate CTS with repetitive typing (i.e., attributing it to work) despite the fact that research suggests intensive keyboard use is actually associated with a *lower* risk of CTS (Atroshi et al., 2007). In a longitudinal study of 3,020 aircraft employees, Bigos et al. (1991) found that other than a history of back problems, job dissatisfaction and high scores on the Minnesota Multiphasic Personality Inventory Hysteria Scale were the best predictors of back injury reports. The authors state that the results “help explain why past prevention efforts focusing on purely physical factors have been unsuccessful” (p. 1). Smith et al. (2016) found that in rats, pain is contagious based on smell. “Bystander” rats (with no injury or noxious stimuli) exposed to olfactory cues from mice experiencing pain sensitivity also developed pain hypersensitivity (i.e., hyperalgesia).

To summarize, there are many lines of evidence that suggest pain is socially, culturally, and emotionally influenced. Moreover, Allan and Waddell (1989) provide a brief history on low back pain and disability, stating that chronic disability due to back pain only began in the late nineteenth century, corresponding with medical information that back pain was due to serious structural abnormalities and that in order to heal, rest was recommended. The authors conclude “much low back disability is iatrogenic” (p. 17).

Psychotherapy and the Treatment of Pain

If the structural model of chronic pain is insufficient, it would follow that non-structurally-oriented interventions could lead to pain reduction. Mirza and Deyo (2007) conducted a systematic review of randomized trials comparing surgical (lumbar fusion surgery) to nonsurgical treatment for chronic back pain. Non-surgical treatment could include physical therapy. However, multiple studies employed a cognitive-behavioral therapy (CBT) approach with no physical therapy for the treatment of pain. In these studies, the CBT approach involved challenging thoughts about physical activities that were not recommended and engaging in rigorous physical exercise. The authors conclude, “Highly structured rehabilitation with a cognitive-behavioral component seems nearly equivalent to surgery in efficacy at 1 year, with fewer complications” (p. 821). By FDA standards, there was no clinically meaningful difference between surgery and non-surgery.

Hoffman et al. (2007) conducted a meta-analysis examining psychological interventions for chronic low back pain (CLBP). The authors included studies of CLBP “from both known and unknown etiologies because of poor empirical associations between the presence of CLBP and evidence of structural pathology and because of concerns about the general unreliability of medical diagnosis and causal attributions for CLBP” (p. 2). In other words, the authors included

studies where individuals were experiencing chronic low back pain without an associated structural abnormality. The psychological interventions were not limited to CBT and included a category for “other” psychological interventions, including psychoanalytic interventions. The main results were that when all treatment groups were collapsed together (i.e., all put into one category for the purpose of statistical analysis), treatment was superior to all control conditions (also collapsed together) on pain intensity, pain interference, and health-related quality of life.

Importantly, the meta-analysis found that when treatment collapsed together was compared with the active control condition (it is not entirely clear what the active control included, but seems to have included some combination of physiotherapy and treatment as usual, defined as the “continuation of care”), treatment was not superior for pain intensity, pain interference, reduction of health care visits, or medications used at follow up. The meta-analysis “found little support for the comparative efficacy of psychological interventions relative to other active treatment conditions” (p. 7). In other words, psychological interventions are effective, but there was little support that psychological interventions are *more* effective than non-psychological interventions (e.g., physical therapy).

Considering the above finding, it can be asserted that the *mechanisms* leading to pain relief are not well understood. The research may suggest there are different pathways to alleviating pain. Another explanation could be that the causal mechanism for pain relief is not the type of treatment but another common factor (e.g., being cared for and listened to by a professional, or believing that treatment will work). Thus, research carefully examining the possible mechanisms contributing to a reduction in pain adds meaningfully to existing research.

Psychodynamic Therapy and Pain

While the mechanisms leading to the alleviation of pain may not be clear, it is clear that psychotherapy is a viable option for the treatment of chronic pain. Since the theory of TMS (discussed in the next section) is informed by psychodynamic principles (e.g., repression; the id, ego, and superego; self psychology) integrating a psychodynamically-informed therapy model with TMS is a natural fit (see *Rationale for the Integration of TMS and CMT* for further discussion). Much of the existing empirical research on psychodynamic therapy examines various Short-Term Psychodynamic Psychotherapies (STPP). While there is a dearth of research on STPP for back pain specifically, there is research suggesting STPP are effective for the treatment of somatic symptoms.

Abbass et al. (2009) conducted a systematic review and meta-analysis of STPP for somatic disorders, with all STPP models having “the common goals of making unconscious phenomena conscious and working through underlying conflicts” (p. 266). Six of the studies involved patients with chronic pain. The authors found 91.3 percent of studies reported significant symptom benefits related to the main physical condition; 76.2 percent found significant psychological symptom benefits; and 77.8 percent reported significant reductions in healthcare utilization. In another systematic review and meta-analysis examining a specific type of STPP called Intensive Short Term Dynamic Psychotherapy (ISTDP), Abbass et al. (2012) found six studies using ISTDP for somatic disorders. ISTDP was found to significantly improve self-reported somatic symptoms and lead to a reduction in medically unexplained symptoms.

Recently, Lumley et al. (2017) conducted a cluster-randomized controlled trial comparing CBT, Fibromyalgia (FM) education, and Emotional Awareness and Expression Therapy (EAET) for the treatment of FM. EAET “borrows techniques from different therapies: experiential,

intensive psychodynamic, prolonged exposure, expressive writing, and therapeutic rescripting” (p. 2355). EAET significantly outperformed FM education on many outcomes including overall symptoms, widespread pain, and physical functioning. EAET and CBT achieved comparable outcomes and notably, EAET had “a higher percentage of patients achieving 50% pain reduction (22.5% vs. 8.3%)” (p. 2354).

Considering the above research, psychodynamically-informed therapy seems to be a viable option for the treatment of chronic back pain.

Tension Myositis Syndrome (TMS)

The medical doctor John Sarno wrote four books on TMS, with each book offering the latest evolution of his ideas on TMS and what he terms “Mind-body Disorders.” The basic principles of Sarno’s theory are quite simple. TMS is “a benign (though painful) physiologic aberration of soft tissue (not the spine) and it is caused by an emotional process” (Sarno, 1991; p. vii). Psychosomatic symptoms (i.e., pain) are “created to assist the repression of rage and other unacceptable feelings” (Sarno, 2007; p. 94). McWilliams (2011) states, “The essence of repression is motivated forgetting or ignoring...Only when there is evidence that an idea or emotion or perception has become consciously inaccessible because of its power to upset are there grounds for assuming the operation of this defense” (p. 127). Sarno asserts that psychosomatic pain is a way to distract oneself from unconscious feelings that are too dangerous and/or too painful to be brought into conscious awareness.

While Sarno uses Freud’s structural model of the mind (i.e., id, ego, superego) he believed Freud was overly focused on repression as a defense against socially unacceptable sexual thoughts. Sarno believed anger and rage are the primary emotions in need of repression, although other “negative” feelings can also be involved in TMS. Sarno (2007) draws many

parallels between modern day back pain and the nineteenth-century patients with hysterical symptoms whom Freud used to develop many of his theories. One key difference, however, is whereas Freud thought hysterics used organic pain for neurotic purposes (i.e., the pain was first physical and then used for other purposes), Sarno believed the mind creates pain to serve a distraction function (i.e., the pain is first emotional and then the mind works with the body to create the pain). The pain is not “made up” or “all in the head.” It is initiated by the brain/mind, which then causes a real, physiological change - via mild oxygen deprivation - leading to pain.

Sarno (1991) proposes there is a myriad of physical disorders that serve the same function (i.e., distraction/aiding in repression) as TMS. These include, for example: headache, peptic ulcer, migraine, eczema, psoriasis, irritable bowel syndrome, acne, asthma, tinnitus, and fibromyalgia. It is important to note, then, that although TMS is best known as a theory of psychosomatic back pain, Sarno believed the theory is relevant to a myriad of other somatic disorders not necessarily involving pain in the back. This makes his approach widely applicable and useable.

As aforementioned, Sarno (1991) posits that the physiology of TMS-induced pain occurs through mild oxygen deprivation. More specifically, “the autonomic system selectively decreases blood flow in certain muscles, nerves, tendons, and ligaments in response to the presence of repressed emotions like anxiety and anger” (p. 72). Sarno’s explanation as to why mild oxygen deprivation is the physiological etiology is as follows: (1) “Many of the body’s reactions to tension and anxiety are the result of abnormal autonomic reactions” (p. 72), (2) Heat, deep massage, and active exercise are all capable of relieving pain, and all of these increase blood flow, thereby increasing oxygenation, (3) Fassbender and Wegner (1973) found “microscopic changes in the nuclei of biopsied muscles from back pain patients suggesting

oxygen deprivation” (Sarno, 1991; p. 73), and (4) Lund et al. (1986) found abnormal or low muscle oxygenation in patients with fibromyalgia, which Sarno believed was an equivalent of TMS. Sarno (1991) de-emphasizes the importance of understanding the pathophysiology of TMS, stating “Though it may be of academic interest, knowing the physiology of TMS with certainty is not essential” (p. 81).

Sarno (1991) describes common personality characteristics of the TMS patients he has seen. They include: (1) a high degree of conscientiousness and sense of responsibility for self and others; (2) low self-esteem (resulting in a strong/compulsive need to achieve); (3) competitiveness; (4) being accustomed to putting significant pressure on oneself; (5) being accomplished in their domain of expertise; (6) perfectionism; (7) tendencies to deny emotional concerns; (8) high levels of unconscious anxiety; (9) narcissism (especially narcissistic rage); (10) family conflict; (11) a strong sense of the “tyranny of the should” (p. 50); (12) parent(s) or caregivers that disapproved of the TMS patient’s anger (implicitly or explicitly); (13) strong superego tendencies (i.e., internalizing that it would be culturally/social unacceptable to express severe rage); (14) a history of trauma; (15) high levels of fear related to somatic pain. (James, upon reading the book, would remark “It’s almost like he wrote the book about me.”) Sarno also reports that TMS patients usually have a history of experiencing what he terms the “symptom imperative” (or what Freud would have called symptom substitution), meaning that when one symptom goes away (e.g., through something like physical therapy), if the underlying emotional issue was not dealt with, a new symptom will emerge (e.g., pain will appear in a new location, or someone will develop a TMS equivalent like irritable bowel syndrome).

In a survey of 104 of his own patients, Sarno (2007) found the “perfect-good tendency” (defined as a drive towards perfectionism and being “good” due to a desire to seek others’

approval, often compulsively caring for others at one's own expense) to either be the predominant factor or a very significant factor in 94 percent of his patients. He cites life pressures (e.g., financial pressures) and child abuse as other common contributors to rage that must be repressed.

TMS Treatment

There are two foundational components of TMS treatment. First, treatment centers around helping a patient accept the idea that emotional factors are the cause of physical pain. This is done primarily through providing information and explaining TMS (often times through attending a psychoeducational group for multiple meetings), which helps the patient build insight into the nature of the disorder. Second, the patient must then “act on that knowledge and thereby change the brain's behavior” (Sarno, 1991; p. 90). Sarno asserts patients must “think psychological,” which means when physical pain occurs, one must think about concurrent psychological and emotional experiences. In doing so, pain can no longer serve a distracting function, and thereby the pain will diminish or go away completely. Sarno also recommends “talking to your brain,” essentially telling the brain that the person is not going to allow for a defensive pain response.

Resuming all physical activity is part of the acting on the knowledge and is considered one of the most important parts of recovery. The patient must overcome fear related to engaging in vigorous physical activity. Resuming physical activity commences once a patient has reasonable confidence in the TMS diagnosis. Sarno also recommends discontinuing all physical treatment (e.g., physical therapy) because physical treatment reinforces the idea of the structural model of pain. Stopping such treatment reinforces the idea that repressed emotions are at the

core of the pain. Sarno recommends reviewing 12 “daily reminders” at least once a day (see Appendix 1).

It is critical to note that Sarno is clear that processing emotions is *not* a required part of treatment. While accepting the TMS diagnosis and the idea that emotions like rage are causing pain may contribute to the unearthing of repressed emotions (and subsequent processing of such emotions), this is not a requirement of treatment.

Psychotherapy for the Treatment of TMS

Sarno (1991) estimates that 95 percent of his patients go through his program without psychotherapy. He believes the five percent in need of psychotherapy have more significant levels of repressed emotion. Put another way, one’s feelings may be so threatening, and so deep, that there is an almost unbreakable resistance to the idea that an emotional, instead of a structural or physical cause, is the reason for physical pain – the person has little tolerance for difficult affective experiences.

Sarno does not elucidate specific psychotherapy techniques, but given the other tenants of his program, it can be extrapolated that therapy involves working with patients to lessen the rigidity of repression as a defense, leading to the person being better able to accept a TMS diagnosis. It would seem to follow that therapy must both unearth repressed emotion and help the person tolerate the corresponding affective experience (i.e., develop a coping mechanism for difficult emotions that does not involve somatization). To reiterate, though, changing one’s personality to be less anxious or angry is not necessary to become pain-free. Instead, fully accepting that repressed emotions are driving the pain response is the sine qua non of healing. Sarno (1991) states,

It is not changing one's emotions; it is recognizing that they exist and that the brain is trying to keep one from being aware of their existence through the mechanism of the pain syndrome. That is the key point in understanding why the knowledge is the effective cure (p. 108).

While not a requirement per se, given the symptom imperative, it would seem working through/processing repressed emotion while developing greater affect tolerance would be the best defense against developing a new TMS equivalent.

Empirical Support for TMS and TMS Treatment

Sarno (1991) reports on TMS treatment outcomes:

In 1982, we did a follow-up survey on 177 patients who had been treated between 1978 and 1981. Seventy-six percent were leading normal lives with little or no pain, 8 percent were improved, and 16 percent were unchanged. Some of those patients had not had the benefit of lectures, and in many other ways the program was not as sophisticated as it is now (p. 103).

While such results are impressive, they should be interpreted with extreme caution. There is no discussion of how the survey was conducted, information about response rate, what scales/measurements were used to assess pain, no control group, no random assignment to treatment or control conditions, and other methodological considerations. Sarno reports on another TMS study:

In 1987, a similar follow-up study was done, this time on a group of patients who all had CT scan– documented herniated discs and had the TMS program between 1983 and 1986. This time, 88 percent (ninety-six people) were successful, 10 percent were improved, and only 2 percent were unchanged (p. 103).

While this study has the same limitations (and what “successful” means is not operationalized), it is particularly noteworthy that all of these patients had structural abnormalities of the spine.

In another outcome study, Sarno (2007) reports “summer” 1999 data from 104 patients seen consecutively for two and a half months. Between six and seven months post-treatment, patients were interviewed via telephone to assess treatment outcomes. 85 participants responded. There were four treatment categories:

1. Consultation and lectures only: fifty-nine patients (69 percent)
2. Consultation, lectures, and group meetings: five patients (6 percent)
3. Consultation, lectures, group meetings, and psychotherapy: twelve patients (14 percent)
4. Consultation, lectures, and psychotherapy: nine patients (11 percent; p. 180).

The results were as follows:

1. Thirty-seven patients (44 percent) reported they now had little or no pain.
2. Twenty-two patients (26 percent) reported they were now 80 to 100 percent improved.
3. Thirteen patients (15 percent) reported they were now 40 to 80 percent improved.
4. Thirteen patients (15 percent) reported no change to 40 percent improvement (p. 180).

Functional mobility was also assessed:

1. Forty-six patients (54 percent) reported they were now unrestricted physically.
2. Eighteen patients (21 percent) reported they were 80 to 100 percent of normal.
3. Twelve patients (14 percent) reported they were 40 to 80 percent of normal.
4. Nine patients (11 percent) reported no improvement to 40 percent of normal (pp. 180-181).

While this study represents the most thorough in terms of measurements and methodology, it should still be interpreted with caution given the lack of randomization, the potential for researcher bias, and the fact that Sarno screens patients to assess the probabilistic likelihood that they can benefit from the program (he acknowledges that very few people will be open to TMS as a diagnosis). Thus, these results do not represent the “average” chronic back pain patient within the population. Nonetheless, the results do suggest that for a subset of chronic pain patients, TMS treatment may be highly successful.

Anecdotal Support for TMS and TMS Treatment

The anecdotal support for treating TMS is more substantial than the empirical research. There are numerous celebrities that have touted the benefits of TMS treatment including: radio host Howard Stern and actress Anne Bancroft (Neporent, 1999), news anchor John Stossel and television writer and producer Janette Barber (Stossel, 1999), filmmaker Terry Zwigoff (Pearson, 2010), comedian Larry David (Belluz, 2017), professional golfer Ben Crane (Weir, 2008) and former Democratic Senator Tom Harkin (Farber, 2014). Well-known “celebrity” medical doctor Andrew Weil recommends *Healing Back Pain* (Sarno, 1991) in his book *Spontaneous Healing* (Weil, 2000). In 2016, Beilinson et al. released a documentary titled “All The Rage (Saved By Sarno).” The documentary describes Sarno’s work and chronicles one of the documentarian’s experience with chronic pain and TMS. There is a well-supported and comprehensive TMS Wiki page (http://www.tmswiki.org/w/index.php?page=The_Tension_Myositis_Syndrome_Wiki) and a nonprofit organization called the PPD/TMS Peer Network that sponsors the site. On the Wiki site, as of this writing (January 2018) there is a section titled “Success Stories by Symptoms & Diagnoses” with 72 different symptoms and diagnoses listed with links to success stories.

As of this writing (January 2018) Sarno's (1991) book has 1,660 reviews on Amazon.com with an average 4.5/5 star rating; his 2001 book has 553 reviews with an average 4.5/5 star rating, and his 2007 book has 343 reviews and an average 4.5/5 star rating. There is a website dedicated to Sarno titled "Thank You, Dr. Sarno" (www.thankyoudrsarno.org) with 178 thank you letters to Dr. Sarno. (To illustrate the transformational effect TMS treatment has for some individuals, I have included three thank you letters from the site in Appendix 1. To minimize selection bias, I used the three most recent letters as of January 28, 2018.) Lastly, I will note that both myself and Dr. Axelbank were healed and pain-free using a TMS treatment approach (this offers both anecdotal support and also is important to note given the potential for bias and our desire for the treatment to "work" for James).

Control Mastery Theory (CMT)

As mentioned, the case of James involved a therapy approach integrating the principles of TMS with CMT. Here I provide an overview of CMT (see *Rationale for Integrating TMS and CMT* for an explanation as to why I thought the integration made sense).

CMT, developed by Weiss, Sampson, and the Mount Zion Psychotherapy Research Group (now called the San Francisco Psychotherapy Research Group) is an empirically supported "model of how psychopathology develops (traumatic experiences lead to pathogenic beliefs) and how psychotherapy works (the disconfirmation of pathogenic beliefs)" (Silberschatz, 2013c; p. 231). Thus, CMT is not a particular set of therapeutic techniques but instead represents a meta-theory of psychopathology and the therapy process. Although CMT can be used to understand how therapies from different modalities work, its underpinnings are significantly influenced by psychodynamic/object relations theory (Messer and Warren, 1998). Control Mastery Theory uses a structured, empirically supported approach to case formulation

called the *Plan Formulation Method*. From the individualized plan formulation, the therapist uses a variety of techniques to disconfirm the patient's pathogenic beliefs: "With such a correct formulation in mind, there are a myriad number of ways (techniques) that a therapist could employ to help the patient. The most effective approaches or techniques will be those that match the patient's problems, needs, and personality" (Silberschatz, 2013c; p. 231).

CMT asserts that pathogenic beliefs most often originate in traumatic childhood experiences (although pathogenic beliefs could develop later in life as well). Such beliefs are "usually unconscious, are extremely frightening and constricting because they suggest that the pursuit of an important goal is fraught with danger" (Silberschatz, 2013b; p. 4). A child develops pathogenic beliefs in an attempt to maintain caregiver/attachment bonds. While pathogenic beliefs can be adaptive in childhood, they become maladaptive and destructive. However, the beliefs are maintained due to the perception that other beliefs and behavior would be dangerous.

An example helps clarify the theory. If, during the process of a child's separation and individuation, the caregiver became depressed and more distant, the child could develop the pathogenic belief that greater independence results in other people (in this instance, the caregiver) being depressed, and emotionally abandoning the child. Thus, to maintain the attachment bond, the child may stop pursuing her own separation/individuation needs, which may indeed be adaptive within the family dynamic. However, as an adult, that same person may behave in ways so as not to be too much of an individual (e.g., always letting other people have the spotlight) or may become highly anxious upon receiving a promotion (which could lead to greater autonomy and separation).

CMT posits that in therapy, the patient has an unconscious plan/strategy for how to “disconfirm or relinquish pathogenic beliefs in order to proceed with normal development” (Silberschatz, 2013b; p. 8). Therapy is effective when it helps the patient disconfirm his pathogenic beliefs (i.e., the disconfirmation of such beliefs is the purported *mechanism of change* across all therapies). There are three primary ways to disconfirm pathogenic beliefs, and most patients will use a combination of all three:

- (a) use the therapeutic relationship per se to disconfirm beliefs,
- (b) use the knowledge or insight conveyed by the therapist’s interpretations to disconfirm beliefs, and
- (c) test the pathogenic belief directly with the therapist (Silberschatz, 2013b; p. 10).

There are two types of tests patient’s use: *transference tests* and *passive-into-active tests*. “In a transference test, the patient attempts to assess whether the therapist will traumatize her in the same ways as she was previously traumatized in her family of origin” (Silberschatz, 2013b; p.12) and in a passive-into-active-test, “the patient tries to traumatize the therapist, as the patient had been traumatized earlier in life, in order to see if the therapist can deal with trauma in a more effective manner than the patient could” (p. 14).

Using the *Plan Formulation Method*, the therapist assesses the patient’s pathogenic beliefs and develops a highly individualized plan of how to disconfirm such beliefs in the course of therapy. There are five components to the *Plan Formulation Method* (Curtis & Silberschatz, 2013; pp. 87-88):

1. *Traumas* the patient has experienced
2. *Pathogenic beliefs* the patient has developed
3. The patient’s *goals* for therapy

4. How the patient is likely to *test* the therapist
5. *Insights* that would be helpful for the patient to obtain

To reiterate, CMT is not prescriptive in terms of specific technique, although interpretation (in the psychodynamic sense) is often used. Instead, technique is “discussed in terms of “plan compatibility,” that is, the congruence of therapist interventions with the patient’s plan” (Messer and Warren, 1998; p. 154).

Empirical Support for CMT

Here I will only briefly highlight key research findings and components of CMT (for a more comprehensive review, see Shilkret & Silberschatz, 2013 and Silberschatz, 2013a). First, research on CMT has focused on therapy process, not outcome, often utilizing single case, repeated measures designs (Messer and Warren, 1998). Second, much research on CMT has been done *after* the completion of therapy: “the research paradigm has been to empirically investigate how psychotherapy works regardless of the therapist’s (or the patient’s) theory of how therapy works (Silberschatz, 2013a; p. 190). The plan formulation method has “excellent interjudge reliabilities (typically in the .8 to .9 range)” (p. 193) and has been applied to cases with diverse psychopathology and diverse theoretical orientation. CMT has shown to be an effective way to understand both short- and longer-term therapies. There is strong inter-rater reliability in terms of trained judges agreeing upon what represents a patient’s test, and there is a statistically significant correlation between passing a test and the “patient’s level of experiencing, boldness, relaxation, and expression of loving feelings, anxiety, and fear (p. 198). In other words, a patient is more productive after the therapist passes a test. Moreover, there is a statistically significant correlation between the plan compatibility of an interpretation and the patient’s productivity, which offers support for the importance of plan compatible interventions

(as opposed to say, dogmatic technique). Plan compatibility has also been shown to be positively correlated with therapy outcome.

Rationale for Integrating TMS and CMT

A TMS approach to treatment has, anecdotally, been transformative for hundreds (if not thousands) of patients. For a small subset of those seeking TMS treatment, psychotherapy is needed, but Sarno does not prescribe specific psychotherapy techniques. There exists literature and theory of how to treat TMS patients from psychotherapists that have trained with Sarno (e.g., Anderson & Sherman, 2013; Anderson, 2013), but no empirical research (1) detailing a TMS-informed treatment with the use of video-recordings and a full narration of treatment, and (2) quantitative outcome measurements of such a treatment. Moreover, there is a dearth of high quality, empirical research on Sarno's treatment model for TMS.

Since the theory of TMS already integrates psychodynamic theory (e.g., Sarno [2001] cites Freud's structural theory of the mind and Kohut's ideas on narcissism), and since one of the central tenets of psychodynamic therapy is to make what was unconscious, conscious, it seemed a natural fit to integrate a psychodynamically-influenced therapy model with the theory of TMS. I will next discuss the ways in which psychoanalytic therapy and the theory of TMS add to each other.

The theory of TMS provides *a priori* assumptions about the etiology of one's chronic pain (repressed negative emotion) and the defense mechanisms the patient will use (repression as a primary defense with potential isolation of affect and/or dissociation). While it would be axiomatic within psychoanalysis that symptoms always have meaning, it is far from likely that a psychodynamic clinician would develop a TMS-based formulation. In *Pathways to Pain Relief* (Anderson & Sherman, 2013), two psychodynamically-trained therapists who also trained with

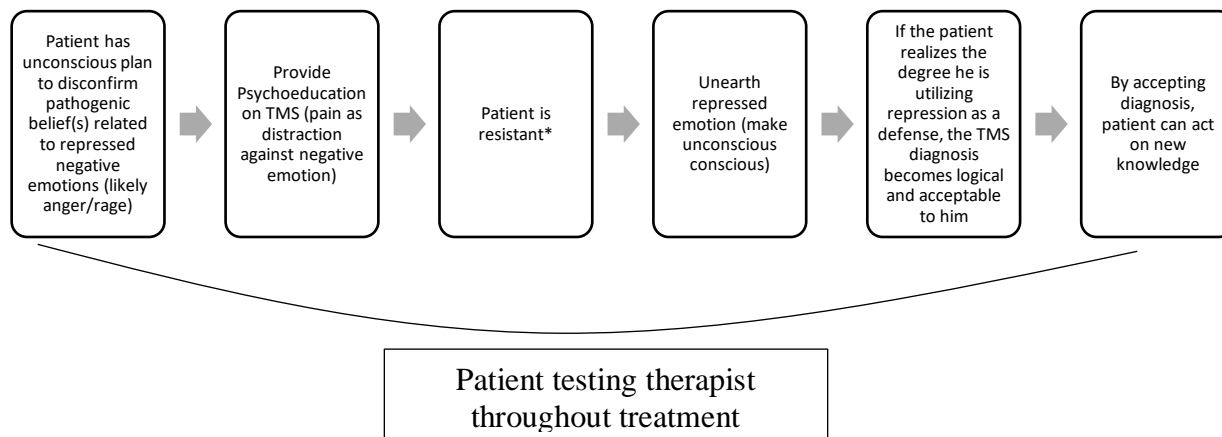
Sarno discuss how the psychodynamic clinician without knowledge of TMS is susceptible to making the *wrong* formulation. Specifically, the clinician might focus on how the patient needs to “accept his limits,” and that the desire to be pain-free represents a form of omnipotent fantasy. The therapist might encourage the patient to mourn the loss of physical ability. This is clearly antithetical to Sarno’s approach.

Sarno’s treatment approach also involves specific cognitive and behavioral techniques (see *Tension Myositis Syndrome Treatment* above). To be clear, Sarno is not borrowing from CBT for the treatment of pain. In fact, he is quite critical of the behavioral theory of pain as serving a secondary gain function (Sarno, 1991). Instead, these are strategies that he has developed through his work with TMS patients.

Broadly speaking, psychodynamic theory and therapy offer a framework for understanding the unconscious, dealing with defenses, eliciting affect in therapy, and working through difficult feelings, often times through the therapy relationship (i.e., the transference). Psychodynamic theory also provides a framework for how to dyadically regulate and metabolize difficult feeling states. CMT, more specifically, offers a structured approach to case formulation while also offering a model flexible enough to easily incorporate the theory and treatment of TMS. Whereas assigning the patient to review Sarno’s 12 daily reminders would go against a standard dynamic therapy (i.e., psychodynamic practice does not usually involve assigned out-of-session activities), such an intervention is not inherently inconsistent with CMT, as long as the assignment is considered plan-compatible. Below, I discuss how I conceptualized, pre-treatment, the ways that TMS and CMT would work together.

Integrating TMS and CMT

Figure 1 represents how I envisioned an integrated TMS/CMT treatment would proceed.



**This can be assumed because if a patient was not resistant to the idea that negative emotion was causing the pain, the patient would have healed from reading one or more of Sarno's books, which has been the case for many people.*

Figure 1: Conceptual Model of Integrated TMS/CMT Treatment

With someone diagnosed with TMS, there is already an explicit focus of therapy: physical pain as a distraction against repressed feeling. There are also certain prescriptive exercises (e.g., thinking psychological). Thus, from the theory of TMS, I hypothesized the following would be effective therapist interventions:

- 1) Help the patient become more aware of negative feelings (e.g., rage)
- 2) Help the patient become aware of defenses against negative feelings
- 3) Help the patient experience and tolerate affect without relying on somatization (i.e., negative emotion does not have to be repressed)
- 4) Help the patient track/monitor pain and develop greater capacity to consider emotional antecedents to pain (e.g., helping a patient recognize that she was angry and then had a pain flare-up)

Every patient has an individualized plan formulation that informs and guides the therapist as to how to work with the patient to disconfirm the patient's pathogenic beliefs. At the same time, a TMS-informed formulation allows for hypotheses regarding components of the plan formulation. Figure 2 provides examples:

Figure 2: Examples of probable components of a TMS patient's plan formulation

Traumas

- The patient had early experiences with caregivers where anger/rage/other intense feelings of the patient evoked strong reactions from the caregivers (e.g., the patient remembers that every time he would yell at his mother, his mother would begin sobbing).

Pathogenic Beliefs

- The expression of anger/rage damages or destroys close relationships
- Having angry feelings, even if unexpressed, means I am a bad/evil person
- I must sacrifice my own needs, wants, desires, and feelings to maintain close relationships
- If I express anger, I will be punished or abandoned

Goals

- Be in less physical pain (conscious goal)
- Be able to experience negative emotions previously repressed without destruction of self or other (therapist)

Tests

- Express anger, argue, or communicate other negative emotion to therapist to see if the therapist will be destroyed, retaliate, or will abandon me (transference test)

- Be dismissive of emotions and feelings; tell the therapist that anger has no purpose/place in the relationship (passive-into-active test)

Insights

- The patient's anger was not the root cause of the caregivers' emotional volatility
- Feeling angry is not the same as acting on the anger
- Ambivalent feelings about relationships are normal
- The patient can assert his own needs without ruining relationships (i.e., the perfect-good tendency is not necessary)
- The patient had to repress significant amounts of negative feeling and at one point this was an important survival/attachment strategy, but is not any more

Taken together, then, I propose that an integrated TMS/CMT treatment will involve providing psychoeducation about TMS and prescribing Sarno's tenants of treatment (thinking psychological, resuming physical activity, discontinuing other treatments, and reading daily reminders). By helping the patient to identify repressed emotions and passing a patient's tests related to pathogenic beliefs, the patient will be able to tolerate negative affect that previously had to be relegated to the unconscious, resulting in somatic pain as a distraction against feeling. As the patient gains insight into the degree that he was using repression, the diagnosis of TMS as an explanation for somatic pain becomes logical and believable, and in fully *accepting* the TMS diagnosis, the patient's pain should dissipate.

Summary

Chronic pain and chronic back pain is a health epidemic that cannot be explained by structural issues of the back/spine. Psychotherapy is an effective treatment for somatic complaints and back pain, although the exact mechanisms leading to a reduction in pain are

unclear. There is limited research on psychodynamic therapy for back pain. There is also limited research on the theory and treatment of TMS, although anecdotally the theory has proven to have significant utility. There is a natural integration between psychodynamic theory and therapy with the theory of TMS. CMT, specifically, offers a flexible, broad, empirically supported framework to integrate with TMS. Integrating TMS into a psychodynamic therapy model is unique in that there is a more explicit, pre-determined focus and formulation; there is a dedicated psychoeducational component of treatment; and there are specific behavioral interventions recommended. Such a treatment has not been studied before. Further development and testing of a treatment model could help not only those suffering from back pain, but also those suffering from the myriad of TMS equivalents.

Chapter IV

Assessment of the Client's Presenting Problems, Goals, Strengths, and History

Presenting Problems and Medical History

James sought treatment for longstanding chronic pain that was interfering significantly with his daily functioning. He was spending considerable time researching possible explanations for, and treatment of, his chronic pain, avoided and/or altered physical tasks due to his pain, and spent most of the day thinking about the severity of his pain. During the initial interview, he brought a device to place on the seat to try and make sitting more comfortable, but when he saw the cushioned chair arranged for him, he stated, "I can't sit in that chair... I'm usually not too good on a soft cushion" (James stood for roughly half of the 1 hour and 45-minute interview). Shortly thereafter he stated, "I'm going to tell you something to break the ice a little. My doctor who I've been seeing for over 30 years says I look fantastic on paper, but I'm falling apart one piece at a time." Indeed, James appeared in good physical condition and looked younger than his stated age.

James had a long and complex medical history. Due to back pain that developed later in his life, James began seeing a chiropractor. Because he did not experience improvement, he consulted with a second chiropractor who referred him for medical exams revealing his "back was a mess" with a disc protrusion of one-half an inch. He subsequently had a five-and-a-half hour back surgery with a doctor "known all over the country." While James' surgeon asserted that James could return working and that his back was in "good shape," James' pain came back "before I got out of the hospital." James consulted with another doctor and it was determined he needed a hip replacement. His hip was replaced two months later, upon which James "felt pretty good" for about six years. When James' pain returned, he attributed it to picking up a heavy

object while doing yard work: “about two weeks after that my back and my hip started to hurt” (this was not the hip that had been surgically replaced). He subsequently had his other hip replaced but his hip “never felt better.” James began taking multiple non-opiate pain medications and anti-inflammatory medications. James had pursued various treatments including: multiple courses of physical therapy; myofascial release; over-the-counter vitamins and supplements; dry needling; spinal injections; and muscle injections.

From this point forward, James experienced pain while sitting, experiencing a “very uncomfortable tingling sensation” in his buttocks. He tried to avoid sitting as much as possible and would research the seating apparatus at restaurants and other public spaces before going to his destination. His pain had an inconsistent presentation: “At one point I was able to sit but couldn’t walk, then at another point I could walk but I couldn’t sit. Now I can’t do either one.” He experienced a “shooting pain” in his knee if he walked for longer than 30 minutes; tightness in his feet and stomach; and pain in his shoulders. Walking up stairs was difficult as was bending down.

James went back and forth as to whether it was possible that there was a physical explanation for his pain. Early in the interview, he stated,

I’ve had every exam possible...At this point right now, more than one very well rated orthopedic or neurosurgeon has said there’s nothing wrong with my back. As a matter of fact, my particular neurosurgeon said that my back is probably very good for a guy that’s been through as much as I have. There’s nothing wrong with either one of my hips.

There’s really no scientific evidence to support what’s going on in my body right now. But, shortly thereafter, James was discussing a cortisone injection he received in his leg a few weeks prior and stated,

Everything felt normal. My whole body felt relaxed. My stomach muscles relaxed... Anyway, that makes it look like the cortisol in my blood might be even more of a possibility... When you stop and think about it, it has to be something bigger than what might be getting squeezed in the hip or what might be going on in the back, because at one point in time I was sore literally from my shoulders all the way down to my feet. And because I have this tightness in my feet as well as the rest of my body, that's an indicator that something should be wrong with my back, but nobody sees anything being wrong.

James estimated he had been through 8-10 surgeries throughout his life. He summarized why he was seeking therapy by stating that he had seen multiple physical therapists, two neurosurgeons, four pain management doctors, and received "every injection that you could think of, and here I am [seeking therapy]." While not stated in the initial interview, in a later sessions James remembered experiencing back pain as a pre-teen and irritable bowel syndrome (IBS) as a young adult. (Sarno [1991] considers IBS to be a TMS equivalent.)

During the initial interview, James focused on how his pain was leading to functional impairments but did not discuss feelings of hopelessness, depression, or anxiety. His mood was euthymic and he did not appear or sound depressed or exhibit outward behavioral manifestations of anxiety.

Quantitative Assessment Measurements

In addition to gathering initial qualitative data related to James' experience of pain, a battery of quantitative assessment measures was used. The Initiative on Methods, Measurement, and Pain Assessment in Clinical Trials (IMMPACT; Dworkin et al., 2005) recommends that, "6 core outcome domains should be *considered* when designing chronic pain clinical trials. These 6

core outcome domains were: (1) pain; (2) physical functioning; (3) emotional functioning; (4) participant ratings of improvement and satisfaction with treatment²; (5) symptoms and adverse events; and (6) participant disposition³” (p. 10). The following measurements were used per the recommendations of IMMPACT and are considered to have excellent psychometric properties:

- 1) Beck Depression Inventory (Beck et al., 1961).
- 2) Numerical Pain Rating Scale (Farrar et al., 2001).
- 3) The Short Form McGill Pain Questionnaire and Pain Diagram (Melzack, 1987).
- 4) 36-Item Short Form Survey Instrument (SF-36; Ware and Sherbourne, 1992).
- 5) Brief Pain Inventory Short Form, Interference items only (Cleeland and Ryan, 1994).
- 6) The Roland-Morris Low Back Pain and Disability Questionnaire (Roland and Morris, 1983).

Because emotional functioning was of special importance to the present study, the following measurements were used to further assess emotional functioning and are considered to have excellent psychometric properties:

- 7) Outcome Questionnaire 45.2 (OQ-45.2; Miller et al., 2003).
- 8) Beck Anxiety Inventory (BAI; Fydrich et al., 1992).

Because Sarno (1991) discusses child abuse as a common feature for a subset of TMS patients, the Adverse Childhood Experiences (ACE) Questionnaire (Felitti et al., 1998) was also used.

² Note that I did not include a quantitative measure for this domain because I assumed that throughout the course of the treatment, the qualitative self-report by the patient would be sufficient. Retrospectively, it might have been illuminating to administer the Patient Global Impression of Change scale as Drowkin et al. recommend.

³ This recommendation would not pertain to a single-case study and thus no measure was included.

The original design was for the patient to complete the assessment measurements after the initial intake interview. (I thought it was important to conduct an initial interview first in order to build rapport and to assess the appropriateness of the case for the current research.) However, because the initial interview lasted almost one hour and 45 minutes, assessment measurements were completed before the second meeting, with the exception of the Brief Pain Inventory Pain Interference items, which were completed before the third meeting due to the patient running out of time to complete the measurement before the second meeting.

Quantitative Assessment Measurements Results

Results of all assessment measures can be found in Tables 2-10. The Beck Depression Inventory-II is a 21-item self-report measurement used to assess depression symptomology. James received a score of 19, indicative of mild depression. He most strongly (i.e., a score of 2) endorsed items related to pessimism and agitation.

A 10-point Numerical Pain Rating Scale (NRS) was used to assess pain intensity in which 0 represented no pain, 5 represented moderate pain, and 10 represented the worst possible pain. James was to indicate the number that best described his pain on average in the last 7 days. James' score was a 6.5. An NRS is a standard primary outcome measure for chronic pain treatments and can be used to assess if the patient is improving over time (e.g., if James' pain intensity scores decreased in subsequent measurements). A change of 2 points is considered a meaningful change in pain (Drowkin et al., 2005).

The Short Form McGill Pain Questionnaire and Pain Diagram (Melzack, 1987) was used to assess the *quality* of James' pain. The self-report questionnaire contains 15 sensory (e.g., throbbing; sharp) and affective (e.g., sickening; fearful) pain descriptors resulting in a total score and sensory and affective subscale scores. There are no established clinical cut-offs. Higher

scores indicate greater pain symptomology, with sensory scores ranging from 0-33, affective scores ranging from 0-12, and total scores ranging from 0-45. James received a sensory score of 6, endorsing severe cramping, moderate aching, and mild shooting pain. He received an affective score of 4, endorsing moderate “fearful” and “cruel-punishing” levels of pain. His total score was 10. The pain diagram was not used because I believed I had an accurate picture of the locations of his pain from his self-report during the interview and throughout the course of therapy.

The 36-Item Short Form Survey Instrument (SF-36; Ware and Sherbourne, 1992) is a self-report measure that broadly assesses health related quality of life and can be used as a generic measure of physical functioning. There are 8 subscales, with possible scores ranging from 0-100 and a higher score representing better/higher well-being/functioning. There are no clinical cut-off points or interpretive categories for various scores. James received a score of 25 for physical functioning and 25 for role limitations due to physical health. These were his lowest (worst) scores, consistent with his presentation in therapy. He received a 32.5 for pain and 37.5 for social functioning. Social functioning is composed of two items and assesses the degree to which physical or emotional problems are interfering with normal social activities; James responded “some of the time” on one item and “quite a bit” on the other item.

The Brief Pain Inventory (BPI) Short Form is a self-report measure and the interference items were used to assess physical functioning and the degree to which pain interfered with seven categories of functioning (general activity; mood; walking ability; normal work; relations with other people; sleep; and enjoyment of life; Cleeland and Ryan, 1994). Whereas the Roland-Morris Low Back Pain and Disability Questionnaire (see below) specifically assesses *back pain* and interference, the BPI is not specific to back pain. This was helpful given James’ widespread

pain. Each item ranges from 0 (does not interfere) to 10 (completely interferes). BPI total interference is calculated as the average score of all 7 items. There is not research on clinical cut-off points for patients with low back pain. However, the BPI has been studied more extensively with cancer patients (Song et al., 2016). James received a total interference score of 2. In patients with cancer, total interference scores of 2-5 were categorized as “moderate” pain interference (Shi et al., 2017). James reported the highest pain interference score in the category of “enjoyment of life” (a score of 7) and “normal work” (a score of 3). During the initial interview, James did not speak at length about how his pain had stripped his enjoyment of life, but as therapy progressed, James’ pervasive sense of joylessness (especially post-retirement) was more thoroughly discussed.

The Roland-Morris Low Back Pain and Disability Questionnaire (Roland and Morris, 1983) was also used to assess physical functioning and has the benefit of being a back-pain specific measurement. The self-report questionnaire is composed of 24 statements related to how much back pain increases the difficulty of normal activities (e.g., “I walk more slowly than usual because of my back,” “I sleep less well because of my back”). Each item is scored as 1 point, with total scores ranging from 0-24. There are no accepted clinical cut-off points representing different categories of disability. James received a score of 7, endorsing items related to changing positions frequently; not doing household jobs he otherwise would; avoiding bending; avoiding heavy-lifting; and becoming more irritable and bad tempered with people because of his back pain. James endorsed the item “My back is painful almost all of the time.”

The Outcome Questionnaire 45.2 (OQ-45.2; Miller et al., 2003) is a 45-item self-report measure. Scoring is composed of a total score and three subscales: Symptom Distress (SD), Interpersonal Relations (IR), and Social Role (SR). James’ scores were clinically significant for

SD and SR. James' SD score indicated that he was significantly bothered by his symptoms (i.e., pain). His SR score suggests he was experiencing difficulty with his social roles (i.e., husband, retiree).

The Beck Anxiety Inventory (BAI; Fydrich et al., 1992) is a 21-item self-report measure used to assess anxiety. Scores range from 0 to 63. James received a score of 7 which is indicative of minimal anxiety. The only item he endorsed as “moderately” was numbness or tingling, which was likely related to his pain symptomology. Thus, consciously, James was not experiencing clinically significant levels of anxiety as measured by the BAI.

The Adverse Childhood Experiences (ACE) Questionnaire (Felitti et al., 1998) is a 10-item self-report yes/no questionnaire that assesses ACEs before age 18. James endorsed the item, “Did a parent or other adult in the household often or very often...Swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?” This was consistent with his self-report of his father being emotionally and verbally abusive.

Patient Goals for Therapy

James had relatively unambitious goals for therapy. He stated, “I just would like to lead a little bit of a more normal life. I don't need anything spectacular.” Through further inquiry, we developed James' goals as follows:

- 1) Be able to engage in enjoyable physical activities without experiencing pain or experiencing major anxiety about the possibility of experiencing pain. The three physical activities James specifically mentioned were playing billiards and bowling (both of which he had stopped doing due to pain) and walking for longer than 30 minutes.

- 2) Be able to sit “without extreme discomfort.” James was currently frequently avoiding sitting.
- 3) Feel confident in his ability to engage in physical activities such that he could go on vacations/travel without significant worry that his back would hurt and without significant worry that specific cushioned chairs would trigger his back pain (e.g., James was hesitant to go on a cruise for fear that the seats on the cruise ship would induce pain).

Relevant Psychosocial History

James grew up with his father, mother, and older sister. James described his father’s tendency to lose his patience quickly and how he was easily angered. James’ father was frequently verbally abusive. During the initial interview, James stated,

This is something that you might appreciate. He always used to say to me when he didn’t like something that didn’t go his way that I might be responsible for...that I was sick mentally. He criticized me. But to be quite honest with you at one point in my life my dad was probably my best friend.

As James’ words suggest, he had a conflictual relationship with his father, further exacerbated by working for his father for many years. James often described his father’s financial stinginess. When James was about to have his first child, he asked his father for an increase in pay, and his father said, “No problem. I’ll let you work more hours.” When James was an adult, his father became very ill. James would ultimately make the decision to take his father off life support while his father was comatose. James stated, “I have to be honest. That’s a decision that’s always haunted me.” James described his mother as a “sweetheart” who “couldn’t do enough

for you.” James identified with his mother and felt like his sister was more similar to his father. As a late adolescent, James encouraged his mother to leave his father. He stated,

If you wanted to leave, I’ll come with you, and we’ll make it work...And she says no I won’t leave him, I love him. And I says you’re only saying that because you’re scared and don’t know where to go. We can make it work.

James reported “not getting along” with his sister, but did not elaborate. When James’ mother died shortly after his father passed away, James and his sister were in a bitter fight over their parents’ financial assets and their respective inheritances.

James had been married for 43 years. He initially stated, “My wife has been my strength,” and thought his wife was “always the most beautiful girl in the room.” James believed that if he wanted his family to be financially successful, he would need to make the majority of the money, which created a feeling of pressure. He also described being sexually dissatisfied with his relationship, feeling like he always had a stronger sexual drive than his wife. At one point in the relationship, James considered leaving his wife. James regularly sought out prostitutes for the majority of the marriage.

James had two children and three grandchildren. James was frustrated that his pain interfered with his ability to do be of pragmatic help to his daughter. One of James’ granddaughters had chronic, potentially life-threatening medical conditions, which James described as a major stressor. James did not describe his relationship with his son beyond stating that he was proud of his son for having a high-paying job.

Presentation at the Beginning of Therapy

James had no history of seeking mental health treatment. James had a jovial, upbeat interpersonal style, casually speaking with the receptionist and making a few jokes while filling

out the required clinic paperwork. There were many striking features of James' initial presentation.

First, I had never encountered a patient that stood for the majority of the therapy session. This is perhaps more impressive given the initial interview lasted one hour and 45 minutes. I felt aware of how, by standing, James had relatively more power in the room than if he had been speaking with me at eye level. However, given that he had no previous history of psychotherapy, I also thought his standing could reflect a lack of being socialized into the process of therapy.

Second, I noticed that James emphasized he had seen some of the best doctors in the country. This didn't strike me as idealizing as much as him letting me know that he had thoroughly done his research when selecting medical professionals.

Third, James provided significant levels of superfluous details. Because he also spoke without much affect, it was at times difficult to ascertain what was important within a given story. James also often responded to questions indirectly and could be tangential. He would sometimes eventually return to the initial question or he would forget what the question was. For example, at one point he was talking at length about his history of physical treatments and stated, "Anyway, I forgot where I was supposed to be going with this." James reported having a "terrible" memory, and his wife had actually given him a historical timeline of his pain and surgical procedures. James' memory, however, seemed fully intact with no signs of cognitive impairment, and I understood his "forgetting" to be indicative of repression.

Fourth, James *consistently* spoke in the negative, stating the opposite of what he seemed to actually experience. McWilliams (2011) states,

The traditional definition of reaction formation involves this conversion of a negative into a positive or vice versa...Reaction formation is a favored defense in those psychopathologies in which hostile feelings and aggressive strivings are of paramount concern and are experienced as in danger of getting out of hand (pp. 140-41).

While James did not state positives per se, it seemed clear he was covering up negative feelings. As examples of James talking about medical professionals that he clearly felt angry and disappointed with: "I didn't hold any hard feelings against the doctor except I thought he should have been more upfront with me," "I don't blame him," and "I didn't really hold a grudge against the back doctor, but I thought he should have been more open." In talking about the person who hit his car while driving: "I don't begrudge him" (despite calling him a "slime bag" in the previous sentence). When asked how it felt to open up to me as his new therapist, James stated, "It doesn't bother me to sit here and discuss these things with you." My supervisor was quick to point out that it is a psychoanalytic truism that there is no negative in the unconscious (e.g., "I don't begrudge him" is represented unconsciously as "I begrudge him").

Fifth, James consistently isolated affect and used defensive laughter. McWilliams (2011) describes the defense of isolation of affect as "isolating feeling from knowing" (p. 131). When speaking about his father's verbal abuse, his affect did not change at all. Although I felt empathically attuned with James (I believe his disclosure of a history of seeking out prostitutes is evidence that he felt emotionally safe with me), my reflections did not appear to deepen James' affective experience. While describing a particularly painful surgical operation, he was laughing. When I asked him how it felt to speak with me (an especially important question given his lack of experience with therapy), he laughingly said, "I don't know if you'll be successful

with me, but I hope I'm not your first failure." He also laughed while discussing feeling extremely self-conscious about his looks as a child.

Sixth, James engaged in considerable defensive splitting. McWilliams (2011) states, "Clinically, splitting is evident when a patient expresses one nonambivalent attitude and regards its opposite (the other side of what most of us would feel as ambivalence) as completely disconnected" (p. 116). James actually acknowledged that he "flip-flopped" often. The two main areas James used this defense were in speaking about his relationship with his wife (i.e., on one hand, describing her as incredibly supportive and beautiful, while on the other hand having a long history of soliciting prostitutes) and in discussing his pain. As aforementioned, during the initial interview James both asserted that there really wasn't a physical explanation for his pain, while also asserting that there must be a physical explanation for his pain. He was both committed to psychotherapy, while also thinking that there could be a physical explanation for his pain. Although this could be interpreted as *ambivalence*, my countertransference reaction was that James was fully inhabiting *both* positions (one at a time) and seemed to lack an observing ego capacity that could acknowledge the contradictions in what he was saying.

Finally, there was a fantastical/unrealistic quality to James' understanding of pain. For example, James thought that sitting in the "wrong" chair one day could trigger pain multiple days later. James also thought that the initial onset of his pain was related to something he had lifted two weeks prior to the pain beginning. He thought that an injection in one part of his body could ameliorate pain throughout (e.g., a leg injection could decrease shoulder pain). He thought that the resveratrol in wine might have counteracted a chemical imbalance in his blood and attributed resveratrol to being a pain reducer instead of the seemingly more sensible idea that when he drank wine he became more relaxed.

Acknowledging all of the above, I still found James to be likeable due to his friendly disposition. As an emblematic example, at the end of the initial interview, I dropped my pen and James picked it up for me. I also thought he was impressively open about his life's hardships and struggles, even if he spoke with little affect. I thought some of his initial defensiveness was likely due to the fact that this was an initial interview and did not immediately assume his defensive structure was rigid. I did, however, get the feeling that it would be difficult to get a word in during the course of treatment, which I later came to understand as a power struggle between James and me.

James was superficially receptive to Sarno's work and the theory of TMS. However, in a telling moment representative of James' subtle lack of commitment to therapy, he stated, "You're my last hope, and I'll do whatever you think I need to. The only thing I can't do is read a lot of books" (i.e., James actually was *not* willing to do whatever I thought he needed to). James nonetheless agreed to read *Healing Back Pain*. I had initially proposed we meet for 16 sessions because other research utilizing CMT had used a 16-session model, and I (naively) thought that 16 sessions would likely be enough to cure James of his pain. James had better foresight than I did; when I brought up the 16-session model, he said he felt like I "had my work cut out" given his presentation.

Strengths

I perceived James' biggest strength to be his dedication to reducing his chronic pain. When James stated, "If I could write a check for 50,000 dollars and go back to where I was that summer I did the yard work, I would write the check," I thought he was speaking to his willingness to do whatever it took to get better (retrospectively, I understand this statement to be more about James' fantasy that external forces, like money and a medical professional, could

cure him). James seemed to have reasonably good social support, although he acknowledged that his family was “sick” of hearing him talk about his pain. James also had a history of being highly resourceful and had made a living out of solving difficult problems in his job, so I thought that as he understood more about TMS and its treatment, the theory would have a logical appeal to him.

Diagnosis

At the beginning of therapy, James met DSM-5 criteria for Somatic Symptom Disorder, with predominant pain, persistent, severe. James’ pain consumed much of his mental energy and had left him feeling joyless and hopeless. He thought there was a physical/structural problem causing his pain despite multiple medical doctors suggesting he was in good physical health. He had major anxiety related to different environmental triggers (e.g., chairs) that might cause his pain to become worse, and he devoted significant amounts of time to researching possible explanations and treatment options for his pain. He had been experiencing pain for multiple years, and his pain manifested in his back, stomach, feet, hips, legs, and shoulders. It was also clear that James’ pain was impairing his ability to occupy his social roles (husband, father, grandfather, and friend) in the ways he desired.

James had casually remarked that he was perfectionistic and that,

“If I could have made as much money cleaning houses [as in his professional work], I would have been a cleaning person. I just love to clean. I’m a fanatic like that. Probably to the point that some people would say I’m off my rocker, pardon the expression.

While I hypothesized James to have an obsessional character style, based on the initial interview he did not meet criterion for an obsessive-compulsive disorder or obsessive personality disorder.

CHAPTER V

Case Formulation and Treatment Plan

Formulation

For my case formulation of James, I used both psychodynamic theory and principles of TMS theory. Since James was seeking treatment for chronic pain, it seemed of primary importance to formulate the nature of his pain. From the initial interview, I believed James fit the TMS model well. Part of this belief stemmed from the fact that multiple medical specialists told James that physical/structural issues were no longer a good explanation for his pain. Moreover, it seemed clear that James had experienced the symptom imperative, with the location of his pain changing depending on the day and/or the most recently performed operation (e.g., back pain going away after surgery and hip pain immediately emerging). James' pain was inconsistent, with some days being better than others. His level of functional impairment varied as well. Such inconsistent pain manifestations seem to be a positive indicator for TMS.

James also fit the personality profile of a TMS patient. Between James' seriously ill grandchild, his guilt related to cheating on his wife and deciding to take his father off life support, his multiple geographic moves, his retirement (e.g., "I was devastated when I had to stop working. No two ways about it."), his difficult relationship with his sister, and his father's serious emotional abuse, James had plenty of circumstances to cause emotional upset. Yet, he isolated affect and tended to "forget" the details of painful experiences (i.e., use repression). He used reaction formations and emphasized that he did *not* feel angry, upset, or disappointed. I hypothesized that James was experiencing significant levels of repressed anger/rage and significant levels of guilt. It seemed clear that had James expressed anger or negative emotion as a child to his father, his father would have responded with verbal abuse. Thus, James developed

the pathogenic belief that his anger and other negative emotions were toxic and not to be (consciously) felt or expressed. His myriad chronic pain issues were an excellent distraction from such emotion, and his endless pursuit of the next treatment option was a way to avoid dealing with painful and difficult feelings. It was also striking that his father had deemed James to be mentally “sick,” and now James was living out such a sickness.

Although I hypothesized that his relationship with his father was the most significant source of repressed rage, I thought he was likely harvesting significant anger towards his wife as well. Her comparatively low sexual drive created major friction in their relationship. Moreover, James felt immense pressure to be the primary breadwinner for the family. Even though James was “devastated” when he had to stop working, he also said he “felt like someone had taken the knife out of my back. I felt like the pressure was off.” Thus, I thought James’ child-self had major resentment at having to be responsible, a manifestation of both the perfect-good tendency and narcissistic rage that others would not provide for him. James was also clearly angry with the medical professionals that had performed his surgeries and various forms of treatment, which appeared to be the anger he was most in touch with (although still repressing). Additive to the more chronic sources of anger, rage, and guilt were daily experiences that could aggravate him. I hypothesized that since James had retired, there was more time available to sit with his emotions, but since that was unconsciously experienced as dangerous, it also meant there was a greater need to avoid such feelings (via pain).

From the lens of psychodynamic character formulation (McWilliams, 2011), James fit an obsessional character style. Most obviously, James was completely obsessed with his pain. McWilliams states, “The basic affective conflict in obsessive and compulsive people is rage (at being controlled) versus fear (of being condemned or punished)...that affect is unformulated,

muted, suppressed, unavailable, or rationalized” (pp. 292-293). James had an intensely controlling father. Early on in the therapy, he described feeling like he was being punished by God for some combination of taking his father off life support and cheating on his wife. As discussed, his affective experiences were some combination of suppressed, unavailable, and unformulated⁴. The favored defense of the obsessional character is isolation of affect, which James used considerably. As aforementioned, James took great enjoyment from cleaning, a classic obsessive-compulsive tendency. (Sarno’s description of typical characteristics of those with TMS overlaps considerably with the typical obsessive character style.)

Initially, I thought of James as being organized at the neurotic level of functioning (McWilliams, 2011). Partially, I believe this was due to my inexperience with borderline pathology, and partially because I did not experience a particularly strong countertransference reaction to James (actually, I felt very little in any direction). I experienced James as likeable despite his interruptions of me, and given he had never been in therapy before, I found him relatively open and disclosing. As the treatment progressed, it became increasingly clear that James was operating at borderline level of functioning and, in retrospect, James’ verbally abusive father, his defensive splitting, and his general rigidity were present from the beginning.

To be clear, I am referring to a borderline level of personality organization as described by McWilliams (2011) and more recently by McWilliams and Shedler (2017) in the *Psychodynamic Diagnostic Manual – 2 (PDM-2)*:

⁴ A word is in order about repression and unformulated experience. Repression involves experience that *is formulated*, but then is too threatening to be consciously experienced or expressed. Unformulated experience (e.g., Stern, 2010) has not been symbolically/cognitively represented, and thus is not “repressed” so much as it is stored away (often times in the body). I tend to think of unformulated experience as more closely related to the defense of dissociation. Of course, someone can use both repression and dissociation, as may have been the case with James.

Note that the term “borderline,” when used by psychodynamic clinicians to denote a *level of personality organization*, has a different meaning from the term “borderline” as it is used in the DSMs, in which only one specific variant of borderline personality organization has been labeled borderline personality disorder...Our use of the term “borderline” is thus broader than that of the DSMs (pp. 18-19).

To illustrate this point, James would not have met criteria for Borderline Personality Disorder as described in the DSM-5 (American Psychiatric Association, 2013). As used in the PDM-2, levels of personality organization range, on a *continuum*, from neurotic, to borderline, to psychotic. All character styles (e.g., hysterical, obsessive, narcissistic, etc.) can fall anywhere on the continuum, although obsessive and hysterical styles are more likely to fall within the neurotic range (McWilliams & Shedler, 2017). Defining characteristics of those with borderline functioning include “difficulties with affect regulation...recurrent relational difficulties; severe problems with emotional intimacy; problems with work; and problems with impulse regulation” (p. 21) as well as self-harm behavior during periods of distress. Further, they demonstrate an *absence* of mature defenses and rely on primitive defenses, most commonly splitting and/or projective identification. Denial, withdrawal, introjection, omnipotent control, acting out, somatization, severe dissociation, primitive idealization, and primitive devaluation are other possible defense mechanisms used by those with borderline levels of organization. Note that there is no set number of characteristics an individual would need to meet in order to be categorized as functioning at a borderline level. However, if an individual meets criterion for any of the DSM-5 personality disorder diagnoses, they will generally be functioning at a borderline level (McWilliams & Shedler, 2017).

Treatment Plan and Treatment Goals

I approached treatment planning from a TMS and CMT perspective. From a TMS perspective, there are both conceptual and more concrete components of treatment planning. Conceptually, I hypothesized that if James could unearth repressed emotion (guilt, rage, and any other major negative feelings), the TMS model would then make logical sense to him (i.e., pain as a distraction against negative emotions). Although not strictly a requirement, I thought it was likely that subsequent to unearthing repressed emotion, I would also need to help James develop new coping mechanisms such that he could process/metabolize difficult feelings, developing a wider affective tolerance. Upon James gaining insight into his unconscious emotions and possibly developing new self-regulation abilities, he would no longer need to rely on somatization. More concretely, I also planned on using the central tenets of a TMS treatment: I would provide continuous psychoeducation on TMS; introduce James to Sarno's 12 daily reminders; James would practice thinking psychological; he would work towards resuming all physical activity (once he began to develop some confidence in the TMS diagnosis); and he would discontinue all physical treatments (under the supervision of his medical doctors).

Because the current research was examining individual psychotherapy for the treatment of TMS, I did not make it a requirement that James attend psychoeducational group(s) on TMS, nor did I make it a requirement that he consult with a TMS-informed medical doctor to receive an "official" TMS diagnosis. From James' self-report, it seemed he had already received medical guidance that physical/structural issues were not the cause of his pain, so I thought going to another medical doctor might not be particularly beneficial. I also was not confident that James would be willing to attend TMS groups or see a TMS-informed doctor (during the initial interview, he described a medical treatment he had pursued in which group work was part of the

program, and he had an attitude that it was “great” if group work helped other people, but he did not think it helped him). At the same time, I had two medical referrals prepared for James and was ready to provide him with the referrals if it seemed indicated during the course of treatment.

Because I felt that the TMS model provided a solid foundation for treatment planning, I was less strict with creating a formal plan formulation. My plan formulation was:

Goals

See *Patient Goals for Therapy*. I would add the following:

- 1) Have a wider range of conscious affective experiences.
- 2) Be emotionally honest with others without fear of retaliation, judgement, and/or abandonment.

Pathogenic Beliefs

- 1) James does not express anger for fear that he would be met with retaliatory anger.
- 2) James does not consciously experience anger for fear that it would overwhelm him emotionally.
- 3) James does not interpersonally share negative emotions (e.g., anger, disappointment, sadness) for fear that the other (e.g., his wife) will emotionally abandon him.
- 4) James will not allow himself to be pain-free because he believes he is deserving of punishment due to his cheating and taking his father off life support.

Tests

- 1) James will express negative emotion and see if the therapist is dismissive, abandoning, or retaliatory, or if the therapist can empathically attune and help James cope/regulate difficult affect (transference test).

- 2) James will blame himself for past behaviors (i.e., express his feelings of guilt) and see if the therapist responds in a way that suggests the therapist believes James is a bad person deserving of punishment (transference test).
- 3) James will isolate affect and use other affect-deflecting defenses to see if the therapist will collude with James' defenses or if the therapist will challenge James, demonstrating a legitimate interest in his emotional life (transference test).
- 4) James will be emotionally abusive towards the therapist to see if the therapist responds by withdrawing, isolating affect, or using similar defenses as James did growing up or can remain engaged while not standing for the abuse (passive-into-active test).
- 5) James will act controlling of the therapy to see if the therapist can assert himself and not withdraw emotionally like he did with his father (passive-into-active test).
- 6) James will argue with the therapist to see if the therapist responds in a retaliatory manner (transference test).

Insights

- 1) James' father's anger and emotional abuse did not stem from James' behavior (i.e., his father's personality and pathology were the issue, not James).
- 2) It is possible to have sustained, dependable relationships that are emotionally honest.
- 3) James' defensive structure (somatization, splitting, isolation of affect, reaction formation) were adaptive growing up in a home environment that was chaotic, emotionally abusive, and lonely, but such defenses are no longer needed to the same degree.
- 4) Feeling angry is not the same thing as *acting* on such anger (e.g., having a murderous fantasy does not mean that James will then go kill someone).

- 5) Having negative feelings does not make someone a “bad” person or deserving of punishment; part of the human experience is feeling angry, sad, hurt, and disappointed.
- 6) A single action does not define an entire person. James can still be a “good” person, even if he did something he believes was wrong (e.g., pull his father off life support).
- 7) James’ cheating on his wife was multiply determined. James experiencing relational dissatisfaction but staying with his wife parallels his mother’s behavior. It is possible to feel regret (or another negative emotion) while also understanding motivations for behaviors like cheating.
- 8) It is possible to experience anger/rage/sadness without an internal collapse. James did not have soothing object experiences, which contributed to his avoidance of difficult affects.

Traumas

- 1) James’ father was hypercritical of James (e.g., calling James “sick mentally”) and emotionally abusive. His father “ruled by fear.”
- 2) James’ father was emotionally abusive towards James’ mother (e.g., he once threatened to kill her). James’ attempt to protect his mother (suggesting they leave his father) was thwarted. James was left feeling trapped and emotionally isolated.
- 3) While his mother was “sweet” James did not confide emotionally in his mother. He was left alone to try and manage his emotions.

As aforementioned, CMT is not prescriptive in terms of technique and the goal is plan-compatible interventions. The Plan Formulation can also change over time. Beyond TMS and CMT formulations, I also approached treatment knowing that basic kindness is an important tenet of treatment for those with obsessional character styles (McWilliams, 2011). I have also

been considerably influenced by attachment research. David Wallin (2007) describes how those with obsessive styles often have a “dismissive” attachment style. The dismissive style involves dismissing the importance of relationships (i.e., the dismissive person disavows dependency needs). Wallin states that for the dismissive patient, a central goal of the psychotherapy is for the therapist to come to matter to the patient. Thus, I anticipated that James would be dismissive of the therapy relationship and me as a person, but hoped that over time, James could consciously experience our relationship as being important to him.

It is also important to note that my supervisor utilized techniques of Davanloo’s (1978) Intensive Short Term Dynamic Psychotherapy (ISTDP). After the initial interview, Dr. Axelbank emphasized that I would want to confront James when he was defending against affect. Although I was initially resistant to this approach because I thought it ran counter to my own personality, I did not believe it was in any way inherently contradictory to my Plan Formulation or the TMS approach. Confronting James’ defensive maneuvers had the potential to help him access warded off affect and I agreed with my supervisor that there could be a kindness in confrontation, especially given that James had no real relational model of healthy confrontation and assertive communication.

James and I initially agreed to once-weekly therapy sessions. Because I had seen multiple clients in the past for twice-weekly and “double” therapy sessions, and because those with obsessive character styles often take longer in a given session to access affect, I was open to the idea that more than one session per week could have merit (indeed, we eventually switched to twice-weekly sessions and then one double-session per week).

CHAPTER VI

Course of Treatment

Phase 1: Sessions 2⁵-20

Sessions 2-3: Developing rapport, early defense analysis, psychoeducation, enhancing understanding of pain and mindbody interactions

In the first few sessions, I hoped to gain a better understanding of the patterns of James' pain (e.g., possible triggers; when he used the pain to distract from feeling), begin to analyze his defenses against affect, and provide psychoeducation about TMS and the therapy process.

Initially, I was unsure of how often I would reference the theory of TMS; I wanted my initial focus to be on general rapport building and basic empathic listening and reflections. Prior to my first meeting with James, my supervisor said that with a TMS patient, the therapist "Always wants to give the message that we are here to talk about feelings, one way or another." I wanted to make sure my interventions communicated the centrality of emotions for our work together.

James began session two by referencing that he had seen multiple pain management doctors, and when I pointed out he had already told me this, he lamented his tendency to forget ("God, that happens an awful lot"). As in our first meeting, James isolated affect and spoke in the same unemotional tone throughout the session. He was usually long-winded and tangential.

James was able to connect how his *expectations* about activities (like yard work) being painful contributed to his experience of pain. Throughout this phase (and for essentially all of treatment) James would go back-and-forth about the etiology of his pain. For example, when I suggested that his emotions "primed your body to respond physically with pain" James

⁵ I considered the initial intake interview to be session 1, which is why Phase 1 starts with session 2.

responded “exactly.” Shortly thereafter, he discussed how “deep down inside” he still believed a bulging disc was the source of his pain. There were countless instances of James acknowledging emotions causing pain and then asserting solely physical explanations. Despite James’ alternating explanations, I felt highly encouraged because he had read half of *Healing Back Pain* and the book resonated deeply:

I think I’m a prime candidate. It’s almost like he wrote the book about me. I’m a perfectionist. I get dry mouth when I talk to people because I get subconsciously nervous. I’m always striving to please people that I’m around. But the big thing is the perfectionism. I’m a perfectionist in probably everything that I do.

In contrast, it also emerged that James had a strong fantasy of something external curing him: “I guess maybe I’m looking for the easy way out, which is what my son used to always say to me. He says, ‘You’re looking for that surgery that’s going to solve all of your problems and it’s not there.’” (James hoping for an external, transformational object [Bollas, 1989] was a major theme throughout therapy). In this phase, I also tried to dispel the idea that TMS treatment revolved around emotional catharsis. James had a fantasy that we needed to “uncover” a “deep-seated” issue, but I thought our work needed to focus more on *experiencing* and *feeling* the issues James was already cognitively aware of.

There were early signs of James’ resistance to therapy. For example, when I pointed out in session two that James had only stood once towards the end of session (as an indicator of progress), James talked at length about how “certain types of chairs are favorable for me to sit in.” This was especially striking because he was sitting in the exact same type of chair both sessions. James also demonstrated some seriously unrealistic thought processes. For example, James felt as though he had “never fully came out of the anesthesia...I never came out of that

fog” from a surgery that occurred years ago (James did not show signs of any cognitive impairment).

During this phase, James’ feelings of guilt were a recurrent theme (e.g., “I feel like I’m being punished for something that I did in the past...God is punishing me”). Consistently, when James would discuss feelings of guilt, he would then divert to discussing his physical pain. I thought if I could help him link his feeling (guilt) and defense against feeling (focusing on pain), it would expeditiously help him accept a TMS diagnosis. It was clear that James’ two biggest sources of guilt were taking his father off life support and cheating on his wife.

James would offer contradictory statements (i.e., splitting) about taking his father off life support: “I didn’t find it difficult to make the decision” and then “It’s stressful and sad that I had to make a decision that most people don’t have to make.” Notably, when I asked James if he still thought about his father’s death, he responded, “I try and keep myself busy to not think about my *physical problems*.” I was struck by his response because we had just been talking about *emotions*, not physical problems. This seemed like a glimpse into how James’ mind worked, transforming the emotional into the physical. As another example of James’ splitting, in the same session he talked about major resentment towards multiple surgeons and an incompetent anesthesiologist, and his history of recurring pain, but said with total seriousness that he had “very good luck” with his surgeries.

As James provided large amounts of superfluous detail, I strived to constantly re-direct him towards more emotional content. James often times answered my questions about his *feelings* with *thoughts*. My interventions seemed to work best when I told him what I might feel if I were him:

Me: I imagine that would make me quite mad at the anesthesiologist.

James: Well, I was angry with him...And I was angry at Dr. X who did the back surgery. James expressed his anger with medical professionals, especially because he felt “lied to” about the necessity of certain procedures. (Throughout treatment, James feeling like people were trying to manipulate him, usually for their own financial interests, was a recurring theme. We would eventually link this to his father’s behavior.)

Interspersed with James’ defenses and diversions, James elaborated on his relationship with his father, especially his father’s lying, manipulation, “bipolar” mood swings (e.g., “One minute he’s perfectly fine and the next minute something triggers something and he’s throwing the table over or he just goes into a rage and storms out”), but also how “for a long time, I thought my dad was my best friend.” James had a tendency to use defensive rationalizations (e.g., his father being controlling of his mother was labeled “old-fashioned”) and when I pointed this out to James, he said, “Yeah, I kind of subdue it in my subconscious or whatever.”

I also developed a better understanding of James’ main relational model as one of domination and submission. At the end of session two, I asked him how he felt, and James responded, “I feel it’s a good step in the right direction. I’m trying to give you all of the *ammunition* you need. I’m trying not to hold anything back” (italics added).

Throughout this phase, I tried to orient James to the process of therapy (e.g., “We want to be explorers of your emotional life”), TMS, and emotions. James often referred to the idea that if there wasn’t an action to take, it wasn’t “worth having feelings” about something, to which I tried to explain that wasn’t how emotions work:

James: I can’t do anything about it, now it’s history. But it is one of those things that’s buried back there with everything else that might be cluttering my head.

Me: You can’t do anything about it, but you can still have strong feelings about it.

In session three, James reported engaging in increased physical activity and feeling “exceptionally better while moving around.” He had finished reading *Healing Back Pain* and said, “Everything that he touches on in that book, that’s me to a T...if someone had to write a book about me, holy cow, that’s it.” James especially resonated with his father’s “mental abuse” (trauma), his myriad of surgeries, “all of the pressures I’ve been under my whole life,” and his “basic personality of perfectionism and conscientiousness.” He stated, “The most important thing is that nobody can find anything physically wrong with me.” I took James’ resonance with the book to mean that I could be more confrontational and attempt to dig further into emotional material.

I explained the pillars of a TMS treatment, and much of session three was focused on helping James to think psychological. I used the yardwork as an example:

If we were to think psychological, we wouldn’t say the bag was the issue. We would say that the bag was just sort of the trigger for your mind to hold onto but that really there were emotions that were being distracted from or protected against. What was going on in your life that could have generated stress, anxiety, anger, or frustration?

James continued to isolate affect, divert, and be tangential, despite my re-directions and interpretations of him moving away from feeling. James struggled to think psychological and had special difficulty grasping the idea of unconscious processes even as I provided him with multiple, relevant examples from his own life. My supervisor had implored me to try and bring more affect into the room, and I felt aware that psychoeducation wasn’t going to help James think psychological at this time and was moving him away from feeling.

James again returned to discussing his feelings of guilt about his father, and also began discussing his anger towards his sister for “shirking her responsibilities” at the end of their

father's life. James used defensive rationalization: "That's just her personality," and reaction formation: "It doesn't bother me," both of which I challenged him on and again provided psychoeducation that one can have strong negative feelings even if "that's the way things are" (like his sister being selfish and "greedy"). James remained stuck on the idea that he "can't complain" about life circumstances out of his control.

At one point, James stated, "I haven't had anyone do anything for me my whole life. I had to fight tooth and nail to get everything I have." Yet, his affect was still completely isolated. James continued to use splitting in this session (e.g., while discussing retirement he said the constant pressure of making money "never bothered me" and shortly thereafter said he "felt like someone took the knife out of my back" when he finally retired). I also got the feeling that his splitting was being inter-personalized; whatever position I took (e.g., financial pressures are stressful) he would take the opposite position (financial pressures don't bother him). Although it could feel like we were arguing, James also provided clues that he appreciated my confrontations on his inconsistencies and re-directions towards his feelings: "I feel that you're trying to get to my innermost anger and get it out and hopefully that's going to alleviate some of the stress that's going on in my mind." He was dismissive when I tried to bring this into the transference (e.g., when I asked him how it felt that I was constantly re-directing him he stated I was "doing my job").

At the end of session three, we discussed how James could practice thinking psychological in the upcoming week. I also asked James if he was ready to try playing billiards, but he said he was not. I provided psychoeducation about how avoiding activities could fuel his fear/anxiety. We also discussed him practicing linking his mind and body states, and he provided the example of his shoulders hurting more when he was under stress. I emphasized we

wanted to make his body “an ally that’s trying to speak to you, instead of the enemy that’s holding you back.” At the very end of session three, I praised James for the hard work he had done in and out of therapy thus far, and he stated, “*I’m committed to the fact that there’s nothing physically wrong with me*” (italics added for emphasis). I was amazed, and believed James was being completely genuine (I still believe this, although I think he was also splitting).

Sessions 4-5: Increase in affect (guilt), further psychoeducation, superego testing, building narratives

With James experiencing functional improvements already and with his stated commitment to nothing being physically wrong with him, my supervisor implored me to interrupt James when he diverted away from emotional content and increase my re-directions, interpretations, and work in the transference.

In session four, I thought James might be testing me to see if I could serve as a less harsh, auxiliary superego (Strachey, 1999). He started off the session discussing a recent car accident he got into, how he could only blame himself, and how he was “angry as hell.”

Me: What did you do with the anger?

James: I had to suppress it, I mean, what else was I going to do? I’m thinking about buying a punching bag and hanging it in the garage...I have nothing to do when I get angry except suppress it.

I was encouraged that James seemed more forthcoming with his anger and was demonstrating insight into his own defensive process. However, he still *expressed* no anger (or shame) as he spoke. Moreover, he stated it “didn’t bother him” (a reaction formation) that his insurance rates would go up.

Me: If it doesn’t bother you at all, why do you talk about it?

James: Only because I guess that's my release right now for doing something stupid...it's not the money that bothers me, it's the stupidity.

Me: I see. You can be very self-critical.

James also brought up the idea that his over-the-counter magnesium pills might have contributed to him being lackadaisical on the road (this being an example of James' unrealistic thought processes). I reflected that "it's hard to be a perfect driver" and James laughed; I perceived him to feel relieved at me communicating that he didn't need to be so critical with himself, passing the test of being a kinder introject than his father had been. In session four, we also developed a narrative around the origins of James' perfectionism (a coping mechanism developed to try and avoid setting off his father's rage).

James continued to discuss feelings of guilt, and I used constant re-direction and detailed inquiry (knowing that pulling for details can elicit greater affect; Fosha, 2000). I hoped that James' affect would increase and we could attenuate some of his shame through him seeing that I could remain calm in the face of him speaking about past transgressions. James used his typical diversions, providing superfluous detail and continuing to rely on reaction formation (e.g., "It didn't bother me" to lie to his wife). Although I increased my challenges and confrontations of James' defenses, he still relied on the same defensive tactics. What seemed most effective was trying to create a narrative around his use of prostitutes (i.e., that he was sexually frustrated, and that sexual frustration is a difficult experience).

James reported difficulty thinking psychological since the last session, saying that he tried but, "The only thing that I think about day and night is that I can't get out of this pain I'm in." When I invited him to think psychological about why he stood up 40 minutes into session while discussing his relationship with his wife, he was myopically focused on the chair's lack of

comfort. Towards the end of the session, I tried to offer a narrative interpretation about James' anger:

Me: With your father, you couldn't express your anger with him because you said earlier that he "didn't want to hear that crap." And with your wife, it's kind of like you couldn't express your anger with her either."

James: Well, I'm a Libra. Whether there's any logic to it or not, I'm a peacemaker. I'm not the person that's going to stir up an argument, I'm the person that's going to try and get everyone to accept the terms."

Me: Or you're going to do something else. You're going to clean up perfectly, or you're going to go get prostitutes, but you can't direct anger at the source.

James: "Yeah, maybe." (James would often respond to my interpretations with a "maybe.")

I further pointed out that he never got to express anger towards his mother, either.

In session five, James seemed more somber as we continued to discuss his feelings of guilt. Although he still used his typical diversions, provided superfluous details, and isolated affect, my countertransference increase in experiencing emotions led me to believe we were reaching greater affect. I continued to try and offer kinder reflections to combat some of his internalized self-criticism. I consistently reflected how much fear James was in regarding his pain and the state of his body. Multiple times in the session, James would say something like, "I don't know if I answered your question or not" and I told him we were here to help him, not for him to try and answer my questions well. I believe this passed a test of his; unlike his other relationships, our relationship did not need to be organized around domination and submission.

James had moments of linking his mind-body experience (e.g., discussing how his expectancy about uncomfortable chairs contributed to anxiety, which then contributed to the experience of sitting being more uncomfortable). At other times, he was highly focused on physical explanations and acknowledged as much: “I’m still looking for that physical problem, but it’s not there.” I provided psychoeducation about how our culture conveys messages about structural issues causing pain, and then said:

Me: You’ve been searching for this physical explanation for so long, and our culture invites it in a way, that it’s so hard to even consider letting go of that.

James: Yeah, you’re absolutely right. Because it’s been such a long time since I could sit at the kitchen table for two hours and work on my laptop and not worry about if I’m going to be in pain or not...Like you say, I’m holding onto that fear.

Me: The fear occupies so much mental space that it really drowns out other feelings.

James: Absolutely. I’m preoccupied...I just can’t get off the fact. Something has been hurting for so long that I can’t let go of it anymore. I would definitely and wholeheartedly be admitting to that 110 percent.

Me: It’s consumed you.

James: Exactly.

I took this exchange to suggest even though James would go back-and-forth about his pain etiology, we were developing a shared narrative about his pain. I was struck by his more definitive word choices (e.g., “Exactly”). I also felt more emotion emanating from James:

James: I know I keep searching for something physical. I’m having a really hard time letting go of that fear that I’m not going to be normal again, that I can’t sit without pain, that I can’t walk. That’s the problem.

Me: It's scary to feel like your body is failing you.

James: Especially for a guy like me that's been active all my life.

In session five, I further worked with James to build a narrative around his retirement and pain:

Me: If you weren't in pain [as a retiree] it would almost be like a prisoner that got out of jail and doesn't know what to do in the free world because they're so used to being in prison. That could be kind of scary. It's like prison is a miserable place, but it's also a routine.

James: I have a roof over my head, I get three square meals.

(James then discussed the car accident he brought up in the prior session, with no recollection that we had previously discussed this.) It occurred to me in this session that James being in pain in retirement was a way to punish himself, much like his father had constantly punished him. When I brought this up, it did not yet resonate with James. James did, however, acknowledge that he had "always had a hard time relaxing" and how this was just like his father. James agreed that retirement posed emotional challenges.

As we continued to discuss James' pain, he mentioned that the pain in his leg began at the same time his wife retired, and I began to wonder if this was a major source of unconscious rage (I did not ask James about this). Towards the end of the session, James said, "This [therapy] is like a last resort. It logically makes sense to me, but I can't buy into it yet until I see where we are going with it and whether it helps." (This was, arguably, the biggest stuck point throughout therapy. James wanted his pain to decrease and then commit, and I would consistently tell him it had to be the other way around. My supervisor rightly pointed out that James also *had* made progress, and that he was devaluing the therapy and myself in saying this.) James' assertion of

not yet buying into therapy was a striking example of James splitting (two sessions ago, he had stated his full commitment to nothing being physically wrong).

At the very end, I checked in with James to see how he was feeling about therapy. He said he “enjoyed talking” with me, that he began reading *The Mindbody Prescription* (Sarno, 2001) and said, “Everything he’s saying in the first chapter I can relate to all of it. It’s me. It’s there. But because I’m so far into this search for a physical cause, the only way I’m going to believe anything is if I can see some sort of result.” He also mentioned he was hoping to resume moderate physical exercise and had downloaded some breathing phone applications. James was fairly stuck on the idea that he needed to rid himself of anger, so I provided psychoeducation again about the goal being to *experience* feelings, not *expel* them, and that Sarno’s approach requires only *accepting the diagnosis*. I brought up that he may always experience feelings of guilt and anger, and James said, “I’ve got more buried in my head than most people do. I guess it’s always been a problem to accept it and work through it because it’s easier to bury it and avoid it. Especially with my wife.”

Sessions 6-8: Needing to see improvement before committing (increase in ambivalence), further exploration of guilt and anger

Just as James would follow emotional content with diversions or descriptions of physical pain, I began to notice the same held true across sessions. More emotionally vulnerable sessions would be followed by regressions to more severe isolation of affect and James’ characteristic defenses. Broadly, I thought James was increasingly open with me through the first five sessions and increasingly acknowledged the mind-body connection (to be clear, he still used splitting and expressed solely physical explanations in each session as well).

In session six, James was more long-winded with physical explanations and isolated affect to a greater degree. James noted that he was “sore as hell” from the increased physical activity and continued the sentiment that he needed to see results before committing to the therapy. I was keenly aware of the redundant nature of his speech and felt annoyed in the countertransference. My challenges and confrontations didn’t seem to be working, so I spent most of the session simply reflecting the “intense fear and anxiety” he felt. I reflected that it was important to him I understand deeply how much pain he was in, something other medical professionals (and his father) did not do. I wondered to myself whether James was inducing my annoyance as a way of showing me just how stuck he felt with the pain.

At one point, I mentioned that I was quite sure treatment would fail if we “keep talking about the physical.” Initially, James and I had contracted for 16 sessions (a 16-session model has been used in CMT research, and I also naively thought 16 sessions might well be adequate to cure a TMS client). Because James had felt significant pressure throughout his life (a strong TMS correlate), we agreed that a 16-session limit would not be therapeutic. James admitted that he never thought 16 sessions would be enough. I let him know that the therapy still could not be completely open-ended because I would be leaving the Clinic by the end of the year, but that we could work until then. (My supervisor and I pondered after the session the degree to which James’ affect tolerance was limited and agreed that a longer therapy could be helpful to develop greater affect tolerance and self-regulation.)

James brought a tape-recorder into session seven because he felt like he was struggling to retain information session-to-session (to my knowledge, this was the only session he did this. I hypothesized he was using significant levels of repression between sessions). James continued focusing on the physical in session seven (along with isolating affect and using frequent reaction

formations, i.e., “it doesn’t bother me”). My frustration was building as he offered explanations that defied logic (e.g., he thought the weight of his sheets were disrupting his sleep, yet, in a different bed with the same sheets, he slept fine). I reflected to James that it was like his “current environment is an endless booby trap of pain activators,” and that viewing everything around him as a possible trigger for pain was significantly increasing the likelihood of him experiencing pain. James agreed and acknowledged he “didn’t have an answer” to how healing could occur with his current physical explanations. I provided psychoeducation about how pursuing physical explanations and treatments (whether that be physical therapy or buying a new pair of sheets) “perpetuates the idea that there is some non-emotional cause.”

Much of the session felt argumentative. I thought it was an important test to show James that we could disagree and argue without exploding in rage, and that we could maintain our connection, holding on to the good and the bad of each other instead of splitting.

Me: I appreciated you expressing the conflict between us. I appreciated that you really got into it with me.

James: While talking, the thought occurred that this won’t work, but I wasn’t going to get up and walk out. I’m holding on to you for dear life you might say.

I also tried to educate James about the trajectory of recovery for pain patients and that often, pain gets worse before it gets better (as the patient experiences more negative emotions previously warded off, pain increases to try and intensify the distraction). This was bad news to James (e.g., “The problem is that when things go negative, they never seem to get better. They just get worse and worse”). He was extremely hesitant to engage in any psychological or physical activity that might make him worse (this was another stuck point throughout therapy).

James also acknowledged he still felt “like deep down inside, something physical is the problem.”

James had returned from vacation when I saw him for session eight. He continued to revert to physical explanations in a way that I found maddening (e.g., he had been in less pain on vacation and had tolerated sitting on chairs well, but instead of linking this to feeling less stressed and thus in less pain, he was focused on the quality of the chairs suiting him well). I told James that I “didn’t want to argue” with him over the etiology of his pain and tried to find common ground in that we both knew focusing on physical explanations hadn’t worked for him in the past. James continued to emphasize needing to see the TMS approach “work” before committing; how he had been increasingly sore when doing more physical activity; and that he had “already told you the things buried in the back of my head.” I explained to James that it was one thing to talk about painful experiences cognitively, and another thing to *experience the feelings* of such experiences.

Towards the end of the session, James began to open up, discussing how his father was “loveless” and that he knew he talked about his father in a “detached” way. I asked him what he imagined would happen if he re-experienced some of his relational pain related to his father, and he said he didn’t know if he could and that he “doesn’t want to go back there.” After this more emotional exchange, James returned to a “what’s in the past is in the past” sentiment.

Sessions 9-13: Increase in emotional vulnerability, pain reduction, increased commitment to TMS theory, focus on external transformation

Beginning with session 9, James and I agreed to meet twice-weekly. In my previous experience, twice-weekly sessions had worked especially well for patients that were more defended against affect. Moreover, because James was having trouble holding onto the content

of sessions week-to-week (e.g., him bringing in a recorder), I thought twice-weekly sessions would provide a greater sense of continuity and possibly decrease James' splitting. James agreed with the idea that twice-weekly sessions could lead to greater emotional vulnerability, although also rationalized that he could meet more often because he was retired (i.e., instead of focusing on finding therapy enjoyable or, at the least, helpful).

In session nine, James provided details about his father's own traumatic experiences. I provided psychoeducation that he could both have compassion for his father and feel angry with him. James further elaborated on his father's "emotionally manipulative and greedy" nature, his extremely volatile anger "smashing things when angry" and how he "never showed love" to James. James noted that he tended to "black out" his childhood, which I thought was a fitting description for his repressive defenses. He also further discussed his sisters' greed. Throughout the session, he didn't divert to his physical pain once.

James described how as a child, he would "bang my head against the wall" when he had difficulty because of his allergies. It seemed we had returned to building a narrative of James' emotional pain and I felt more emotionally connected to James. (James would still start off by saying that X topic didn't bother him and only through re-direction and detailed inquiry open up.) James appeared to be gaining new insight into just how manipulative and controlling his father could be, constantly wanting to have power over James. When I reflected to James that he must have felt suffocated and trapped, he said "Yes" and described his fantasies of escaping home. When James described how his father "only expressed anger and a slight smile" I had two internal reflections: 1) James had no model for the expression of varied emotions; and 2) By not expressing anger, James was avoiding being like his father. Throughout the session, I attempted to be disciplined about exploring James' emotions and reflecting what I thought he might be

feeling, avoiding interpretations that might lead to argument (e.g., I didn't tell James about my thought that not expressing anger was a way to avoid being like his father). At the end of the session, James remarked that he noticed when he didn't focus on the pain, he felt better (James was particularly emotionally present throughout the session and thus not focused on the pain).

Approaching session 10, I felt aware of how vulnerable James had been in session 9 and thought he might revert back to the pain. Instead, James began the session by stating his sister reminded him his father said James was "a mistake." (His sister had also reminded him of his father smashing things when angry, and I thought it was a positive prognostic indicator that repressed experiences were emerging.) He subsequently discussed how a few nights prior, he had felt "pretty good all day" and woke up in the middle of the night "*scared*" *that he was getting better*. He said he "might have actually been feeling sorry for myself" regarding his history of pain. I offered the interpretation that getting better might be scary because children who grow up with emotionally abusive caregiver(s) often feel unlovable or undeserving, and that perhaps James felt undeserving of being free of pain. He responded the idea was "interesting" (although I think the interpretation may have had validity, it was premature). James continued to discuss traumatic childhood experiences and how his parents' constant fighting "hurt" him.

James stated he was "opening up to the Sarno method" and he had "experienced the difference between focusing on the pain and not." He also downloaded a phone application that discussed eight characteristics of TMS patients, stating he "fell into all eight categories." Given James' earlier important disclosure about being scared of getting better, I tried throughout the session to emphasize that feeling conflicted about improving made sense: while on the one hand, his pain hinders him, on the other hand, his pain serves many functions (i.e., distraction from

emotional pain; filling a void post-retirement). James was in agreement that pain served many functions.

After James had been emotionally vulnerable much of the session, he stated he “wasn’t sure how much further you can take me.” I responded with laughter. I think James and I both knew this was a defense against greater emotional vulnerability and relational intimacy, and he shortly thereafter returned to the idea that he had “blacked out” much of his childhood.

James continued to open up in session 11. He started the session by remarking that perhaps his father was “still controlling” him. He discussed his feelings of guilt about “pulling the plug” on his father. For the first time, he acknowledged that part of the guilt was due to feeling like it was “revenge” to end his father’s life, also returning to the idea that James’ own greed was a motivating factor. He also described his father threatening to kill his mother if she put him in a nursing home. Given that these felt like significant emotional disclosures, it is perhaps not surprising James also used frequent reaction formations (i.e. “not bothered”), and rationalizations (e.g., describing his own greed and then describing how his decision was the “right” thing to do).

James reported feeling “stuck” when talking about his father and asserted there was no way he would be able to feel his repressed emotions about his relationship with his father. I thought this was a defense against further emotional exploration, but because James had been emotionally vulnerable in session, I took this as James providing me with supervision (e.g., see Casement, 2000) not to push him further.

As James opened up in new ways, he also described his fantasy of a cathartic moment that would cure him of his pain. I stated, “I don’t believe I am going to discover something, then you’re going to cry, and then you’re going to walk out dancing and be pain free.” (Internally, I

had a strong inclination that James had a fantasy of a transformational other [Bollas, 1989], in part because he had not experienced good enough caregiving growing up.) I reflected to James that perhaps he was tired of doing the work to try and heal himself, and he agreed.

I felt particularly lost in session 12, as James reverted back to “moving on” and “it is what it is,” asserting he would not be able to access previously warded off feelings:

James: I’m not going to start screaming at my parents in the therapy room.

Me: I think that’s your fantasy, not mine.

I hypothesized James was mentioning such an extreme because he was feeling scared of the progress we were making. I told James there was a middle ground between screaming at his parents and burying his feelings.

He was using significant amounts of rationalization and overloaded me with content to the point I had trouble finding the silver thread in what he was saying. I asked James if he was aware of costs to his rationalizing, and he said, “Well yeah. There’s an inner frustration,” but when I further inquired to understand what he meant, he diverted. Because James had been more emotionally forthcoming in sessions, I did not further challenge him.

James had reported feeling in less pain while his wife was away for a few days. In talking about his wife, he engaged in significant splitting (e.g., “She’s the best” even though he contemplated getting a divorce). When I pointed out that her leaving seemed to be a clear catalyst for his pain reduction, he was highly argumentative: “No, I want her back [home].”

James began session 13 by pondering, with a laugh, if he could put a “dummy in my living room” to speak with as a secondary therapist. I was struck by the aggressive nature of his comment, and I thought this was likely a test to see if I would respond with aggression. In the moment, I did not confront him (I did bring this up in the next session). In the session, James

reported: feeling in less pain; being more physically active; making progress; feeling “great;” being more calm; and feeling like I “must be doing some magic” on him. I responded that the magic was him talking about the emotionally difficult parts of his life. James’ mood was jovial, excited, and optimistic. I thought he might be unconsciously testing me to see if I could enter into his joy. I felt genuinely happy for him and asked for details about his positive feelings.

At one point, James discussed being an excellent bowler, but also having a history of drinking and driving when bowling. I took this as another important test: would I shame him for drinking and driving, or could I enter into his joy despite his darker sides as well? I focused my inquiry on his bowling accomplishments, and he appeared relieved.

Sessions 14-18: Frustration with progress, increased focus on and expression of anger and frustration

James asked for a “roadmap” regarding the therapy in session 14. Given I had clearly outlined the therapy process and James had reported significant improvement in the prior session, I thought this was likely a way to pressure me and see how I would respond (i.e., a passive-into-active test). Because of the aggressive quality to such pressure, I returned to the dummy comment in the previous session to see if we might explore its meaning. James responded that the comment “meant nothing.” (He later mentioned that he felt a lot of pressure from his wife to heal, which seemed to explain his roadmap inquiry.)

James redundantly discussed his prior surgeries. I asked James what he was really trying to communicate, and he said, “How angry I am.” I re-directed James towards his anger. With some affect, he talked about his “rage” and how he felt like he had been “manipulated” by one of the doctors. When James would rationalize his doctors’ behavior, I tried to provide psychoeducation that he could feel angry even if he could construct a narrative explaining why

the doctors behaved in a certain way. Internally, I wondered why James was now talking about his anger with other medical professionals and if much of what he was saying could be understood as transference (i.e., anger with me). I didn't explore this because from James' earlier comment ("it meant nothing") I didn't think he would be open to such an interpretation. I also felt increasingly aware that James' medical doctors all sounded highly similar to his father.

In session 15, James reported not sleeping well and feeling frustrated with his progress. I reflected and validated that progress can be slow and hard. James spent most of the session talking about bowling and billiards, and I took this as a further test to see if I could enter into his enjoyment of activities. I also thought him discussing these activities might mean he was unconsciously more seriously considering engaging in them again. Although the session felt slow to me, I thought given James' history of self-imposed pressure that it was important I not set the precedent that every therapy session needed to involve some sort of emotionally revelatory experience. At the end of the session, discussing his frustration, James said, "I can be my own worst enemy."

In session 16, James reported playing pool. Given this had been one of his treatment goals when therapy began, I was thrilled. However, James discussed feeling frustrated and irritated because he wasn't playing pool at the level he desired. He also reported feeling irritated that progress was slow and acknowledged "doubting your competency," although he subsequently said he thought his lack of progress was mostly due to himself. It was striking that James complained about his lack of progress just as he had reached one of his treatment goals. I felt keenly aware of James' joylessness in life, and how life was just a series of tasks to work on. (Salzman [1982] eloquently describes the "prison" of the obsessional character's mental world, and it seemed James was in a prison of endless tasks).

I thought James was again testing me to see if I would respond by lashing out, so I tried to emphasize that we could make room for him feeling frustrated with me. I offered the interpretation that, “every time you say something that could be perceived as negative, like questioning my expertise, it’s like you have to say something positive to counteract it,” and how with his father, I imagined there was no room to be critical. James responded that he could be critical, “but my father wouldn’t listen to me.” I also attempted to link James’ endless problem solving (e.g., needing to improve his billiards play instead of being happy to play billiards), as a coping mechanism he developed to deal with his father’s emotional outbursts. James was actually quite receptive to the idea that he had developed a hypervigilant, problem-solving style in response to his father.

James had been working through Schubiner’s (2010) *Unlearn Your Pain Workbook* since session nine⁶. We didn’t often talk about the workbook, but he reported creating a chronology of his pain and linking his pain to pressure, anxiety, and family conflicts at every stage. James had been using the workbook sporadically, and at the end of the session, I asked him to try journaling every day for the next week (whether in the workbook or elsewhere), to help him think psychological about what might be upsetting him in a given day.

James began session 17 by stating that his wife had said, upon returning from vacation, “Tell Justin I’m definitely a trigger.” This seemed to confirm my hypothesis that James was harboring significant anger towards his wife. Although this was how the session began, James spent most of the session discussing other people who had transgressed upon him: his priest

⁶ James acquired the book without any recommendation on my part. Because Schubiner’s approach is TMS-congruent, and because journaling about rage is often times part of a TMS-informed treatment, I didn’t see this as a major confounding variable (I also hadn’t thought in advance to create criterion that would state such an activity was not to be completed as part of the treatment contract).

making a “snarky comment” about James’ casual attire; people improperly completing yard work on his home; his dentist “messaging up” one of his teeth; and a medical assistant not taking seriously the possibility that he got bitten by a tick which could be creating physical pain.

I thought James was displacing much of his anger. He discussed an increase in anxiety about his body “falling apart” and feeling full of anger with no “release” for his aggression, but was still hesitant to attribute this to his marital relationship. I found James to be emotionally honest and more expressive than usual, so instead of trying to interpret the possible displacement of anger, I tried to reflect that he felt angry with other people not being as conscientious as he was (James had pointed out that in his line of work, he always had to “guarantee” the work for a year, but others never seemed to do the same). I further wanted to reflect James’ anger because I thought he might be testing me to see how much genuine anger he could express in the therapy room. Internally, I also wondered if James had major trouble asserting his own needs with these various professionals because there was no room to assert his needs with his father.

James had played pool once more since session 16. He said he hadn’t played more because of how busy his schedule was, which I found dubious given James was retired. He also reported attempting to journal but mostly just writing down what happened during the day, focusing on the most obvious stressors, which he didn’t find particularly helpful. It seemed James still struggled with the concept of thinking beyond his conscious experience, and I also hypothesized that he had major deficits in observing ego capacities. Thus, I didn’t see this as resistance to the TMS approach. (Throughout the remainder of the therapy, James would sporadically journal and eventually stopped using the Schubiner [2010] workbook because he felt that it wasn’t helping.)

In session 18, James discussed at length how the seat of a new car he had purchased was extraordinarily uncomfortable (he had brought this up over the past few sessions as well). I interpreted to James that it seemed there was major conflict for him around taking care of himself (citing, for example, him “not having time” to play pool). With the car, I thought he just didn’t like it but was trying to rationalize why not (he had, in fact, wanted a more luxurious car but went with a more “practical” vehicle). James went on to share a story about misplacing and losing thousands of dollars in cash, which I took as confirmation of my interpretation (i.e., he felt conflicted if he was worthy of such money). Throughout the session, I consistently reiterated that pain is a “fantastic” distractor against feelings of anger, frustration, and conflict.

Sessions 19-20: Further increase in frustration, interpretive summaries of central psychodynamics

James reverted back to heavy discussion of physical symptoms in session 19, describing the soreness of his stomach and how he was “waiting to see progress from what we are doing.” I was irritated with James’ redundancy and his inability to hold on to the fact that he had made progress (e.g., playing pool), and my main interpretation throughout the session was that when James felt frustrated and emotionally overwhelmed, he returned to focusing on the physical. I attempted to summarize many of the upsetting things he had been discussing: his romantic relationship; intense feelings of guilt; growing up in a “loveless” home; losing large sums of money; and feeling significant amounts of internal pressure. I also reminded James that his own self-report was of progress and how he seemed to feel in less pain when he was emotionally open about his feelings towards his wife and father.

I tried to redirect James to discuss his relationship with his wife, and James responded, “that’s opening up a whole can of worms.” He proceeded to talk almost exclusively about the

positive aspects of their relationship and when discussing any misgivings, reverted to the “it’s in the past and can’t be changed” mentality. I felt a sense of hopelessness in the session. Not only did James struggle to hold on to the progress he had made, but he also wasn’t adhering to the TMS treatment principles (i.e., he was avoiding physical activity, and, more importantly, he was consistently *not* thinking psychological. He would revert to physical explanations like that of his car seat being uncomfortable instead of considering his emotions about the car). Nonetheless, at the end of the session, James said we were “just scratching the surface” of his emotional life. He then stated, “We might be friends for life” (i.e., that he might be in therapy forever). I took this as a sign that some of James’ expressed frustration was more about acting out aggression towards me and seeing how I would respond, instead of literal frustration with the lack of progress.

Likely due to my own frustration, in session 20, I was highly interpretive. I felt like I had a strong grasp of James’ central dynamics, defense mechanisms, and relationships, and we had enough rapport such that I could press him on these topics. My interpretations centered around the following: 1) James had a traumatic childhood with his father’s extreme volatility, 2) When James felt out of control emotionally, he reverted to physical explanations and potential cures as a way to re-gain a sense of control/self-mastery, 3) James had major amounts of guilt, resulting in him feeling undeserving of a pain-free existence and undeserving of good things (like the luxury car he wanted), 4) James’ decision to cheat on his wife was related to feelings of rejection and inadequacy growing up, 5) James’ history of somatic experiences was not just recent; even as a child, he had back pain and other somatic complaints (e.g., food allergies); 6) James had stopped putting effort into the TMS program due to self-doubt, being scared to get better, and a desire to avoid intense negative feelings, and 7) James’ half-commitment was sabotaging his

own progress (i.e., James was being his worst enemy). James responded to my interpretations by providing more content and he again re-iterated that we were just scratching the surface of his emotional life. Retrospectively, I believe this session served as the catalyst for the next phase of our work together.

Phase 2: Session 21-24

Session 21-24: Resistance followed by deep emotional processing and development of emotional pain narrative

James began session 21 by stating that he was “re-committed” to a Sarno approach after hitting an “all-time low” with his pain the night prior. He had reviewed all of his medical records and felt a new “logical” sense that nothing physical was wrong with him. I somewhat playfully reminded James that we had reached this conclusion before (his own guess was “maybe four times already”). I reflected it was challenging for James to believe that focusing on emotions was the solution, reminding him that since beginning therapy, James had pursued no less than five different physical treatments (e.g., he thought his gut biome being out of balance was the source of his pain and began taking probiotics).

I explained to James that commitment to therapy involves doing the work *outside of* sessions (e.g., resuming physical activity) but also doing the work *in* session. I further explained that it’s one thing to talk about committing and another to actually commit, and that actual commitment in session meant making a concerted effort to talk about painful feelings. James understood the difference. I also reiterated we didn’t have to process all of James’ trauma, but he did have to *accept* the TMS diagnosis to heal. James struggled to grasp this, still feeling like he needed to change his personality in order to heal. James continued to divert and avoid emotions in session, and I consistently re-directed him. I was trying to emphasize that his

diversions were a way to avoid doing the exact processing we had discussed as representing commitment to therapy. James stated that the most salient feeling he currently had was “crippling anxiety” about the possibility of being in this much pain forever.

In session 22, I brought up how it felt like James had an “emotional castle that I can’t get to open,” and James reported that in the prior session, he was actually “fighting back tears.” This was a significant emotional disclosure for James. However, he proceeded to isolate affect throughout the session, and I felt hopeless. I held on to the idea that from a CMT standpoint, James might be testing me to see if I would give up on his emotions. Most of the session James discussed all of the daily activities he does for other people (e.g., running errands for his wife), and I reflected his conflicts around taking care of himself.

As my frustration was building, my supervisor pointed out that James’ intensely rigid defensive structure was, fundamentally, an attempt to protect himself, and that any letting down of his guard around his father could have resulted in him getting “clobbered” emotionally. I tried to hold on to this heading into session 23.

I began session 23 by giving James Sarno’s list of daily reminders (see Appendix 1) and encouraged him to review them daily. I also created a diagram for him of his pain, using washing his car (something he had done and felt afraid of due to the bending) as an example. I tried to illustrate conscious emotions (anxiety, fear), unconscious emotions (rage, anger, guilt, feelings of inadequacy and feeling unlovable), and pain as a distraction. I provided examples of how he could talk to his mind. I also gave James an example index card that said, “My physical pain is a distraction. Pain helps me to avoid the following emotions:”. James was to create his own index card, filling in the blanks. My hope was that some of these tangible reminders might help him with object constancy (i.e., holding in his mind what we talked about). Perhaps the

index card would also act as a transitional object (Winnicott, 1986), allowing him to hold on to me during our separation between sessions.

James agreed that when he gets into “fear-mode,” his pain worsened. He also acknowledged, relative to treatment beginning: “I still am in a better place” in terms of pain; that he was kneeling and bending in ways he “could never do before;” and that if he “wanted to shoot pool, it wouldn’t be a problem.” (I mention all of these to illustrate that James had made improvements based on his self-report.) I continued to emphasize to James that his expectancies of pain significantly influenced the pain he experienced (at one point, James responded, “Yeah, that’s a given”). James pointed out that to change his expectations of pain, he needed to “go back into the past and release that frustration and guilt and anger from all of the events that have brought me where I am right now where I’m afraid of everything.”

James began talking about his father in a more emotional way than I had ever seen before:

My father ruled the house with anger and fear...My father was the biggest problem of everything. I’m probably extremely fearful of everything today because he raised me fearful...He was intimidating. He kept us in a constant state of fear because if we did something he didn’t like, we never knew what he was going to do...I’ve mentioned this before but, one time, he got mad at my mother and threw the whole damn table over with dinner on it...what kind of bullshit is this? That’s not how normal people behave. That’s not called for. I don’t give a shit if you had a rough day or not.

I was struck by James’ honesty and noticed he was looking away more frequently as he spoke. I also noticed his use of definitive language and that he was *not* rationalizing his father’s behavior. I thought this was an opportunity to deepen our affective work together:

Me: Let's stick with this memory of your father throwing the table over. I want you to try and explain to me in detail, try to paint the picture as much as you can. Where were you, for instance, in the house or the room when this happened?

As James provided more detail, I aimed for increasingly greater specificity. At one point, I asked James what he would have liked to have said to his mother, and he responded that he *did* say this:

Mom, you really can't stay with this man, he's unstable. You need to get away from him, whether you divorce him or you leave him. I'll come with you, I'll do the best I can to take care of you.

His mother responded, "No, I can't do that, I still love him." James acknowledged the "radical" nature of asking his mother to leave his father. I thought James was being self-compassionate.

As James began to divert, I reflected the "profoundly painful" nature of this memory:

Me: And so it's hard to stay focused on this because this is really the digging up of feelings you've tried to bury.

James: Yeah.

Me: And now I'm asking you these detailed questions about it and I imagine there's a part of you that really wants to get the fuck away because it's like, "I don't want to re-live..."

James: (interrupts) No. But I know that going back to all of this stuff is also the answer to getting better.

James began discussing his father's controlling, manipulative nature and then said:

James: When you stop and think about it, my father crippled me in a matter of speaking.

Me: So yeah, let me just reflect that back to you: Your father crippled you.

James: Absolutely. Between the fear, and holding me back...it was like a whirlwind of disappointment one right after the other.

Me: And so much fear.

James: All the time.

I felt myself deeply moved by what James was saying and could feel the emotion in the room:

Me: What does it feel like to talk about all of this right now?

James: I'm getting a little choked up...Those years were probably the worst years of my life. Growing up in that house, with my mother and father fighting all that time. That's brutal. It was brutal. I felt bad for my mother. I think that's the core of the problem right there. That upbringing was terrible.

Me: I find myself feeling sad.

James: (laughing) I can see that you're getting emotional like me. Yeah, I think that's the core of everything. But, you can't change what's in the past, you can just try and move forward from it.

I later asked James if there were other detailed memories to help us anchor his past experiences. He described his father once taking his car away for a week, with James' car representing "the only thing that gave me any kind of hope." I asked how James felt towards his father and he responded, "I hated his guts."

James did point out the "double-edged sword" of their relationship, and how he "still thought of him as my best friend." I reflected that he "wanted a close relationship" with his father, and James stated, "I was looking for love from somebody. I got it from my mother, but not my father."

Later, I provided psychoeducation about how trauma gets “stuck” in the body, linking James’ fear of his father with his current fear of his environment. James resonated (“I’m stuck”). He went on:

James: Which is what I’m going through right now with my body. I see a little bit of a decline in my physical well-being and then right away I go to the fear state.

Me: From an early age, you needed that fear response and you were constantly in this hypervigilant state, always scanning your surroundings. And you got stuck there.

James: Yeah, exactly.

Me: And that makes sense when you talk about your father’s volatility. It makes sense why you got stuck there.

James: Yeah, I grew up with that my whole life. And now, even though he’s dead, if I saw him today I’d probably still be afraid of the guy.

I pointed out that James also learned from his mother to, “swallow feelings and keep going” (he had earlier in the session described how his mother would do this). James responded, “Maybe this is why I stay with my wife, because my mother taught me to just bury it and keep on going.” I was rather shocked by James’ unsolicited drawing of this connection and the incredible honesty he was demonstrating.

I felt aware of the emotional rawness of the session and let James know it was quite possible he would experience an increase in pain because his “mind wants a larger distraction to try and create distance from these feelings,” to which James agreed. At the end of the session, James stated, “I’ve got to be honest with you, I probably could have very easily gone into tears talking about my dad. I try not to think about him or those years because he held me back so bad it’s just unbelievable.”

Session 24 occurred the next day, and we basically picked up from where we left off. As I had predicted, James' pain increased after session 23, but he understood the pain response to be related to the painful emotions he was experiencing. In session 24, James became teary-eyed while stating his father "didn't show me love." I was reflecting to James that his father was both explosively angry and manipulative, and also that James experienced a profound *absence* of emotional nurturance.

As James continued to discuss his traumatic childhood, he remarked multiple times about the vagueness of his memories. I provided further psychoeducation about the nature of trauma and how the traumatized brain quite literally lays down memories differently, emphasizing to James that it was more important we developed a narrative that resonated for him. (I wasn't sure how much James' memory reflected repression, dissociation, or memories never laid down, but I didn't think it mattered much in this moment.) I was also reflecting to James the painful *aleness* of his childhood, to which James agreed. I was especially amazed when James, unsolicited, made the connection that his history of pursuing prostitutes was a way to distract and emotionally numb himself from painful feelings towards his parents.

Sessions 23 and 24 had a quality of emotional honesty and vulnerability that made me think we had experienced a major therapeutic breakthrough. James was *experiencing* his feelings more, and I felt like we had developed a resonant narrative around James' childhood and how his emotional pain and fear eventually turned into physical pain and fear. I was highly encouraged. Retrospectively, I would say these sessions represented the pinnacle of James' emotional experiencing. If I was to graphically represent the therapy, Phase 1 and 2 represented a slow, up-and-down, but steady increase in James' emotional expression and understanding of

the mind-body connection, as well as our own relational connection and intimacy. Phase 3 began a decline we would never recover from.

Phase 3: Sessions 25-34

Sessions 25-30: Heightened resistance after Phase 2, analysis of resistance, further discussion of guilt and anger, increased attack on therapy

In session 25, I was hoping to continue building the momentum from the prior two weeks of sessions. James began the session discussing how his pain had significantly increased since the prior session (which I had explained could well happen and James had completely forgotten) to the point that he took Xanax (he had recently received a prescription from his primary care doctor). Upon taking Xanax, his pain decreased. While James was prescribed Xanax for *anxiety*, he had a theory that the Xanax relieved muscle tension directly. He was argumentative when I suggested that his increase in pain and his taking an anxiolytic resulting in pain reduction both provided support for the theory of emotionally-induced pain. James expressed frustration that we “hadn’t made any progress.” (My supervisor pointed out, rightfully so, that it was a mistake to not challenge him on this point. I instead reflected that it was hard for him to hold on to gains.) James then stated that he “wasn’t sure how much further we can go,” and that he was considering ending therapy. I reflected to James that a couple of weeks ago, we “might be friends for life” and now he was contemplating leaving. (I thought James contemplating ending therapy was a clear reaction to the prior two sessions. I also thought that he was testing me: would I continue to “fight” for our relationship? How would I respond to more serious threats of leaving?)

James considered seeing a different therapist. When I explored this fantasy, James described how a different therapist “might offer a new technique.” I affirmed James for being so

open with me while also interpreting his non-commitment and his long history of looking for the next potential cure. (Admittedly, as a training clinician, it felt difficult to interpret this as resistance when there were plenty of times I questioned my own competence. Nonetheless, given our previous two sessions, I believed this was appropriate.) James expressed frustration with how long we had been working together, and I reminded him that he himself said he never thought 16 sessions would be enough.

Eventually, James talked more about his feelings of guilt related to his father and his marriage. He also mentioned that his mother's "dying wish" was to die at home (instead of a nursing home), and James felt guilty she died in the nursing home (even though she died while James was holding her hand). Thus, James was still discussing painful past experiences, but I felt keenly aware of his attack on the therapy. Even though I thought we had a fairly strong bond, I felt anxious about him leaving. I thought it was likely he was showing me - through relational enactment - how he felt with his father, but I thought it would be dismissive to interpret this so soon. I tried to take his feelings seriously that perhaps another therapist would offer something different and more helpful. After the session, my supervisor discussed how when people get closer to their core issues, they often want to run from therapy.

In session 26, I asked James how he felt after our last session. He said he "forgot" what we talked about, and when I refreshed his memory about him discussing termination, he said he "immediately dismissed from my mind that I would stop therapy" and wanted to continue. I again referred to the concept that an *increase* in pain is often times part of the path towards healing, and James asserted forcefully that he did *not* want to experience more pain. James had taken an increasingly high dosage of Xanax, and it was clear that his anxiety was overwhelming

him. He appeared agitated at the start of session and would later describe feeling like he was “at a breaking point” with his pain.

In session 25, James had brought up how one of his friends had chronic pain, was on “14 medications,” and engaged in a psychotherapy treatment program in which she stopped all medication and got better within a couple of months (this was one of the stated catalysts for him pondering seeing another therapist). In session 26, I brought up how the Sarno model involves stopping all physical treatments, and his current medication regimen was another form of non-commitment to the therapy. James again asserted that he “needs to live from day-to-day” and that *anything* that increased his pain (even temporarily) was a non-starter. (Retrospectively, I think part of our relational enactment was him railing against me, and me coming back with an emphasis on his non-commitment.) When I brought up that his partial commitment to the program was a “roadblock,” he replied, “That’s a roadblock for you, not me.”

Halfway through the session, James began talking in greater depth about seeking prostitutes. For the remainder of the session, I used a similar approach to sessions 23 and 24, slowing him down to get plentiful details about his experiences. James discussed a particularly scary instance in which he was physically assaulted. Thus, while James was attacking the therapy and pressuring me, he continued to discuss traumatic prior experiences.

At the end of session 26, James brought up wanting another opinion on the “compression” in his back, and I referred him to two TMS-informed medical doctors geographically proximate. James began session 27 highly agitated. He was upset because the doctors I referred him to “weren’t spine specialists, just orthopedists.” He said he “didn’t want to make this a pissing contest” but that my referrals were not helpful. I could feel his aggression. James proceeded to talk at length about how much pain he was in. I reiterated my early

interpretation that his returning again and again to discussing his pain was a way to try and ensure I took his pain seriously, something he felt previous medical doctors (and, emotionally speaking, his father) had not done. The interpretation fell flat. When James was myopically focused on the pain, it could be almost impossible to break him out of it until he was ready. Eventually, we continued to discuss his solicitation of prostitutes and the danger and excitement in his behavior. James acknowledged wishing he had married someone with a higher sexual drive, which I thought was an honest and vulnerable emotional disclosure.

Despite my continued attempts at re-direction, James again discussed his pain at length in session 28. He had newfound hope that “spinal compression” would explain his pain and had a medical consultation scheduled. He was also going to get a cortisone injection. I tried to point out the repetitious nature of James’ speech and how we had been down the road of pursuing other pain treatments before. When I asked him how he felt about me pointing this out, he said he felt “hopeful” about his new self-diagnosis. I felt completely hopeless. (From a CMT standpoint, I thought this might be a passive-into-active test in which James was being emotionally unavailable, much like his father had been, to see how I would respond. My hypothesis was that to pass the test, I needed to continue to be interested in him while not dissociating, somaticizing, or distracting from my own negative reactions to James.)

Again, after ad nauseam discussion of pain, James discussed his relationship with his wife: how he felt like they were “just living under the same roof;” that she doesn’t “share in the pain” with him; and his sexual frustration. I reflected how *alone* James felt with his pain throughout his life, but the reflection did not lead to new material.

In session 29, James continued to discuss his hope in the spinal compression hypothesis (e.g., “something’s tight in there but no one wants to operate on it”). I was discouraged and felt

hopeless listening to him, aware of his extreme rigidity and relentless return to physical explanations for pain. Again, James discussed his relationship with his wife. Internally, I was increasingly hypothesizing that James needed his pain to distract himself from his relational discontent. James discussed a petty argument they got into, and how he was “always satisfied with my wife until the pain.” I pointed out that James had previously mentioned contemplating getting a divorce, much preceding his current pain (James seemed to be using a more significant degree of defensive splitting in this session), and that James sought out prostitutes for years of their relationship. He rationalized his behavior by saying “the relationship was good with everything but the sex.”

Towards the end of the session, James said he was “sexually satisfied” with his wife. I challenged him on this point (another example of splitting) and he said, “Yeah, I can’t even get an erection anymore.” I offered the interpretation that I thought sometimes James stated what he *wanted* to be true instead of what *actually was* true. I was trying to help James understand his “flip-flopping” as he described it.

I also brought up the pattern that recently, when I empathized with James (e.g., “it’s hard feeling sexually frustrated”) he would state the opposite, almost no matter what we were talking about and regardless of what he had previously said. I explained that I thought my empathy might be threatening because it was putting him in touch with more painful feelings (which he had been majorly avoiding recently). James disagreed. It felt as though nothing I could say was helpful. I was increasingly frustrated and exasperated, and I found myself having a hard time holding on to the idea that only a few weeks ago James was disclosing traumatic elements of his past.

In session 30, when James began talking about his pain again, I said, “Is it helpful to talk about the pain?” He responded, “Not really.” I asked him if I could re-direct him towards possible unconscious processes, and he agreed. Because I felt like nothing I was doing was working, I decided to disclose my own history of TMS (I consulted with my supervisor prior to making such a disclosure; my supervisor informed me that he usually shares his own TMS story with his patients). Although James seemed comforted by the idea that I understood, experientially, what chronic pain felt like, he also was careful to note that I didn’t have the same structural abnormalities he did and essentially rationalized why I was a good TMS candidate and he was not (e.g., “If your foot was broken, wouldn’t you pursue surgery?”). Again, it felt like James was determined to disagree and argue with me. (My supervisor had, at one point, described the therapy as like “hand-to-hand combat,” encouraging me to get into the trenches with James, and this analogy rang especially true during this phase of treatment.)

James continued to discuss his feelings of guilt, and I encouraged him to speak with a priest since he was concerned about “going to hell” (James liked this idea and subsequently did). Again, because it seemed most of my interventions weren’t going anywhere, I tried to alter course and mentioned to James that we had spent very little time in therapy discussing his relationship with his own children. James discussed trying to provide a different emotional experience than he had growing up, but spoke with little emotion. I was struck that he actually appeared to have broken the cycle of intergenerational trauma. He genuinely seemed to be a much more supportive and loving parent, and I reflected this to him. At one point, James described how he and his daughter were very similar, and then described her as “fragile but not willing to show it.” James seemingly had no recognition that the logical inference would be that he was also fragile but unwilling to show it.

Sessions 31-34: Further attack on the therapy, confrontation, acceptance of non-commitment

Beginning session 31, James and I went from twice-weekly meetings to once-weekly “double” sessions (i.e., one hour and 40 minutes long). I explained to James that I thought double sessions might allow us to do deeper emotional processing since, rather predictably, a certain amount of each session was dedicated to James talking about his pain before he would move on to more affectively-laden content. (While I believed this to be true based on my work with other therapy clients, the decision was also motivated by my own non-therapy work schedule becoming more impacted and James and I struggling to find two days per week to meet.)

James began session 31 stating that he felt worse. When I re-directed him to what might be going on emotionally, he brought up that he might unconsciously feel lonely. He discussed his feelings of aloneness growing up and elaborated on his history of feeling rejected by women because of his “frizzy hair,” lack of confidence, and “not knowing how to French kiss.” My approach during this session was mostly trying to use reflections and give James language for what I thought he might be feeling (i.e., instead of asking him how he felt, I was trying to hypothesize what I thought he probably felt and pre-emptively use the language, which had consistently worked well throughout treatment).

James linked his history of loneliness with current feelings of loneliness in his marital relationship. I interpreted that James had no model for a healthy romantic relationship and no guidance from his father. This resonated with James and he discussed how he tried to be helpful to his son when it came to dating.

He then further discussed his feelings of guilt and regret that it was so late before James' family realized his mother was dying. I could feel James blaming himself for both of his parent's deaths, and I commented this was not James' fault; James' father was like an emotional vortex for the family, and his mother didn't know how to assert her own needs. (I was struck by James' identifications with his mother.)

James was emotionally honest in session while discussing his loneliness and guilt. Then, James brought up that even though we were talking about emotions, he didn't feel better, causing frustration. He said his wife inquired about me providing James with more skills. I felt his aggression and pressure, while reiterating there was no quick fix and the goal of therapy wasn't one breakthrough cathartic moment. I reminded James I had provided him many skills and made multiple recommendations, which he only sporadically used. I reflected that more skills did not seem to be the issue. James was talking about his relationship with his wife and discussed enjoying "keeping her on her toes" relationally. I felt aware James was trying to keep me on my toes as well with his aggression and constant discussion of pursuing other treatment options. I thought James was continuing to test me by applying pressure and acting aggressive to see how I would respond, and I tried to stay focused on being relentlessly interested in his emotional experience while reflecting core emotional dynamics (e.g., "You didn't get the love and guidance you needed").

James expressed major frustration with the process of journaling and how he "just ends up writing the same stuff" day after day. (It occurred to me that because James had serious impairments in observing ego capacities, he had an immensely difficult time observing his experiences when journaling and struggled to engage in self-reflection.)

James began session 32 stating that after our last session, he felt significantly better for “about half a day.” Throughout therapy, James would lament not having more free time despite the fact that he was retired. In session 32, we focused on how James had spent all of his life running away from distressing thoughts and how he engaged in constant action as a defense from such thoughts (this being an explanation for why he felt like he had such limited free time post-retirement). James was aware of his tendency to always be engaging in some form of activity and readily agreed. I brought up that not only does constant action drown out distressing thoughts, but that James also engaged in activities that gave him a sense of self-mastery (e.g., washing cars, cleaning, housework). Although James agreed, this intervention didn’t lead to an opening up of new material.

Because James previously stated he found visuals helpful (like the previous pain diagram I gave him), I provided psychoeducation on trauma and the idea of “decoupling” past traumatic experiences and present-day experiences. I reflected that growing up, calmness for James was always followed by extreme volatility (i.e., his father’s rage). James resonated with this idea, adding that he was living in “constant fear.” I interpreted that one of the reasons James engaged in constant action was that he had become “programmed” to associate relaxation as a pre-cursor to danger. Moreover, without pain, James would feel increasingly calm, further signaling danger. (Part of my aim was to try and find new, resonant narratives for James in terms of the function of his pain.) I noted that even the act of sitting, which caused James so much pain, is an act of calm and a more vulnerable position than standing. James agreed with my interpretations (e.g., “Exactly”), but when I discussed the idea of grounding himself in the present as a way to remember that he’s not currently in danger, he seemed confused. After multiple attempts at

explaining, I chose not to belabor the point because I felt how intellectualized we were becoming, which never seemed to be helpful for James.

Per the usual, James spent part of the session discussing the potential spinal compression in his back and how he was holding out hope for a physical cure. Instead of arguing with James, I attempted to “roll with the resistance” (Miller & Rollnick, 2013), reflecting that I knew James was holding out hope for a physical cure. I did interpret that “we both know” if the physical examination didn’t give James the result he wanted, he would come up with a new explanation for the pain; James begrudgingly agreed. In this session, James was more receptive to the idea that being “totally fixated on physical explanations” (his words) was interfering with the therapy (although he was still fully committed to pursuing physical treatment).

I found myself feeling sad for James, which was not my usual countertransference reaction. I remarked how I felt sad for him because I thought we had a solution (the TMS approach) that could lead to a cure, yet he wouldn’t let go of the physical explanation. I enumerated some reasons why TMS theory made sense: James himself noted the “book could have been written” about him; his pain location and intensity were sporadic, which was a positive indicator for psychosomatic processes; spinal compression would not seem to explain such a recent surge in pain; and that the *Unlearn Your Pain* (Schubiner & Betzold, 2010) journal he was working in stated, as I had, that an increase in pain can be a sign of progress.

In session 33, James was ruminating on his pain and how his medical consultation revealed a “23-25 percent bulging disk.” I clarified with James – and he confirmed - that one of the best medical hospitals in the country had already noted this and *did not think it explained his pain* (he had various rationalizations for this, including that the prior medical hospital only looked at his exam in black and white, whereas the new location looked at it in color, resulting in

greater clarity). Despite this, James continued to ruminate on his pain and discussed at length the various potential surgical procedures he was considering and different possible physical explanations. I pointed out that he seemed to have a solid plan in place and that he was ruminating: “You’re ruminating. You’re replaying this loop of decisions, but it doesn’t feel like you’re getting anywhere.” I interpreted to him that I thought his tendency was to talk about the pain, which raised his anxiety, which then led to further discussion of his pain, calling this a “pain trap,” and he agreed, later referencing the concept and stating, “I’m trying to get out of the pain trap...when it hurts real bad, that’s all I can think about.”

My frustration was building, and much of the session felt argumentative and disjointed. (Retrospectively, James may have been testing me both to see how I would handle his aggression, and also to see if, unlike his father, I could share in the responsibility for his perceived lack of progress.) James stated he didn’t know “if I’ve gotten the right tools yet to try and work through” the pain, “and that’s where it comes back to you.” James then referenced how I had mentioned decoupling:

James: Like last time, you said we have to uncouple all of those thoughts from your mind. You know, that’s a nice word, but, I’m burying them, and then you’re saying uncouple. So you’re basically saying I’ve gotta get that shit out of my head altogether. I need to totally disorient myself from those thoughts. And that’s difficult for anybody. Some of it’s family issues, some of it is, I look at my wife every day and can’t help but feel guilty for how I’ve behaved these past years, it’s very difficult to uncouple or, as you would say, for me to totally disconnect from those thoughts, but these are the types of tools that you are giving me.

Me: Give me some coaching here. You have a way of taking my words and making them your own. But often times in that process, what I'm saying and what you're hearing goes through an incredible process of distortion.

James asked for clarification. I reiterated both the idea of pain as a distraction against repressed emotion and the idea of decoupling:

Me: The idea with the uncoupling is that you start thinking about a situation with your father and go, "There, I was in fear because I was in a situation with my father, but here, my father is gone and there's no need to be in fear." But then you take that and you say, "You want me to disconnect from my feelings." But at no point did I say disconnect from your feelings.

James: You said uncouple. That's almost the same thing.

Me: No, it's not.

As we continued to argue, James became as angry as I'd seen him in therapy. His anger escalated when I brought up his lack of commitment to using tools we had discussed. We also argued about research on imaging studies and spinal compression (i.e., we were increasingly arguing about anything and everything). I asked James about his anger:

Me: There's a real intensity to you right now, tell me about that.

James: Yeah, 'cuz you pissed me off. (Major intensity in his voice.)

Me: Yeah, tell me about that.

James: (Diverts.)

Me: I'm asking about how I pissed you off. I want to know.

James: Just the way you turned things around. You're criticizing me saying how I take things and distort them, and yeah, 'cuz I'm the one living with the pain.

Although uncomfortable for me, I knew it was important for James to be able to express his anger with me. I thought his reaction to feeling “criticized” was likely similar to how he experienced his father (i.e., a transference reaction). James diverted away from talking about our relationship, discussing at length how he had to live with the pain; how he couldn’t commit to a psychological approach because he “hasn’t seen results;” how when he tried resuming physical activity for a month, he became “so freakin’ sore I can’t move anymore;” and how he was “trying to stay on a humane spot where I can function every day.” James acknowledged that he might not be understanding my language correctly (as my supervisor rightly pointed out, I often used language that was more complex and thus less experience-near for James). When I validated that my use of language was not helpful, James calmed down and discussed feeling “discouraged” that he “couldn’t make my mind conquer my body.”

Throughout the session, James and I argued about his commitment to the TMS approach, with James entrenched in the idea that in order to further commit, he needed to “see progress.” I reiterated that I thought he needed to commit first and then the progress would come. (As aforementioned, I was unconsciously colluding with James in implicitly agreeing that he hadn’t made progress.) At one point, I brought up that almost every session, he stated we weren’t making any progress, and I thought this was his way of beating up on me. He acknowledged trying to “keep me on my toes.” (Our argumentative tone with each other in this session was likely a relational enactment of domination and submission, with both James and I struggling for power and control.) James had some awareness of how his behavior was self-sabotaging (e.g., “I know I’m fighting you on one hand and that’s a disadvantage to you”) although at other times emphasized he thought I needed to take more responsibility for his lack of progress. (Although I try to adopt a relational, intersubjective framework in therapy as a general principle, I struggled

to feel like I was partially responsible for his current levels of pain.) I interpreted that James was “stuck in his ways” and tried to link this to how he felt out of control with his father. James agreed he was “very much set” in his thinking, and we agreed that ultimately, the change would have to come from James if he was to get “unstuck”:

James: You’re right. I’m stuck. I admit it. I just don’t know how to get out of that unstuck mode. I’ve been here for too long. It’s just the same shit every day.”

I reflected to James his feelings of discouragement and that to try and work on his emotional life felt like a daunting task compared to pursuing other physical approaches.

After session 33, I felt discouraged because for every brief moment of James and I connecting (e.g., him acknowledging his profound state of being stuck) there were many more moments of diversions, ruminations, and attacks on the therapy. My supervisor and I discussed the idea of James’ lack of commitment. My supervisor encouraged me to be clear and direct with James that if he wanted to heal, he needed to adhere to the Sarno approach (i.e., think psychological, stop physical treatments, and resume normal physical activities). I needed to explain that I wasn’t telling James he had to use this approach, but that we were at a fork in the road in terms of him either committing or changing the therapy contract to a more emotionally supportive therapy without an emphasis on pain reduction.

In session 34, after some discussion of his pain and then discussing how he felt various forms of pressure from his family, James again brought up feeling like he “wasn’t making any progress.” I brought up that we were at a “fork in the road,” and that I didn’t think he could make any more progress without further commitment (as outlined above). James responded that he was unwilling to stop pursuing physical explanations, and I explained that we could continue our work together until I left the Clinic in about three months, but that the treatment would be

more supportive and less focused on pain reduction. James was initially quite angry, saying it was like I was “bailing out on him.” I emphasized that he really did have a *choice*, and my goal was for him to feel more autonomous and like he had control over his treatment, but that focusing on the physical greatly hindered our progress. James acknowledged that “the whole time” since therapy began, he had still hoped that something was wrong with his back. (Even though James and I essentially changed the therapy contract in this session, in some ways, this ended up being more of a formality. By and large, James continued to discuss his pain and his wanting me to help him heal, and I also continued to work with him on pain instead of truly adopting a more “supportive” therapist stance.)

I provided further clarification about the Sarno approach because James stated he wasn't clear as to what we were working on. Amazingly, when I checked to ensure his understanding, James linked his relational friction with his wife, his frustration with medical professionals, and his children “getting on my nerves” to the tightness in his groin and back (i.e., James had made the mind-body connection). James was still focused on the idea that he needed to “clean them out” (referring to his emotions), and I reiterated the goal is to accept the TMS diagnosis, not to rid himself of such feelings. I said that through such mind-body linking (“through thousands of repetitions”), how emotions impact the body becomes increasingly clear. We went over further examples, and James discussed his “love/hate relationships” with his children. James also discussed the “void” in his life that prostitutes filled, and how, since retirement, he had never been able to fill the void.

James then began discussing his professional life and how if he didn't like someone he was working with, he could “drop them.” When I made the interpretation that perhaps he wished he could “drop” his family sometimes, he said “good analogy.” At the end of the session, he

said, “maybe I can mentally dump my wife.” (Although my interpretation about his wife seemed to resonate, his comment about dropping people likely had a transference meaning as well.) Internally, I wondered if in giving James a choice about how to continue therapy (i.e., that we didn’t have to focus on pain reduction), it de-pressurized the therapy environment and led to James being more emotionally authentic and open.

Phase 4: Sessions 35-41

Sessions 35-41: Increased self-awareness, further entrenchment/rigidity, narrative work, confrontation and discussion of termination

With the “double” sessions, James and I would cover a lot of ground in a given session. This was certainly true in session 35. We discussed how James had an “overactive” mind, and how since retirement, he felt “lost.” James discussed feeling like medical professionals were “corrupt,” driven by money and ulterior motives. I reflected that James must feel like I, too, was driven by ulterior motives (i.e., my research), but he diverted. I interpreted that these perceptions related to James’ relational model with his father, one of “manipulation” and being driven by money. James agreed that his father was like this but was not convinced he was projecting onto medical professionals.

I continued to feel aware of James’ rigidity and stubbornness. I tried to link how his stubbornness was a way to cope with his father: “When you are constantly being met with punishment, it doesn’t invite a sort of, “gee, maybe I am wrong” response.” It invites a stubborn, rigid, defensive position.” He acknowledged his father was volatile, critical, and aggressive, but also said that he was *not* stubborn (something he flip-flopped on; he would later say he *was* stubborn, but only because he was “almost always right”). I reflected to James that I thought his upbringing was “more terrifying and difficult than either of us know.” (I made this reflection

because I often felt aware that *cognitively*, I knew James had experienced severe relational trauma, but *emotionally*, I felt little in session.) James responded, “Absolutely.”

Throughout the session, James defaulted to being closed-off emotionally. Although he would half-agree or agree with my reflections and interpretations, he would not open up emotionally or provide new material (e.g., feelings or facts about his relationship with his wife). When he appeared to be reaching more emotional material, he would shut down and offer a form of “it is what it is” or “it’s in the past” sentiment.

James was set to receive a medical injection the following day and continued to be focused on physical/structural explanations for his pain. He acknowledged that even if the procedure did not work as desired, he still would not be willing to attribute more of his pain to emotions. I reflected that I thought his emotional world felt more chaotic and less “solvable” than the physical, and he agreed. James continued to increase his awareness of how his pursuit of the physical sabotaged our work. He also continued to express his frustration with the therapy, while also stating that he “enjoyed talking with me.” Throughout the session, it felt like James just needed to argue and rail against me (i.e., the content of what he was saying felt less important).

In the session, I felt somewhat hopeless and also rather trapped; because James did not seem to have the observing ego capacities required to reflect on my interpretations and the process of therapy, I felt like there was little room to point out some of his relational dynamics and have anything stick. For example, part of me wanted to reflect to him that I thought some of my feeling trapped was probably similar to how he felt with his father, but these types of reflections/interventions had not been effective in the past, with James offering only cursory partial or full agreement.

In session 36, I attempted to change my technique and focused almost solely on what I thought James was feeling, paying almost no attention to the content of what he was saying. He responded well, opening up about a particularly painful memory of his father in which his father humiliated James by having him clean up and organize his house for him (James was an adult while this was happening). I tried to reflect, again and again, how much fear James felt towards his father. James agreed, but again continued to refrain with “I can’t do anything about it now.” I tried to challenge this with a hypothetical:

Me: Why do people grieve when a family member dies?

James: Because it helps them to feel better.

Me: Exactly. Sometimes just to *feel* helps. Even when you can’t “do” anything about it.

I tried to interpret that James grew up in an environment where he had no help processing his feelings, and so, in result, he had no internal apparatus to process feelings and developed a belief that all feelings were toxic, needing to be buried. James responded indirectly by talking about his perfectionism and how he tried to do work-related tasks flawlessly so as not to be criticized.

As we continued to discuss James’ fear of his father, James described doing “backbreaking work” for his father. Internally, it occurred to me that James was in a constant bind: he either had to submit to his father’s will, or he could try and break away, but to do so would create immense guilt (James described feeling like he had to “respect” his parents’ wishes). I reflected that in present day, James both wanted to be free (e.g., going on vacation) and yet there was a part of him that was “paralyzed” by his father’s fear:

Me: It’s like your father’s hooks are still in you. He’s still controlling your life. You don’t want to think about him and that makes sense. You want to be done with him...but the point is you’re still in pain, so here we are.

James seemed to be experiencing more emotion but would fill the space with superfluous details and diversions. He acknowledged that there were times when he might want to cry, but wouldn't. I asked him what it would be like to cry in session, and he responded that it would be "embarrassing," and how he wouldn't want to walk out of the therapy room and have people in the hallway see his crying eyes. I didn't pressure him on this point because I felt like this was an emotionally honest and vulnerable disclosure.

James continued to be more open in session, drawing some unsolicited connections, which I saw as a positive sign. He said he could be "stubborn and rigid just like my father." He also connected that his father was completely lacking in affection and so was his wife. At the same time, James would preface such revelations with "maybe in my subconscious," and in this way I thought it was too threatening for him to fully integrate these experiences into his conscious awareness.

In session 37, James reported that the medical injection he had recently received did not help, and he had a myopic focus on how his hip was the "real issue." He was spending "hours online researching hip surgeons." Just as predicted, James had moved onto the next physical explanation for his pain.

Moving away from discussing the pain, James talked about his relationship with his sister and how she was a "greedy bitch," taking more than her fair share of their parents' money when they died. James could readily connect how his sister was more like his father and how he was more like his mother. James shared a story about his sister lavishly spending the money she inherited on luxury items, while James spent the money on his children. I could sense how resentful and angry James was. James then went back to discussing his pain, and when I redirected him, he stated, "There's nothing more to say here. I get what you're trying to do in

terms of getting me upset about my sister.” I was frustrated with his resistance, and as he droned on about his pain, I reflected, “I think it’s likely that you will walk out of here [the treatment] in as much pain as you’re in right now.” I brought up that even if this was the case, I thought it might be nice to be able to talk about his feelings and have someone bear witness to his traumas. James still persisted in talking about his pain. (Internally, I felt aware of just how scary being emotionally vulnerable was for James. The idea of sharing his feelings with a kind, empathic other was also fraught with danger and mistrust. I also thought that James’ high degree of resistance might be a reaction to the prior session in which he was more emotionally open.)

In session 38, my frustration reached a boiling point, and I mentally prepared to be highly confrontational with James in the session. (My supervisor had also continuously encouraged me to be more confrontational with James, something that I struggled with. I believe I struggled with this for two reasons: one, James had a subtle way of dominating the session, and two, my own natural style is more conflict-avoidant and non-confrontational.)

James stated that he was engaging in another medical procedure the following week and he was hoping it would lead to pain relief. He was back to thinking that spinal compression was the main issue (i.e., not his hip). I pointed out to James that since he had begun seeing me, he had pursued a myriad of different medications and medical procedures (I listed them off, but for confidentiality sake have not done so here), and that I wasn’t clear “how this time would be different.” I further pointed out that just like James had thought other doctors were financially motivated, I saw no reason why this doctor would be different. As James argued with me, I tried to apply increasing pressure. As James had said much earlier in the therapy, I felt like he had given me so much “ammunition” that I was going to plow through his resistance (I use aggressive language here because I believe it captures the spirit of what I was feeling).

James often had a tendency to laugh and make jokes at times when he was feeling either sad or angry, and I confronted his laughter and interpreted it as a way to avoid discussing painful affect. We were talking about his romantic relationship, and when James expressed discontent, he then said, “a lot of people feel this way,” to which I responded, “I don’t have a lot of people in the room. I have you.” James said that if he didn’t laugh about his life, he would “endlessly cry.” It was moments like these where I felt most clear about the Sarno model and how much repression James was using. When James would offer such statements, one typical response of his was to say that he was “trying” in therapy but didn’t know how to access greater levels of feeling or what to say. I pointed out that James had said there were times when he felt like crying, but *stopped himself*, and that I thought James actually did know how to access greater levels of feeling, the issue was that he didn’t *want* to. (One of the implications of my statement was that I thought James was using repression as a defense, not dissociation.) James actually agreed, which I thought was important because his agreement essentially neutralized his defense of “not knowing” how to feel more.

James then repeatedly brought up that he “didn’t know what to do” with whatever feeling he was talking about and asked me what he should do. I interpreted this as a further defense; James had spent his whole life in the world of action as a way *not* to feel, and I told him that the task was not to “do” something with the feeling, but to feel it and let the feeling come and go like a wave (I had used the wave analogy before). (Part of my interpretation here was driven by my supervisor beautifully pointing out that what to do with feelings becomes clear when we give them long enough to settle in.)

Session 38 was likely the pinnacle of my confrontational approach with James, and although he fought me tooth and nail for much of the session, he also seemed to appreciate my

defense analysis. I also brought up that as he continued to pursue physical solutions, it would be important for us to set a firm termination date.

Session 39-41: Further narrative work and resistance

James began session 39 stating that I “hammered [him] pretty good” last session. He was disturbed by the idea that his latest medical pursuit might be “grasping for straws” again. He said if he didn’t get pain relief, he would consider decreasing his current pain medication regimen (i.e., work towards decreasing physical treatments). I took this as a sign to increase pressure and confrontation. When James continued to discuss various medical treatments, I made the point repeatedly that he could spend the rest of his life “looking for the next thing.”

We began talking about his relationship with his father and when James laughed, I immediately confronted him on the incongruity of his laughter. He said that he might be laughing because he felt “guilty” and that I “might be right about the source of my pain.” The majority of the session was spent talking about his father: how his father “stabbed” James in the back with his financial decisions and manipulations; how his father was a “sick man;” how his father “destroyed many parts of my life;” and how his father “emotionally destroyed” him. I was struck by the violent and vivid nature of James’ language.

As in our previous session, when James tried to state that he didn’t know what more to say, I pointed out that the issue was part of him didn’t *want* to say more. James acknowledged that “I don’t want to cry. I don’t want to access the feelings. I don’t want to shed one more tear over him.” I was struck by James’ emotional honesty and how this was such a different narrative than not knowing what to feel or what to do with feelings. I was reflecting to James how his father was “abusive” and how James experienced “trauma” (purposefully trying to use strong

language so James had a clearer understanding of the degree of relational suffering he experienced), and James agreed.

James would still offer refrains that he “didn’t know what we were trying to accomplish” by talking about his father. Instead of trying to assert the value of what we were doing, I interpreted this to James as him not wanting to feel more pain. The one time that I deviated from this technique and asserted that James’ father had an influence on James “whether you think so or not” and that it was “bullshit” that he could just “bury his feelings,” James became argumentative (I believe I was acting out some of my frustration with him).

In session 40, James said that it was “ringing in his ears” that I had said he would continue to look for the next physical cure until he died. Sure enough, the most recent pain treatment had not provided the results he was hoping for. James was clearly distressed and more anxious than usual in session. In my mind, I had a distinct image of James being in a room that was getting smaller and smaller. I used this image to reflect to James how scary it was to pursue another treatment and not have it work, and James acknowledged feeling terrified.

I again tried to focus James on affectively-laden material. We talked for a short while about his father, but there didn’t seem to be much emotional salience there, so when James brought up his wife, I jumped on this. Internally, I had for some time been wondering if one of the biggest barriers to James getting better was that he felt completely trapped in his marriage. I repeatedly brought up that James had described his relationship as “lacking passion,” “loveless,” and sexually frustrating. James was highly argumentative, commonly reverting to, “Wait until you’ve been married for 44 years” as a way to rationalize his discontent. Yet, at another point he said, “Ok, well, if you’re right, then what do I do?” James also acknowledged that there was “good and bad” to his relationship, but then discussed only the positive. I took this as a sign of

how threatening it was to discuss his relationship (which made total sense to me. I was aware of the bind James was in).

The majority of session 41 was spent discussing how James felt profoundly lost since retiring. When I reflected to James how I thought he had never figured out how he wanted to live post-retirement, he agreed strongly and his whole mood seemed to change, becoming more engaged and energetic.

I pointed out that James and I had discussed various physical activities he might engage in (e.g., bowling, billiards, bicycling) but that one can “only play so many games of billiards” in a day and that it seemed like James would do well to have a purposeful activity that took up more time. I said that pain fills up so much of his mental space and that if he had something else to think about, this could be useful. I also pointed out that since James lived in the world of action, and since thinking psychological had proven difficult for him, a more action-oriented approach to pain relief could be useful. I also reflected that I thought James was experiencing a “low-grade depression” and that his life was “somewhat miserable.” He agreed, stating that “there isn’t really anything to look forward to” and how this drew his attention to the pain.

When I asked James what got in the way of engaging in more enjoyable activities, James mentioned that his appearance “daunted” him and that he felt frequently self-conscious. He described believing that some people wouldn’t say hello to him because of the way he looked, providing examples of service workers acknowledging his better-looking friends but supposedly ignoring James. (This conversation led my supervisor and I to speculate that James had some psychotic projections and that his pain might have partially protected him from an internal world that felt utterly chaotic.)

I also reflected that in post-retirement life, James had both lost what enlivened him (work and prostitutes) and had more time to “face your demons.” Internally, I felt the gravity of the fact that his children were not geographically proximate, his relationship was “loveless,” and he had a seemingly unlimited amount of time to fill (i.e., he had minimal social engagements beyond visiting his children occasionally and was not engaged in volunteer or other kinds of recreational activities). I tried to have James brainstorm what he might enjoy doing. James struggled to generate ideas, and I encouraged him to think more about this since it felt like we had identified a major hurdle to him feeling better.

At the end of the session, James said, “Now it feels like we’re making progress.” (I felt conflicted because while I did think James was experiencing an existential crisis of sorts, I also felt like I was colluding with his action-orientation at the expense of doing deeper emotional work, and we were de-emphasizing his relational conflicts.)

Phase 5: Sessions 42-44

Sessions 42-44: Existential void, external transformation, stubbornness, hate, and termination

I had told James on at least two prior occasions that I would be leaving the clinic at the end of the year: once when I brought up that we didn’t need to follow a 16-session model but that therapy wasn’t completely open-ended, and once when we switched to a more “emotionally-supportive” therapy (i.e., session 34). Nonetheless, we had minimally talked about the prospect of termination. (Retrospectively, I believe this was an enactment: we were both unconsciously involved in a fantasy that we would have a major breakthrough and James’ pain would diminish. At the same time, I think it was less than coincidental that in session 41, we were discussing

James trying to fill a void in his life; therapy ending would seem to be a void to fill.) As the end of the year neared, I became increasingly aware of the limited time we had left.

In session 42, James reverted to discussing his physical pain at great length. My attempts to re-direct him towards discussing the void in his life were met with resistance and further discussion of his pain and potential procedures and treatments that might alleviate such pain. I had recently read *Bodies in Treatment* (Anderson, 2013), in which Anderson discusses how pain patients often have the fantasy of an external object healing them. The fantasies are “resistance to “owning” one’s body, in the belief that the body belongs to a powerful other such as God or Mother” (p. 9). I tried to work with James on the idea that he was fixated on someone else “offering you the magic potion to get better.” As James continued to discuss his pain, I reflected to him that I felt like he was “like a brick wall.” (Internally, I felt infuriated with James, and began to understand Winnicott’s [1949] discussion of hate in the countertransference. James’ endless redundancy and “brick wall” like quality became increasingly difficult to tolerate.) I interpreted repeatedly that James felt conflicted about healing and that he was terrified to let his wall down because his rigidity was one of his main coping mechanisms.

Feeling profoundly aware of our state of being stuck and how none of my interventions seemed to be going anywhere, it occurred to me to ask James a hypothetical: if James was on an island with no access to treatment of any kind, what would he do to try and deal with the pain? James responded that he would try to “move around and have a calm state of mind.” I asked James how confident he would be that he could improve his pain, and he said a “five or a six.” I asked him how confident he was that a medical professional could improve his pain, and he said a “four or a five.”

James did not self-reflect that it was curious how he actually thought he had a better chance of healing himself than medical professionals. I pointed out that he gave himself a higher rating, and that this was “good news!” James had no such reaction. For me, this was one of the more perplexing features of James: what seemed to me to be rather obviously good news was not good news to James. (Retrospectively, I understand James’ behavior to be a reflection of how much he needed his pain.) Because James was religious, I reflected to him that I was reminded about the gospel story of the rich man asking Jesus what he needed to do, Jesus telling him to get rid of all of his belongings and come follow him, and the man walking away disappointed. James actually agreed that he was like the rich man, but this did not change his affect. I felt both hopeless and frustrated that James could cognitively acknowledge so much and yet emotionally be completely unmoved. (After this island exchange, I realized how much I had come to dread seeing James. I also thought it was likely that James was letting me know just how impossible it was to influence his father [i.e., a passive-into-active test]. I thought to myself that with many, many years of therapy, James could possibly change. But, I also knew we did not have many years of therapy left.) In session 42, I also provided James with an exact date that I would be leaving the clinic and that treatment would end.

In session 43, James reported that another physical treatment he had pursued was not producing the results he wanted and that he actually felt worse. James appeared highly agitated in session and was complaining more than usual. Very quickly, we were arguing about his pain and resuming physical activity. I pointed out that we had agreed he needed to make more time for him to engage in pleasurable, enjoyable activities (like playing pool), and yet he had not created the time. James responded that pool wouldn’t actually bring him any enjoyment. I remarked that it seemed like James was determined to argue with me, no matter what, given that

playing pool had been one of his original treatment goals. James could acknowledge his argumentativeness and stubbornness but was unwilling to link this to his past.

I pointed out that in all of the treatments James has pursued, he was the common denominator. I brought up that he consistently put up a wall and expected treatments to fail. Later in the session, James described how he didn't "know how to take the wall down." I reflected that I believed he was "seriously traumatized" and "erected a concrete castle," "walling off parts of your experience" to protect himself, especially from his father.

I found James to be especially miserable in this session. Eventually, he told me that he felt "blindsided" by "finding out" that I would be leaving the clinic. While, internally, I thought I could have been clearer throughout treatment about the termination date, I also thought James had repressed/denied the fact that therapy would eventually end. I tried to explore James feeling blindsided, and he discussed feeling "betrayed." I tried to validate that I could see why he would feel this way. After exploration, I offered to James that I thought I could have been clearer with him and that my own analysis was that I hadn't been so clear in part because I was holding on to a fantasy that we would still find a cure. James was surprisingly understanding, responding that he, too, was still hoping that we would "stumble upon" a transformational emotional experience.

I did tell James that I was surprised he cared that the therapy was ending given he seemed so miserable coming to sessions. James said that he "liked coming" to therapy. I was hoping to help him mentalize that in constantly attacking the therapy, that would predictably lead me to think that he didn't particularly care about it, but James went off on a diversion and I didn't redirect him. Towards the end of the session, I tried to emphasize to James that there "is no magic bullet" of healing, and that he was ultimately going to have to be the one to heal himself, not

some external, all-powerful authority figure. James recognized the truth in what I was saying, and the session ended on a somber note.

James began session 44 complaining about his pain and discussing that there was a “new procedure” he was going to pursue, but he didn’t want to tell me what it was. I felt immediately aware of how emotionally unavailable James seemed. I tried to point out to James that this was just the next thing he was pursuing, and he exclusively rationalized how this treatment would be different (it occurred to me that James really could not recognize for a prolonged period of time the absurdity of pursuing another treatment). James’ mind was stuck on: 1) How he was in a lot of pain and needed a cure; and 2) Because the pain came later in life (or, at least, this round of pain), he couldn’t understand how childhood emotions could be causing the pain (i.e., if childhood emotions were the issue, he should have had more pain growing up). While his pain trajectory did not seem theoretically problematic to TMS, I nonetheless validated that pain has a “mysterious” quality to it.

Although James and I could have met twice more, James stated that since he was going to pursue other physical treatments and didn’t think there was much more for us to talk about, he wanted this to be the final therapy session. Internally, I hypothesized that James was actually deeply sad, hurt, angry, and resentful towards me for leaving, but he dismissed all of my attempts to talk further about our relationship. Moreover, as mentioned, I had for perhaps the first time in my training developed feelings of hatred towards James, and thus put up only minimal resistance to the idea of us having a spontaneous termination session.

Towards the end of the session, I wanted to get James’ feedback about the therapy and the Sarno approach:

Me: What do you think you would say to someone that was considering a Sarno-modeled treatment?

James: I've already suggested it to some people.

Me: What advice would you give them, knowing what you know now?

James: Sometimes it's a psychological problem and you need to take a different approach to what you're doing.

Me: And then if they said, "What do you mean?" You would say?

James: Well, sometimes you know, your subconscious thoughts, things that have happened to you in the past or whatever, you might have a deep-rooted problem that you're not even aware of and once it becomes obvious, it becomes easier to deal with every day stress. It's that kind of...well, pain is a distraction, pain and anger are a distraction from more stress and pain. What did you say Justin, how did you say it?

Me: It doesn't matter.

James: Well, anyway.

Me: And if someone said, "No, I think it's really, there's something going on [physically]..." Let's say someone is having headaches or something...

James: That's one of the fellas that I recommended it to. He's doing well, and I don't know why, but he said he's doing fine.

Me: Well let's just say someone else goes, "I'm having headaches," and you say, "Well, you know, check this out," and they go, "No, I really think my blood pressure or, I think there's something physical wrong" would you say it makes sense to sort of push that person to consider emotional issues, or would you say it's not worth it?

James: Well, I would certainly let somebody exhaust medical possibilities first, and then if they were frustrated...[he goes on about a woman he knows that has pursued myriad physical treatments]...I guess I didn't answer your question. Some people I would recommend, maybe you just need to go and talk to someone. Maybe there's something buried in the back of your head that you need to talk with someone about. Sometimes it's good for the soul to get some stuff out. That's why I kind of thought that even though we didn't get any "breakthroughs" I did feel good about what we talked about. And you can certainly have some fun with my stories (laughing). I suppose you keep me honest. Anyway...

Me: And if someone, let's say I saw someone in the future that was somewhat like you in some ways, when would you say I should sort of throw in the towel so to say?

James: That's a good question, Justin. I don't know. Is there really ever, how do you know when the time is? Ok, let me go about this in a different way. If you weren't leaving the first of the year, would I continue to come? Probably. So, we're kind of forced into terminating the relationship. Whether I want to start over with someone else that I'm not sure of...As far as your question goes, I understand for some people it takes years. Maybe I'm that person.

Me: I was genuinely curious how you would respond and had no expectation about what you might say. It sounds like you are generally open to the idea that it might take years to work through things.

James: Well, yeah, in my particular case. I hoped it wouldn't take years, but we've already gone a considerable amount of time and no breakthrough, let's use that word. I

guess I haven't gotten to the point where I'm just totally frustrated with trying to seek a medical answer.

Me: I guess what I'm saying is, if I'm understanding you correctly, you're saying that as a therapist, you would say "keep trying" for someone like yourself.

James: As long as it was affordable...if circumstances allowed that you were still going to be available, I would certainly keep coming. I kind of look forward to talking with you. You're like my friend now. I can discuss anything with you that I want to talk about and I don't have to worry about it getting back to my brother-in-law or my wife or, you know, it's kind of nice. (Pause.) You should feel good about that.

Me: Well, you know, what I feel is that I feel you and I have connected.

James: Yeah.

Me: Even though at times it's been tense.

James: Yeah.

Me: And I think we've shared some special moments together.

James: I did more sharing than you did (laughs). Yes we did. Yeah, we did. We've shared a lot of good stuff. And you've given me some good suggestions, like the priest [I had recommended to James he speak with a priest about his religious guilt], I think that's all been helpful. You know, again, if I had to keep thinking about what I went through with my dad and my poor mom and a lot of the shit that's happened in the past, that would be a total distraction in itself. Ok so, I know your response to that is, if that's in your subconscious, then that's distracting you, and that's what's causing the pain and the anxiety and all of that stuff. I just have a hard time with, why now? And why in the progression of what's going on? It just doesn't make any sense to me. I mean, it's

certainly a possibility. The mind is a very strong thing...I certainly know that I've always had a strong mind and that I could do whatever I wanted to do if I put my head to it. Which, now you're saying, why can't I put my head to this and get through it?

(Laughing) Isn't it amazing how I talk myself into a corner?

Me: (I validate the mysteriousness of pain.) It's hard to go, "This doesn't make sense to me" and you've been consistent with that.

James: There's been such a slow and steady progression of what's gone on. I mean I didn't just wake up one morning and get to where I'm at right now. This is something that has gradually started in one place and then went to another and went to another and maybe I'll never figure out what's going on [stands up]. I don't know, but I cannot put it to rest until I've exploited every possibility. I'm stuck here right now, and I can't get unstuck until I get all of this crap out of my head. And I don't think you're going to undo it, to be honest with you, which we've already proved because we're still here and we didn't get a breakthrough. Again, I sincerely think that I've got a strong enough mind that I've put that stuff behind me to a point where I don't think that's what's really driving my pain right now. There's something wrong and, sooner or later, somebody's going to find it."

Chapter VII

Therapy Monitoring and Use of Feedback Information

After each therapy session, my supervisor and I would separately review the video recording and then meet to discuss treatment. My supervisor generously reviewed each video session in its entirety and provided invaluable feedback throughout the therapy. He consistently implored me to work in the transference, confront the client when he was splitting, and interrupt him as quickly as possible when he would ruminate on the pain. Much like I felt like progress with James was slow, my supervisor likely felt similar with my interventions (which, we agreed, represented a parallel process). Nonetheless, I consistently used interventions recommended by my supervisor and became increasingly confrontational throughout the course of treatment. My supervisor was both immensely helpful in a general psychodynamic sense and more specifically in terms of TMS. I often had questions about psychoeducation; how common/uncommon certain dynamics that were playing out in the therapy were to TMS patients; how much to focus on TMS and pain versus keeping those more in the background; and how to balance the more cognitive components of treatment with a client that clearly needed a focus on affect.

As mentioned in Chapter IV, I used a battery of comprehensive pain measurements as well as measurements assessing mental health (i.e., the BAI, BDI-II, and OQ-45.2). As will be discussed in Chapter VIII, James made no improvement quantitatively (and in a few instances became worse). James did report, on numerous occasions, feeling in comparatively less pain, but on none of those occasions was he administered the assessment battery. Thus, I used James' assessment measures to corroborate that he was "stuck" throughout therapy. Had James shown more quantitative improvement, I likely would have used the measures in other ways as well (e.g., trying to pinpoint what he did in a given week resulting in symptomatic reduction).

Retrospectively, I wish I had administered the numeric pain rating scale each session, because it takes less than a minute and I think session-by-session pain data would have been useful in terms of guiding interventions.

James also provided ongoing feedback, as described throughout Chapter VI, on how he felt therapy was progressing. Because I thought some of what he was saying was more related to his desire to be aggressive with me, it was particularly helpful to have the quantitative measurements as well; beyond whatever relational dynamics existed, James was reporting high levels of pain on self-report measures.

In order to try and develop a deeper understanding of the processes at play throughout the therapy, my supervisor and I conducted a post-therapy SWAP. Retrospectively, this data would have been helpful early on in the therapy and likely would have altered certain interventions (e.g., with the data that James likely met criterion for obsessive personality disorder, a larger emphasis in treatment may have been placed on trying to heal James' splitting).

Chapter VIII

Concluding Evaluation of the Therapy's Process and Outcome

The Outcome of James' Therapy

The quantitative results suggest that James' therapy was a treatment failure; his pain did not improve throughout the course of treatment, nor did his mental/emotional functioning. The qualitative results also suggest that James' pain did not improve with any consistency by the end of treatment. Acknowledging this, it would seem reductionistic to suggest that the treatment was a "failure." According to James' self-report, had I not left the Clinic, James would have continued in therapy, and we had developed a strong therapeutic bond. James had, at various points, referenced that he might need therapy for anywhere from a few years to the rest of his life. Throughout therapy, James developed a much stronger narrative of his many developmental and relational traumas. Below, I offer a further analysis of the quantitative and qualitative results, as well as examine if the theory of TMS and the theory of CMT were effective. I conclude with a psychodynamic analysis of the case and provide recommendations while acknowledging limitations of the current research.

Quantitative Results

(Note that, when possible, Jacobson and Truax's [1991] Reliable Change Index [RCI] was used to determine if there was a meaningful change in clinical symptoms from the beginning to end of therapy.)

Emotional and Social Functioning

On the Beck Anxiety Inventory, James' scores from the beginning to end of therapy were not statistically significant in terms of the RCI (see Table 2). It is worth noting that James scored

in the minimal to moderate anxiety range throughout treatment despite James being in constant fear of his physical state.

On the Beck Depression Inventory II, James' scores from the beginning to end of therapy were not statistically significant in terms of the RCI (see Table 3). While James initially had no complaints of depression and this was not included as a presenting problem, James' final score was indicative of moderate depression and he had also acknowledged feeling depressed towards the end of treatment.

On the Outcome Questionnaire 45.2 (see Table 4), James' scores from the beginning to end of therapy on the subscale symptom distress were clinically significant, which would suggest that James was less bothered by his pain by the end of treatment. However, James' scores on this deviated widely throughout the course of treatment (e.g., his scores went significantly *up* during the second administration of the measurement), and thus this result should be interpreted with extreme caution. On the interpersonal relations and social role subscales, as well as his total score, James' scores were not significant in terms of the RCI.

The Short-Form Survey 36 (SF-36; see Table 5) has two subscales relevant to emotional functioning. On the subscale "role limitations due to emotional problems" James became significantly worse (using the RCI) from the beginning to end of therapy. James' scores deviated widely (e.g., at second administration he was significantly worse; at third administration he was significantly better compared with second administration, and at final administration he was significantly worse as compared to the beginning of therapy, but not as compared to third administration). This subscale is composed of only 3 items, and results should be interpreted with extreme caution (e.g., James' verbal self-report by the end would not suggest he perceived emotional problems to be the main culprit of his current role limitations). James' score on the

emotional well-being subscale did not change significantly from the beginning to end of therapy using the RCI. The SF-36 has a subscale for social functioning, and James' results were not significant using the RCI.

Physical Functioning

The SF-36 has subscales for physical functioning, role limitations due to physical health, energy/fatigue, pain, and general health. Using the RCI, none of James' scores significantly changed from the beginning to end of therapy.

On the Roland-Morris Low Back Pain and Disability Questionnaire, James' score increased from a 7 to a 10 by the end of treatment (representing greater functional impairment). In terms of the specific items James endorsed, James endorsed six items at both the beginning and end (related to changing position frequently, trying not to bend or kneel, back is painful almost all of the time, trouble putting on sock due to pain, avoid heavy jobs around the house, and irritability due to pain). At last measurement, James also endorsed using handrails to get upstairs; getting dressed more slowly; difficulty getting out of a chair; and only walking short distances, but did not endorse not doing jobs around the house because of his back. Thus, his scores suggest he had similar functional impairments from the beginning to end of treatment.

On the Short Form McGill Pain Questionnaire, James' score on the sensory scale increased by one point from beginning to end. He endorsed mild stabbing, severe cramping, and severe tender sensations. His scores decreased by one point on the affective scale, endorsing severe "cruel-punishing." His total score remained unchanged.

On the Numeric Pain Rating Scale, James' initial score was 6.5 and final score was 8.5. According to IMMPACT (Dworkin et al., 2005), changes of 2 points are considered meaningful changes in pain, and thus James was in meaningfully more pain by the end of treatment.

On the Brief Pain Inventory Pain Interference items, James score went from a 2 to 7.71 by the end of treatment. James' initial score was 4.93 points lower than his other three scores, and it is not clear why he had a comparatively low initial interference score when taking into consideration the other measurements he completed. At final administration, James put "completely interferes" (i.e., a score of 10, which is the highest score) for his enjoyment of life. His next highest scores were all 8 out of 10 (for general activity, walking ability, and normal work).

Taken together, James' quantitative results suggest that he did not improve in terms of emotional, social, or physical functioning and that he may have become slightly worse. Moreover, his pain was significantly interfering with his enjoyment of life and he was experiencing major role limitations due to his pain.

Qualitative Results

Comparison of Initial Treatment Goals with End Results

As described in *Patient Goals for Therapy*, James and I developed three main goals for James. In terms of engaging in enjoyable physical activities without experiencing pain or experiencing major anxiety about the possibility of pain (goal #1), this goal was, for the most part, not achieved. James did play pool multiple times during the course of treatment, but he was altering his body position from how he would normally play in order to avoid potential pain. James did not bowl during treatment, nor did he develop a more rigorous walking program. Moreover, James still experienced significant anxiety about the possibility of experiencing pain due to physical activity, although it should be noted that his anxiety was not predominantly organized around *enjoyable* physical activities as much as it was daily physical activities (e.g., bending over to pick up an object from the floor). Although there was a period of time during

treatment in which James was bending and engaging in greater physical activity without increased discomfort, by the end of treatment he was trying to avoid any unnecessary physical activity and was using aids (e.g., a grabber to pick up items).

Goal #2 was to be able to sit “without extreme discomfort.” James decreased the *frequency* in which he discussed chairs as a potential trigger for pain, but he did not explicitly report feeling more comfortable while sitting. It is notable that while James stood for a large part of the initial interview, beginning in session two, he stood only briefly, and from session three to the end of treatment, James stood infrequently (i.e., once every few sessions for 5-15 minutes).

Goal #3 was related to increased self-confidence to engage in physical activities such that he could travel without significant worry and anxiety. By the end of treatment, James did not report feeling more confident in his ability to travel, and James continued to feel angry and frustrated that he could not live his post-retirement life as he desired in regard to traveling freely and often without concern. At the same time, when I began seeing James, he had significant anxiety related to an upcoming vacation he would take, especially regarding the chairs that would be available to him. As it turned out, on that vacation, chairs were not a trigger for pain. Moreover, when treatment ended, James had a vacation planned in two weeks that would involve significant amounts of both walking and sitting. While James continued to be significantly distressed about his overall pain levels, he did not ruminate on how the vacation would make him feel worse and actually reported being excited about the vacation. Thus, I would conclude that James incrementally improved in his self-confidence to travel but did not reach a point where he felt unencumbered by his pain.

Taken together, comparing James’ initial goals with his results by the end of treatment would suggest the treatment was not effective.

TMS Goals and Control Mastery Tests

While James sought treatment for chronic pain and, both quantitatively and qualitatively, treatment was ineffective towards that end, it is also useful to evaluate the therapy in terms of my TMS-related goals and CMT Plan Formulation; such an evaluation offers more nuance related to mental and emotional distress.

As stated in *Treatment Plan and Treatment Goals*, I hoped therapy would help James to unearth repressed negative emotion (especially guilt and rage). When James wasn't talking about his pain, the majority of the sessions were spent talking about James' life experiences related to either guilt or rage, and I would assert that James developed a much stronger understanding of the etiology of these emotions (i.e., his relational dynamics with his father and wife). I also hoped that by helping James develop new coping mechanisms, he could process more of his emotional life and develop a wider affective tolerance. While James did discuss painful experiences in therapy, he struggled to metabolize such experiences and did not develop new enduring coping mechanisms. Thus, this goal was not achieved. While I think there is strong evidence that James developed an enhanced *cognitive* understanding of his feelings, James still had major difficulty *experiencing* his feelings (put another way, he was still highly defended against affect). Moreover, James never seemed to develop a kinder, gentler, soothing introject of me as the therapist. Nor did he develop more external coping skills (e.g., going on a walk when he felt frustrated; having a conversation with a friend; etc.).

I would consider James' inability to process and metabolize emotions to be a major contributor to his lack of progress in therapy. (It is possible that I was ineffective in helping James to process his feelings. However, given James' attachment to me, it seems more probable that this inability was indicative of James' rigid personality structure and character pathology,

and therefore need for *longer* treatment.) Relatedly, I hoped James would develop an enhanced ability to think psychological about his pain, and while he demonstrated the *capacity* to do this (i.e., linking emotions and physical states), he would always revert back to physical explanations (the antithesis of thinking psychological). Thus, I would consider this goal not achieved. Lastly, in terms of TMS treatment, I hoped James would work towards discontinuing all physical treatments; this did not happen (although James briefly experimented with decreasing his pain medication).

My CMT goals were for James to have a wider range of conscious affective experiences and to be increasingly emotionally honest with others. I would consider these goals as partially met. Even if defended, James did develop a wider range of affective experiences. Perhaps more importantly, James showed me, in sessions, his frustration and anger, both with the outside world and with me and the therapy. While this can be understood as his real frustration with his *lack* of progress, this can also be understood as improvement insofar as James was able to be emotionally honest in ways he previously had not been (e.g., with his wife, he “buried” his feelings of frustration and guilt, but with me these feelings were out in the open).

In terms of pathogenic beliefs, as mentioned, James developed an ability to express anger and frustration with me as the therapist, although this was often brief and tended to be indirect. However, his ability to express anger in his outside-of-therapy relationships did not seem to demonstrably change, and thus this pathogenic belief #1 (James does not express anger for fear that he would be met with retaliatory anger) seemed to remain. In terms of pathogenic belief #2 (James does not consciously experience anger for fear that it would overwhelm him emotionally), James continued to avoid *experiencing* anger although he could cognize about the feeling. James continued to be closed off in terms of sharing negative emotions (belief #3:

James does not interpersonally share negative emotions for fear that the other will not support him), although speaking with his priest about his feelings of guilt was a step in the right direction. In terms of James' pathogenic belief #4 (James will not allow himself to be pain-free because he believes he is deserving of punishment due to his cheating and taking his father off life support), this still seemed to loom large at the end of treatment.

I created a list of eight insights I thought would be particularly helpful for James (see *Insights*). Evidence would support James having insight #1 (James' father's anger and emotional abuse did not stem from James' behavior) and #7 (James' cheating on his wife was multiply determined. James experiencing relational dissatisfaction but staying with his wife parallels his mother's behavior. It is possible to feel regret [or another negative emotion] while also understanding motivations for behaviors like cheating). By the end of therapy, James had a much stronger narrative around his father's abusive, traumatizing ways and that these were not a reflection of James. In terms of his romantic relationship, James was able to link how his behaviors paralleled his mothers, how his relationship with his father set him up for a relationship lacking in emotional nurturance, and how his sexual discontentment was a real problem. While I would say that there were many interpretations aimed at helping James develop the remaining six insights (see *Insights*), I do not think James internalized these and thus I would consider them not achieved.

Was TMS an Effective Model?

As described in Chapter VI, James' self-report was that he fit the model of a TMS patient perfectly (e.g., "It's almost like he wrote the book about me," "Everything that he touches on in that book, that's me to a T"). Moreover, TMS, fundamentally, is about *repressed affect*, and

James frequently and consistently described “burying” his feelings. These statements would seem to offer support for the theory of TMS.

At the same time, when James decreased his pain medication (related to the treatment tenet of stopping physical treatments) his pain increased. When James resumed physical activity, he temporarily experienced no increase in pain, but subsequently experienced an increase in pain. And, James consistently struggled to think psychological. He did not seem to find Sarno’s daily reminders helpful, and also did not seem to benefit from journaling.

None of the above statements are inconsistent with the TMS model. Pain often increases because the mind is trying to hold on to pain as a distraction instead of experiencing painful emotions. James’ lack of success with thinking psychological can be explained as 1) a failure on my part as the therapist in helping James develop this skill; and 2) reflective of James’ lack of observing ego capacities (i.e., indicative of a more borderline character structure).

Put plainly, the biggest issue with examining if TMS was an effective model for treatment is that James did not adhere to the treatment model and was never fully committed to the approach. Thus, there are two main conclusions related to the TMS model that can be drawn from the case of James: 1) People with chronic pain often times have the constellation of personality features and life experiences that Sarno (1991) describes; and 2) Partial commitment to a TMS approach to pain treatment is not effective. If James had fully committed to the theory of TMS, one can only speculate about how that may or may not have impacted his experience of pain.

Was CMT an Effective Model?

There were both benefits and drawbacks to integrating CMT with the theory of TMS. Beneficially, CMT offers excellent flexibility in terms of actual interventions; the emphasis is

placed on plan-compatible interventions. This was particularly helpful given that a TMS approach involves more of a cognitive/psychoeducation component (and other prescriptions) than a traditional psychodynamic treatment would. Although I did not analyze the treatment for plan-compatibility to the degree that formal CMT research does, impressionistically, my interventions were consistent with my hypotheses about James' pathogenic beliefs and the insights I hoped he would gain. Additionally, hypothesizing James' tests provided a framework for understanding relational interactions that occurred between us in the therapy. For example, when James was aggressive with me in session, I could understand this as both a potential transference test (to see if I would retaliate like his father had) and/or as a passive-into-active test (to see if I would withdraw, somaticize, and isolate my affect as he had to cope with his father's abuse).

CMT's non-prescriptive nature was perhaps also its biggest drawback. Although I would argue that my interventions were plan compatible and aimed at passing James' tests (and, insofar as James opened up throughout the course of therapy I would say I *did pass* James' tests), he may have benefitted from a model that was more prescriptive in technique. For example, had I adopted the framework of Intensive Short Term Dynamic Psychotherapy (ISTDP; Davanloo, 1978), I would have had a clearer model of how and when to confront and challenge James, and overall had a model with more prescriptive technique for challenging James' rigid defenses.

The other main drawback I experienced was that as it became increasingly clear James was operating at a borderline level of functioning, I did not find CMT to offer much in the way of how to deal with personality pathology (this could also be due to my inexperience with such a model). It also did not offer specific guidance in terms of dealing with a patient with

somaticizing defenses (compare this to, say, relational approaches to understanding somatic experiences; e.g., Anderson, 2013; Aron & Anderson, 2015; Stern, 2010).

Acknowledging potential drawbacks, I would still conclude that CMT was a useful and useable model. I enumerated tests I thought James would use (see *Tests*), and James seemed to engage in all six tests. I found it useful to consider how James might be testing me as I considered potential interventions to use. Although, at a macro-level, James' pathogenic beliefs may not have changed, I would suggest this was more due to his rigid personality structure and us needing more time together to disconfirm his pathogenic beliefs (i.e., we needed more repetitions of James testing me and me passing the tests), than it reflects a problem with the CMT integration.

It also seems important to acknowledge that James felt connected to the therapy, a positive prognostic indicator (Martin et al., 2000). The combination of the TMS and CMT models helped me to develop a solid attachment bond to James. Had an external constraint on the part of the therapist not led to termination, James and I agreed the therapy would have continued. Although this is no guarantee that he would have experienced a reduction in pain, this nonetheless seems to offer some support for the efficacy of the TMS and CMT model.

A Psychodynamic Analysis of the Case

If James fit the TMS model “to the T,” if my interventions were plan-compatible, if James was able to access repressed emotion and discuss his feelings of guilt and rage, (especially related to his wife and father), and if James felt connected to me as the therapist (e.g., “I can discuss anything with you that I want to talk about”), why didn't James experience a reduction in pain or, at a minimum, an improvement in his mental/emotional functioning (e.g., a marked improvement on the OQ-45)?

First, let me acknowledge the obvious: one explanation is that James' structural issues were indeed the cause of his physical pain, and thus therapy was doomed to fail from the beginning (at least related to physical functioning). While I would be remiss not to mention this as a possibility, I do not believe the evidence suggests this is a compelling explanation for at least three main reasons. One, James had seen some of the most prominent doctors and specialists in the country and had been told that his back structure was not a good explanation for the pain he was currently experiencing. Two, James' pain levels fluctuated dramatically (e.g., James feeling pain-free for a few hours after therapy), as did the specific location of his pain (e.g., his feet, stomach, hips, groin, lower back, upper back, or shoulders). It is immensely difficult to reconcile a structural explanation of pain with such dramatic fluctuations. Three, James pursued no less than eight different physical treatments during the course of therapy.

To develop a deeper understanding of James' personality structure, my supervisor and I completed a SWAP after therapy ended (retrospectively, I wish I had done this towards the beginning of treatment to help guide my interventions). The SWAP provides an interpretive report upon completion. According to the report, James' had an average level of overall personality functioning relative to a clinical sample (Overall Personality Health; T=48.6). His DSM-5 Personality Disorder Score Profile results suggest James met criterion for Obsessive Personality Disorder (T=64.9⁷; see Appendix 3 for the SWAP's description of Obsessive Personality Disorder and treatment considerations). Consistent with my supervisor's and my own understanding of James, the SWAP report states, "Obsessional personality is organized

⁷ Note that the SWAP report stated the following: "Obsessional personality may not reach the severity of pathology or level of dysfunction typically associated with a personality "disorder" diagnosis, and may be better conceptualized as a personality "pattern" or "style." Contrary to common assumptions, obsessional personality is unrelated to obsessive-compulsive disorder, which appears to be a distinct syndrome with a separate etiology.

around a need to ward off/defend against intolerable affect, especially fear and rage.”

Obsessional patients “will benefit from an insight-oriented interpretive treatment approach aimed at helping them recognize the ways in which they reflexively ward off emotional experience, and the cost of these defenses vis-à-vis relationships and capacity for pleasure and enjoyment.” My approach seemed to be consistent with the SWAP treatment considerations, and the SWAP report is highly consistent with the TMS model (i.e., that repressed rage is at the root of somatic pain).

Fundamentally, I would argue that the single biggest impediment to James’ improvement was his lack of *experiencing* his feelings. While James could talk about (i.e., cognize) his feelings, he rarely accessed his felt experience. McWilliams (2011) states the “avoidance of intellectualization” (p. 306) is a central tenet of treatment with obsessional patients. James and I significantly struggled to break him out of this defense. Although there were glimpses of a less intellectualized way of relating for James (e.g., when James stated that his father “crippled” him, there was clearly emotion in the room), most of James’ “insights” were intellectual insights (Richfield, 1954). Of such insights, Richfield states,

But acknowledgement by the patient that he is constrained by a seemingly unjustified guilt or anxiety may not be different in its essential character from an ‘intellectual’ insight concerning the same facts. Such insight...is still considered superficial...and can at best be no more than preliminary to the insights which are requisite to cure (p. 393).

As mentioned, my supervisor had been particularly influenced by the work of Davanloo (Davanloo, 1978) and consistently encouraged me to be more confrontational with James (and as mentioned in Chapter II, ISTDP has been shown to be effective for somaticizing disorders). Of obsessional patients, McWilliams (2011) states, “Refusal to advise them, hurry them, and

criticize them for the effects of their isolation, undoing, and reaction formation will foster movement in therapy than more confronting measures” (p. 306). Thus, it seems a case could have been made for or against greater levels of confrontation.

McWilliams (2011) also states that an essential element of treatment for those with an obsessional style is the interpretation of shame. Although I routinely interpreted James’ feelings of guilt, rarely did we discuss feelings of shame (I would say that many of my interventions, like my detailed inquiry into James’ history of soliciting prostitutes, were aimed at shame *attenuation*). Although I think we may not have been at a point in the treatment in which James’ experience of shame could have been interpreted, this nonetheless may have been a technical shortcoming. McWilliams also discusses using “imagery, symbolism, and artistic communication” (p. 306) to bring in more affect into the therapy, and this was also not a technique I implemented. McWilliams does suggest that the therapist must “help them express their anger and criticism about therapy and the therapist” (p. 306), and it seems I fostered an environment in which James could do this.

I understood James to be functioning at a borderline level. Evidence to support this claim includes James’ SWAP results; his use of defensive splitting; his trouble with affect tolerance; his significantly limited observing ego capacity; his help-seeking/help-rejecting behavior; and my (eventually) strong countertransference feelings towards James (i.e., coming to hate him). Although not fully explanatory for why James did not improve more throughout the course of therapy, it seems important to note that between James’ obsessive style (which, by definition, is organized around avoiding intolerable affect), and being at a more borderline level of functioning (which suggests his personality has greater rigidity, with borderline treatments usually lasting much longer) it seems possible that James simply needed a longer psychotherapy. James

experienced severe relational abuse and trauma, and it seems logical that it would take James considerable time to access and experience his deepest emotions, especially when one of those emotions (rage) was a feeling his father used punitively. Had therapy continued, it seems possible I could have further worked with James on developing his ability for affect tolerance, his observing ego capacities, and attenuated more feelings of shame and toxic emotionality, all of which may have led to a reduction in pain.

Wallin (2007) discusses those with a counter-dependent attachment style as being “dismissive” and that one of the central tasks of therapy is for the therapist to come to matter to the patient. To this end, it seemed therapy was progressing in the right direction; James was clearly upset at our therapy ending.

My supervisor often remarked that with pain patients, sometimes they “aren’t ready” to give up the pain yet because it plays too important a role/serves such a large function in their lives. Ultimately, this is how I understand the therapy with James. At the end of Phase 2 of treatment (in sessions 23 and 24), James accessed and was experiencing deeply painful emotions, discussing in greater depth the emotional trauma he experienced in life. From that point forward, the therapy slowly went downhill. I believe James lacked the emotional apparatus necessary to process and metabolize his traumatic experiences, and it may have been a shortcoming on my end that I was not able to help him to a greater degree to process his feelings.

It is also worth noting that James struggled with comprehending certain abstract concepts related to TMS and to the unconscious, which was likely another impediment towards pain reduction (and, as mentioned, I could be long-winded and verbose when trying to provide psychoeducation). Regarding TMS, James routinely did not understand how two events that occurred in close proximity to each other were not necessarily causally related (e.g., if James sat

in a chair and started to experience pain, he had a hard time grasping that the chair was not necessarily the cause of his pain, just like if I wore a green shirt and then won the lottery, the green shirt would not be the causal mechanism). Related to unconscious processes, James often did not grasp the non-linear and non-time-bound nature of the unconscious (i.e., James thought that if emotional trauma was the cause of his pain, he should have experienced the pain much nearer in time with the original trauma).

Lessons Learned and Treatment Recommendations

Between the intensive supervision I received and the complexity of James' case, I learned a tremendous amount about the treatment of chronic pain and approaching pain from a TMS perspective. My learning lessons and recommendations are intertwined.

Recommendation #1: When possible, require the patient consult with a TMS-informed medical doctor as a condition of treatment

When I began seeing James, he informed me that some of the best medical doctors in the world could not find anything wrong with his back. I equated this with receiving a TMS diagnosis. This was a mistake. The difference is that James' interpretation of the doctors' communications was that there *was* a physical issue, doctors just couldn't find it. Although James could have (and likely would have) discounted a TMS-informed doctor's opinion as biased, it nonetheless would have been a medical opinion to reference throughout treatment when James was reverting to physical explanations. If not feasible for the patient to see a TMS-informed medical doctor, I believe the next best option would be to at least consult with the medical doctor(s) the patient has seen, such that there is a crystal-clear understanding of what the doctor(s) have communicated to the patient about the etiology of their pain.

Recommendation #2: When conducting the initial assessment, create a visual history of somatic pain and other physical ailments

James would “forget” (repress) many of his more distal somatic experiences (e.g., chronic stomach pain during college). If James and I had created a scroll of all of his physical ailments and pain throughout his life, and then also created a timeline of what was going on in his life during these times, I believe he would have been better able to hold on to his own narrative and not repress or split off certain emotional experiences. Such a scroll could be added to throughout treatment. (Dr. Axelbank uses something like this for his work with Future Search [Weisbord & Janoff, 2011], and this could easily be adopted to an individual therapy.)

Recommendation #3: Thoroughly assess level of personality functioning at the beginning of treatment and alter interventions accordingly

While this may seem obvious, there are special implications for level of functioning with a TMS treatment. First, there is a dearth of literature on those with borderline obsessional styles. James’ borderline level of functioning was not immediately diagnostically clear to me, and I would argue this could be the case for more advanced clinicians as well. As the SWAP interpretive report notes, “Obsessional patients generally fall toward the healthier end of the personality health-pathology spectrum, and the psychological characteristics described in the diagnostic prototype are often (but not invariably) accompanied by significant ego strengths.” James was friendly and only subtly devaluing of our therapy for the first phase of treatment. He had been married for decades, had a relatively stable family, and had held the same job continuously for his working life. Thus, James did not immediately exhibit the most obvious signs of borderline pathology.

Yet, James engaged in splitting (I had initially thought some of this might be ambivalence as opposed to occupying separate ego states). There are numerous technical considerations for a neurotic versus borderline TMS patient. First, for the neurotic level patient, almost by definition, their symptoms are more ego dystonic. A neurotic level patient is much more likely to respond well to an intervention pointing out that if their pain fluctuates significantly depending on the day, a structural issue is less likely to be the cause. Conversely, for the borderline patient the pain is ego syntonic. There is not distance from the pain, and there is not an observing ego capacity capable of thinking about the pain beyond their immediate experience of it. The borderline patient, then, seems less equipped to link physical pain with emotional causes and may need significantly more scaffolding to do so.

Sarno discusses the concept of thinking psychological. For the neurotic client, this should be quite achievable with some psychoeducation and coaching. For the borderline client with minimal observing ego capacities, thinking psychological is a tall order. James' impaired observing ego capacities seem to be the reason why his journaling would involve only writing about the things that happened during the day; he would not meta-cognize about what they meant or how they connected to his feelings. The technical implication, then, is that for the borderline TMS patient, the therapist must help the patient develop an observing ego before moving towards thinking psychological, resuming physical activity, and discontinuing physical treatments. Something like a rage-journal may also be ill-advised until the patient has some ability to organize their emotional experiences.

I would hypothesize that many TMS patients who read Sarno's work, do not get relief, and who then pursue therapy are more likely to be at a borderline level of functioning. While, for some people, Sarno's message that structural issues are not the cause of pain is *great news*,

for others, this isn't great news at all (I discussed this point with James in session 42 when talking about Jesus and the gospel). It would seem logical that for those for whom the message is not great news, the pain is more likely to be ego syntonic. Moreover, they may need their pain more because experiencing rage, sadness, and/or another negative emotion may be too threatening to their psyches.

If my hypothesis is correct, there is another important implication: therapy will probabilistically be long-term in nature. Those with borderline pathology tend to need longer-term therapy (e.g., McWilliams [2011] states, "they may take up to several years to develop the kind of therapeutic alliance that a neurotic client may feel within minutes of meeting the therapist"; p. 84). Developing basic trust and a more secure relational attachment as well as new observing ego capacities would seem to be prerequisites to processing repressed emotion and linking mind and body. To be clear, this isn't to say that a Sarno approach can't work quickly, just that for those that are seeking therapy for TMS-related pain and don't get better relatively quickly, there may be a bi-modal distribution of short-term and much longer-term clients.

Recommendation #4: Develop a clear therapy contract initially outlining the rules for seeking other forms of treatment

James and I agreed that his endless pursuit of physical treatments while being in therapy was detrimental to the therapy. I had not told James upfront that he could not pursue other treatments while seeing me, which I sorely regret. I believe pre-existing pain medication would have been acceptable to continue (it seems a tall-order to ask someone to discontinue years of pain medication right off the bat), but I would now conceptualize seeking out other treatments as a form of splitting and a near guarantee that the treatment will be negatively impacted. If one of

the central mechanisms of cure for a TMS treatment is *acceptance of the diagnosis*, seeking other physical treatments is not a good idea.

Recommendation #5: Make a firm commitment about how to handle the client's defenses

As aforementioned, my supervisor encouraged me to be highly confrontational with James, pointing out his defenses and making a concerted effort to work in the transference. Also as aforementioned, McWilliams (2011) advises against a confrontational approach. There is evidence to support both approaches, but I think it would have helped my therapy with James if I committed to one approach (and, research supports the idea that the formulation of a focus in therapy enhances outcome; Messer & Warren, 1998). I think there are at least three main considerations that may guide such a decision: 1) The therapist's natural style; 2) The level of functioning of the client (i.e., a highly confrontational approach with a borderline client may not be advisable), and 3) The duration of treatment. To point #3, I would argue that unless treatment can be truly long-term/open-ended, a confrontational approach is favorable as it seems like an excellent way to access deep affect quickly and to break down rigid defenses (Davanloo, 2001).

Recommendation # 6: Carefully monitor time spent discussing pain and TMS

With James, we talked about his pain every session, often times at great length. Moreover, I provided psychoeducation related to TMS, thinking psychological, pain as a distraction, and other TMS concepts with regularity. After significant reflection, I believe this was a major technical failure on my part.

First, providing psychoeducation about TMS is an inherently intellectualized endeavor, something that, as McWilliams (2011) points out, is to be avoided with obsessive patients. While I fully believe it is helpful to provide a framework for pain and to disabuse a client of faulty cultural notions about the etiology of pain, I also believe this can be done relatively

quickly and that the patient can read one or more of Sarno's books and get the required information. I think there is merit in working through examples of thinking psychological and of addressing any questions a patient may have about TMS or a TMS-oriented approach. However, with James, the issue was not informational in nature, but instead that James was repressing/splitting off the content we discussed, and that James was not ready to give up his pain. Thus, my repetitive explanations did not seem to be effective.

More importantly than monitoring the discussion of TMS theory, though, I wish I had drawn firm boundaries regarding James spending time in session discussing his pain. I would seriously consider outlining this in the initial therapy contract moving forward. I thought that by empathizing with James about his pain and by reflecting how much pain he was in, I would act as a kinder object than his father had been. While this may be true, I think James ruminated and discussed ad nauseam his pain as a way to resist the therapy and avoid discussing emotions. Throughout therapy, my supervisor was most critical of my inability or lateness in interrupting James when he was talking about his pain, and rightfully so.

Beyond my inexperience and other therapist shortcomings (e.g., my naturally non-confrontational style), McWilliams (2011) notes that with some obsessive patients, the therapist can barely get a word in until the end of session. This fit my experience with James. Acknowledging that this is a possibility in the treatment, I wish I would have upfront created guidelines that I could refer back to for how often and under what circumstances James would be allowed to discuss the pain. Although this may sound stifling, I believe it would have created a therapeutic environment in which we would have discussed more affectively laden material (although, like any aspect of a therapy contract, this may also have led to James feeling false in session or like therapy was an exercise in compliance).

Recommendation #7: Challenge intellectualization, half-commitments, and splitting

Interpreting an obsessive patient's intellectualization is not a novel idea, but I want to emphasize that for a TMS patient, this is absolutely critical, especially when the patient, like James, was intellectually talking about feelings. James' use of half-commitments (e.g., "that could be the case") were frequent and I rarely confronted him about the use of such language. Davanloo (2001) provides myriad examples of challenging patients on such language, and I believe this would have effectively intensified the transference, creating more affect in the therapy room to work with. Similarly, although I often pointed out when James was splitting, I wish I had been more disciplined and relentless about this so that James could develop a more coherent self-narrative.

Recommendation #8: TMS can be about rage, but it can also be about other feelings

Sarno is clear that TMS can be related to repressed emotions beyond just rage, so this lesson is not contradictory to his theory. Nonetheless, TMS is mostly associated with rage (e.g., the documentary about Sarno's work was titled *All the Rage*). While James exhibited plenty of unconscious aggression, hostility, anger, and rage, he also seemed particularly saddled with feelings of guilt. Thus, I would be careful to overly interpret repressed rage at the expense of missing other important repressed emotions.

Recommendation #9: Honor that some people need their pain

Perhaps the biggest learning lesson for me of this treatment is that for some people, pain may represent the best coping strategy available to them. James had a lifetime of relational trauma and corresponding emotions. He was saddled with guilt and felt trapped in his romantic relationship. Working with James gave me a humility about working with those with TMS; while the idea that somatic pain could ever be the best available option seems difficult to grasp, I

believe this to be true. With years of therapy, my hope would be that someone like James could begin to process and metabolize more of their relational traumas and emotional pain. But, without a kind, empathic, soothing other to aid with such processing, James' physical pain may have been the best coping mechanism he had.

Limitations

The largest limitation of the current study is the single case design. Although qualitatively rich, the current study results cannot be generalized. Additionally, James pursued a myriad of physical treatments and used the *Unlearn Your Pain* workbook during treatment. Thus, the current study does not control for confounding variables. Although this would be more noteworthy had the treatment led to significant pain reduction, it is still important to note. Lastly, although the treatment was informed by the theory of TMS and utilized a CMT framework, neither approach was strictly adhered to. For instance, James never received a diagnosis of TMS from a TMS-informed medical doctor and also never attended TMS psychoeducational groups, both of which would be considered standard tenets of a TMS approach. Moreover, James had mediocre adherence to the tenets of a TMS treatment (i.e., he struggled to think psychological; he, for the most part, did not resume physical activity; and he actively pursued physical treatments). Thus, the current study cannot adequately assess the relative efficacy or lack thereof for a TMS treatment.

In terms of CMT, I have been particularly influenced by CMT and with all of my cases I tend to ask myself how the client is testing me. At the same time, my supervisor was not influenced by CMT and focused more on a general psychodynamic and Davanloo-informed therapy. Moreover, I was not consistently revising my plan formulation. Thus, while I still conceptualized the treatment in terms of CMT and thought often about how to pass the client's

tests, I am a novice at using CMT and could have used the approach in a more disciplined way that perhaps would have been more effective.

Research Recommendations

The most crucial research question related to TMS is why does Sarno's approach work miraculously well for some, but not for others? To that end, it would be particularly useful to understand the personality functioning of those for whom the approach is and is not successful (e.g., is my hypothesis correct that treatment-resistant TMS patients are more likely to have a borderline level of functioning?). Another major question for research is how beneficial is it to talk about TMS and pain? It is one thing to use a TMS-informed notion of somatic pain to understand a patient's current pain, and quite another to provide ongoing psychoeducation about TMS and to discuss pain. What would the relative efficacy be of an approach that only rarely mentioned TMS and focused almost solely on emotional processing? Lastly, it would be particularly useful to develop a structured approach to the activity of thinking psychological. Clearly, this is a central tenet of Sarno's approach, and yet for patients like James, significant help is needed for the patient to be able to engage in such a mental activity.

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Table 1
Inclusion and Exclusion Criteria

| Inclusion Criteria | Exclusion Criteria |
|--|--|
| 1. Subject will be at least 18 years old. | 1. Subject presents with disorder(s) considered inappropriate for the community mental health clinic. The main disorders considered inappropriate for the scope of the clinic were serious mental illness (e.g., schizophrenia, bipolarity); and severe substance use disorders. Severe suicidal ideation was also considered inappropriate. |
| 2. Subject will be fluent in English. | |
| 3. Subject will be presenting for the psychological treatment of chronic pain. | |
| 4. Subject is experiencing somatic pain not solely attributable to a current or previously known medical cause OR subject agrees to seek out medical consultation to rule out somatic pain solely attributable to a current or previously known medical cause. | |

Table 2
James' Scores: Beck Anxiety Inventory*

| Date | 4/6/17 | 8/8/17 | 10/24/17 | 12/9/17 | Decrease between 4/6/17 and 12/9/17 |
|-------------|-----------------|------------------|-----------------|--------------|-------------------------------------|
| Total Score | 7 | 22 | 6 | 13 | -6** |
| Descriptor | Minimal Anxiety | Moderate Anxiety | Minimal Anxiety | Mild Anxiety | |

* Higher scores indicate more clinical symptoms and/or more impaired functioning

**Not statistically significant in terms of Reliable Change Index

Table 3
James' Scores: Beck Depression Inventory – II*

| Date | 4/6/17 | 8/8/17 | 10/24/17 | 12/9/17 | Decrease between 4/6/17 and 12/9/17 |
|-------------|-----------------|---------------------|-----------------|---------------------|-------------------------------------|
| Total Score | 19 | 27 | 18 | 21 | -2** |
| Descriptor | Mild Depression | Moderate Depression | Mild Depression | Moderate Depression | |

*Higher scores indicate more clinical symptoms and/or more impaired functioning

**Not statistically significant in terms of Reliable Change Index

Table 4
James' Scores: Outcome Questionnaire 45.2*

| Scale | Clinical Cut-Off Point | 4/6/17 | 8/8/17 | 10/24/17 ⁸ | 12/9/17 | Decrease between 4/6/17 and 12/9/17 |
|-------------------------|------------------------|--------|--------|-----------------------|---------|-------------------------------------|
| Symptom Distress | 36 | 44** | 62** | 37** | 33 | 11*** |
| Interpersonal Relations | 15 | 11 | 14 | 15** | 15** | -4 |
| Social Role | 12 | 12** | 12** | 11 | 14** | -2 |
| Total | 63 | 67** | 88** | 63** | 62 | 5 |

*Higher scores indicate more clinical symptoms and/or more impaired functioning

**Indicates symptoms of clinical significance

***Decrease between “pre” and “post” scores statistically significant via Reliable Change Index

Table 5
James' Scores: Short-Form Survey – 36*

| | Range of Scores | 4/6/17 | 8/8/17 | 10/24/17 | 12/9/17 | Pre/Post Change |
|--|-----------------|--------|--------|----------|---------|-----------------|
| Physical Functioning | 0-100 | 25 | 25 | 30 | 35 | 10 |
| Role limitations due to physical health | 0-100 | 25 | 0 | 25 | 0 | -25 |
| Role limitations due to emotional problems | 0-100 | 100 | 0 | 66.67 | 33.3 | -66.7# |
| Energy/fatigue | 0-100 | 80 | 60 | 70 | 80 | 0 |
| Emotional well-being | 0-100 | 56 | 24 | 64 | 52 | -4 |
| Social functioning | 0-100 | 37.5 | 50 | 50 | 18.75 | -18.75 |
| Pain | 0-100 | 32.5 | 22.5 | 22.5 | 5 | -27.5 |
| General health | 0-100 | 80 | 85 | 80 | 70 | -10 |

*Higher score indicates higher functioning/well-being

Change between “pre” and “post” scores statistically via Reliable Change Index. Note that in this instance, the change represents a *deterioration* in functioning.

⁸ Accidentally, James completed two copies of the OQ 45.2 on October 24, 2017. Since his scores were very similar and had the same significance, I chose one by random to include. (His scores on the omitted copy were: SD (41), IR (16), SR (11), and Total Score (68)).

Table 6

James' Scores: Roland-Morris Low Back Pain and Disability Questionnaire*+

| | Range of Scores | 4/6/17 | 8/8/17 | 10/24/17 | 12/9/17 |
|-------------|-----------------|--------|--------|----------|---------|
| Total Score | 0-24 | 7 | 5 | 10 | 10 |

*Higher scores represent increased pain and/or disability

Table 7

James' Scores: Short Form McGill Pain Questionnaire*

| | Range of Scores | 4/6/17 | 8/8/17 | 10/24/17 | 12/9/17 |
|-----------|-----------------|--------|--------|----------|---------|
| Sensory | 0-33 | 6 | 11 | 4 | 7 |
| Affective | 0-12 | 4 | 4 | 2 | 3 |
| Total | 0-45 | 10 | 15 | 6 | 10 |

*Higher scores indicate more clinical symptoms (pain)

Table 8

James' Scores: Numeric Pain Rating Scale*

| | Range of Scores | 4/6/17 | 8/8/17 | 10/24/17 | 12/9/17 | Pre/Post Change |
|-------|-----------------|--------|--------|----------|---------|-----------------|
| Total | 0-10*** | 6.5 | 8.5 | 7.5 | 8.5 | 2** |

*Higher scores indicate more clinical symptoms (pain)

**According to Dworkin et al. (2005), changes of 2 points are considered meaningful changes in pain. In this instance, the client experienced a meaningful *increase* in pain.

***A score of 0 was categorized as "No pain," 5 as "Moderate pain" and 10 as "Worst possible pain"

Table 9
James' Scores: Brief Pain Inventory (Pain Interference)*

| | Range of Scores | 4/12/2017 ⁹ | 8/8/17 | 10/24/17 | 12/9/17 |
|-------------------|-----------------|------------------------|--------|----------|---------|
| Pain Interference | 0-10 | 2 | 6.93 | 7.43 | 7.71 |

*Higher scores indicate more clinical symptoms (pain interference)

Table 10
James' Scores: Adverse Childhood Experiences*

| | Range of Scores | 4/6/17+ |
|----------------|-----------------|---------|
| Items Endorsed | 0-10 | 1 |

*Higher scores indicate higher number of Adverse Childhood Experiences

+Because this instrument collects historical data from childhood, it was only administered once

⁹ Because James ran out of time to complete all measurements on 4/6/17, this was completed prior to the 4/12/17 session.

Appendix 1

Sarno's (1991; p. 97) 12 Daily Reminders

- 1) The pain is due to TMS, not to a structural abnormality.
- 2) The direct reason for the pain is mild oxygen deprivation.
- 3) TMS is a harmless condition, caused by my repressed emotions.
- 4) The principal emotion is my repressed anger.
- 5) TMS exists only to distract my attention from the emotions.
- 6) Since my back is basically normal, there is nothing to fear.
- 7) Therefore, physical activity is not dangerous.
- 8) And I must resume all normal physical activity.
- 9) I will not be concerned or intimidated by the pain.
- 10) I will shift my attention from the pain to emotional issues.
- 11) I intend to be in control— not my subconscious mind.
- 12) I must think psychological at all times, not physical.

Appendix 2: Examples of Thank You Dr. Sarno Letters

Ted's Thank You (H, T. 2017).

“I had severe pain in both legs from the ages of 12 to 20. I was diagnosed with everything under the sun, underwent treatments for all, and never get better. Chondromalacia, adolescent femoral patella syndrome, severely pronated feet, childhood arthritis, and of course fibromyalgia- a diagnosis defined as “pain symptoms of unknown origin.” I was in crippling pain my entire childhood. Eventually a family member heard Howard Stern talking about Dr Sarno and approached me about the idea. It had to be the answer. And of course, it was. I read the book, met with Dr Sarno, and within a year, I was as pain free like I was 11 again. I suffered my entire childhood because of a faulty medical system that didn't give Dr Sarno the spotlight he deserved. I feel extremely lucky to be part of the minority that crossed paths with Dr Sarno's dedicated work, and received the simple and effective treatment millions of other sufferers may never see.

Thank you, Dr Sarno. I know you never liked hearing it, but I owe my life to you. I refuse to not say it, its the truest comment I am able to make. I heard Howard Stern call you his hero this week. I guess he's a little better with words than I am. When he said it I realized thats exactly how I feel.

You will never be forgotten.

Ted H

July 18, 2017”

Sherri's Thank You (Sherri, 2017).

“I do thank Dr. Sarno everyday, but mostly I feel immense gratitude for his amazing intuition about human beings, and their pain. Dr. Sarno clearly perceived what most doctors, regardless of how long they practice, will never understand about themselves or their patients.

As experienced by many people; my low-back pain came out of the blue one day, and stayed it with me for twenty years. Similar to many people in my situation, I thought there was something terribly wrong with me, as I was struck with intense pain that I had never experienced ever. I searched for help from a dozen different doctors, and practitioners over the years, and I

would find some relief for a while, but I was never completely pain-free, and never cured. Eventually, I'd have another devastating episode, seek treatment, and then be able to function again for a while.

After two decades, I listened to a story about Dr. Sarno on the radio, and I immediately knew this was my problem. I quickly read as many of his books that I could find, and then set upon creating a method to cure my pain. It took me a little more than a month to be completely pain-free. At first I feared it wouldn't last, but I'm pleased to report that three years later I have no low-back pain. I can sometimes feel my muscles tightening during stressful situations, but I know I can always quickly resolve it in a few moments. So many thanks to Dr. Sarno, and I am hopeful that his legacy will continue to bring relief to millions worldwide for generations to come.

July 18, 2017”

Jim's Thank You, The Magic of Dr. Sarno (Munsey, 2017).

“I was suffering from severe back pain for months. More than once I was unable to get out of a chair because my back was “locked.” It was almost as if my brain wasn't sending signals to my legs. I nearly collapsed while walking on more than one occasion. The pain got so bad that I thought I would have to give up my passion of performing magic. The equipment is extremely heavy and requires a lots of bending and twisting for an hour to set up the show. I remember a phone conversation with my father about the fear of needing to stop performing, and I vividly remember tears rolling down my face as I told him.

I had tried pain relievers, muscle relaxants, physical therapy, acupuncture, chiropractors, steroid injections,

In 2014, I found a YouTube video of Howard Stern interviewing a magician. Near the beginning, Howard got side-tracked and started talking about Dr. Sarno. Intrigued, I looked at the reviews of his books on Amazon and was shocked at the countless success stories. Long story short, within 4-6 months, I was pain free! I have remained pain-free to this day. In fact, 3 days ago, I ran in a 5K race and finished in 23:20. (44th place out of 447 runners — not bad for a 42-year-old). In 2013, even completing a 5K would have seemed impossible to me.

I recommended one of his books to my girlfriend's father. He had been in such pain that he couldn't sit in a car for more than 45 minutes, so his ability to travel was limited for many, many years. After reading Dr. Sarno's book, he experienced success as quickly as I did. He actually began lifting weights again, and this summer he will be driving from Pennsylvania to Boston to see his daughter again!

This picture shows me happily performing a handcuff escape routine in my show. Dr. Sarno is the real magician here as he made the pain for me, and thousands of others, disappear!

His work will live forever. After I was cured, the doctor who had tried the pain injections asked what happened. I told her about Dr. Sarno, and I am happy to say that she asked me to jot down his name so she could read some of his work. It's exciting to think that there will eventually be a shift, even in the medical field, in the mindset of pain treatment, and it's all thanks to Dr. Sarno.

He was a saint and a savior. I love you, Dr. Sarno! Thank you!

Magical wishes,

Jim Munsey

July 18, 2017”

Appendix 3: James' SWAP Interpretive Report Section on Obsessional Personality

Obsessional Personality

Comments: Obsessional patients generally fall toward the healthier end of the personality health-pathology spectrum, and the psychological characteristics described in the diagnostic prototype are often (but not invariably) accompanied by significant ego strengths. Obsessional personality may not reach the severity of pathology or level of dysfunction typically associated with a personality “disorder” diagnosis, and may be better conceptualized as a personality “pattern” or “style.” Contrary to common assumptions, obsessional personality is unrelated to obsessive-compulsive disorder, which appears to be a distinct syndrome with a separate etiology.

Detailed Description: Patients who match this prototype are excessively devoted to work and productivity, to the detriment of leisure and relationships. They tend to see themselves as logical and rational, uninfluenced by emotion; prefer to operate as if emotions were irrelevant or inconsequential; tend to think in abstract and intellectualized terms, even in matters of personal import; and appear to have a limited or constricted range of emotions. They tend to be inhibited or constricted; to have difficulty allowing themselves to acknowledge or express wishes and impulses; to have difficulty allowing themselves to experience strong pleasurable emotions (e.g., excitement, joy, pride); and to have difficulty acknowledging or expressing anger. They tend to deny or disavow their own need for caring, comfort, closeness, etc., or to consider such needs unacceptable. Additionally, they tend to be controlling; competitive with others (whether consciously or unconsciously); critical of others; conflicted about authority (e.g., they may feel they must submit, rebel against, win over, defeat, etc.); prone to get into power struggles; and self-righteous or moralistic. They are also self-critical, tending to set unrealistically high standards for themselves, showing little tolerance for their own human defects, and expecting themselves to be “perfect.” They may adhere rigidly to daily routines and become anxious or uncomfortable when they are altered.

Treatment Considerations: Obsessional personality is organized around a need to ward off/defend against intolerable affect, especially fear and rage. For this reason, obsessional patients prefer to think rather than feel. Reliance on intellectualization, adherence to routine, and preoccupation with work and productivity help to ward off affect, but underlying fear and aggression nevertheless tend to “leak out” in the form of critical attitudes, controlling behavior, power struggles with others, and so on. Obsessional patients will benefit from an insight-oriented interpretive treatment approach aimed at helping them recognize the ways in which they reflexively ward off emotional experience, and the cost of these defenses vis-à-vis relationships and capacity for pleasure and enjoyment. The therapist should be alert to the patient’s tendency to intellectualize, especially the tendency to treat the therapist’s comments as theories to ponder in abstract or “academic” ways. For example, if the patient comments that something the therapist observes about him/her “make sense,” the therapist might ask whether the observation merely “makes sense” intellectually, or whether it is something that patient recognizes in himself/herself and feels to be personally true. In this way, the therapist may gently confront intellectualizing defenses and draw the patient’s attention to emotional life.