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RE-EVALUATION CO-COUNSELING AND
THE TREATMENT OF PEPTIC ULCERS

BY

JACK JUSTIN HEIMS

A report submitted in partial fulfillment of the
requirements for the degree of

MASTER OF
SOCIAL WORK

Portland State University
1974

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CHAPTER I - INTRODUCTION

For three thousand years, the healers of the sick have debated the role that the psyche plays in the etiology and the pathogenesis of somatic dysfunctioning. The debate rages on with viable arguments on both sides (psychogenesis or straight disease approach). That the debate still exists has afforded this paper with a holistic bias.

The topic of this paper, psychotherapy of peptic ulcer patients, initially has been concerned with the current status of the aforementioned debate. The body of this practicum will discuss the theoretical psychological approaches for the control and/or cure of that disease. Finally, it will entertain a new approach, Re-evaluation co-counseling, a peer cathartic therapy.

I. Psyche or Soma?

The concept of totality of the body has been vital in treating the patient with the peptic ulcer, a disease often stereotyped as the psychosomatic disorder. Since the alimentary tract is a system which the mind utilizes with great predilection to relieve its own myriad emotional tensions, the psyche has been incorporated into a definition of disease.¹

Disease is the reaction of the organism, as a whole, responding to external or internal stimuli that seriously alters its equilibrium.² There is simply no dualism, for every pathological process has its organic and psychic components, since it is a product of the psychosomatic unity. Unfortunately, in Western society, the term psychosomatic has negative connotations and has therefore been avoided somewhat in medical circles, thus adding an additional fuel to the heated debate of the role of the mind in the disease process.

Dr. Franz Alexander, the founder of modern psychosomatic medicine, in listing the factors of etiological importance in disease, has supported this holistic view by showing a balance between the possible somato and psychogenetic factors:³

- a. hereditary constitution
- b. birth injuries
- c. organic diseases of infancy which increase the vulnerability of certain organs
- d. nature of infant care (weaning habits, toilet training, sleeping arrangements, etc.)
- e. accidental physical traumatic experiences of childhood and infancy
- f. accidental emotional traumatic experiences of childhood and infancy
- g. emotional climate of family and specific personality traits of parents and siblings.
- h. later physical injuries
- i. later emotional experiences in intimate and occupational relationships

Therefore, only consideration of all these factors and their interaction would afford a complete etiological picture of any disease, in particular, peptic ulcers.

Naturally, empirical evidence of this psychosomatic unity

has been most difficult due to the bias and training of the observer. A recent and reliable study was undertaken by B.I. Lewis at Johns Hopkins Hospital and reported in the "Journal of the American Medical Association." In carefully studying 163 consecutive patients, Lewis found 49% had psychogenic disorders alone and 27% had a combination of psychic and somatic processes. Therefore 76% of the studied patients were suffering totally or in part from an emotionally determined disease. The medical problems of these 163 were predominantly chronic in nature, yet not sufficiently severe as to require hospitalization.⁴

That the mind rules the body, has been, in spite of its neglect by biology and medicine, the most fundamental fact known about the process of life.⁵ Yet treatment for disease such as peptic ulcers has generally worked backward from the symptom. The sore has been the trouble, so the internist either soothes it with an alkaline diet or cuts it out or severs the vagus nerve which carries the offending message to the mind. True, this may heal the sore itself, but the permanent solution has been to stop the sequence of events that lead up to that ulceric sore, otherwise the disequilibrium will surface in the form of another disease, i.e. colitis. Medicine today would do well to take a look at history where a relationship between the mind and the somatic disorders have long been known. For instance, in 640 B.C. Hippocrates was reported to have cured King Perdicas of Macedonia of a gastro-intestinal disorder by the analysis of a dream.⁶ Even the philosopher Plato addressed

this topic by stating, "For this is the great error of our day, that physicians separate the soul from the body."⁷

If medicine today had followed Plato's words, there would be simultaneous and coordinated use of somatic (physiological, anatomical, pharmacological, surgery and dietary) methods and concepts on the one hand, and psychological methods and concepts on the other, thus creating a psychosomatic method of approach to disease.⁸ Due to the nature of the field of social work, this paper will only address the psychological concepts and present a new psychological method to the treatment of peptic ulcers. One can only hope that research of this nature will soon be coordinated with the somatic methods and research. Unfortunately, as of this writing, this coordinated approach is hardly existent.

Thus the answer to the "psyche or soma" question remains confused and only the diseased may continue to suffer because of the lack of coordination of the medical fields.

II. Peptic Ulcer- The Physical and Fiscal Aspects

The term peptic ulcer is a general heading for both gastric and duodenal ulcers.⁹ An ulcer is related to the appearance of gastric juices which create a lesion when the ulcerating powers of the gastric juices (particularly hydrochloric acid) overpower the defense mechanisms of the stomach and duodenum (particularly mucus). When left untreated and with continued hyperfunctioning of this area of the gastrointestinal tract (hypersecretion, hypermotility, and hyperaemia), the lesion becomes a

hole in the wall of the stomach.

The functioning of the stomach is controlled by the autonomous nervous system, a division of the peripheral nervous system via the vagus nerve. Although its functions are carried out below consciousness, it is highly integrated into the structure and function with the rest of the nervous system. It serves the emotional, unconscious and autonomic needs of the various specialized systems, especially the viscera. These needs for expressing distress or exaggerations of normal functioning are converted into characteristic physical signs.¹⁰

Popular speech has recognized the powers of the autonomic system in such sayings as, "I admired the guts he displayed in that act." or "I cannot stomach that behavior." or "I cannot swallow that movie." and et cetera.

Emotions are tied to the autonomous system through endocrine glands, enzymes and hormones via the hypothalamus. The teams of Watts and Fulton, and Huff and Sheehan found that when the hypothalamus was excited it resulted in the release of gastric juices of the parietal cells in the stomach lining. Oppen and Zimmerman found concomitant with disease of the midbrain were erosions of the stomach lining.¹¹ After 165 observations of 26 patients (13 of which had ulcers, 13 control), Mittleman, Wolff and Scharf¹² revealed the following association of affective reactions and the physiological functions of the stomach:

"Tension, anxiety, resentment, guilt, obsequiousness, and desperation already present, accentuated or induced were almost always accompanied by an increase in hydro-

chloric acid, mucus, and pepsic secretions. Peristaltic activity became continuous and contractions increased in magnitude."

Of Davies'¹³ 205 chronic ulcer patients, 84% had symptoms starting directly after emotional traumatization.

Hereditary is also a factor in the predisposition to peptic ulcer.¹⁴ Bauer found that chronic diseases of the stomach were discovered three times as frequently in families of patients with peptic ulcers than the control. H.H. Rieker,¹⁵ in twin studies confirmed the role of hereditary factors. However, H. Necheler¹⁶ has raised the point that what might be thought of as hereditary may be simply eating, rearing and living habits. However, the general concensus among the more noteworthy researchers, namely Alexander and Dunbar¹⁷, support hereditary as being a factor especially when one considers the stomach as being weakened by hereditary factors.

Sex was seen as a factor in ulcers. Prior to 1936¹⁸, men dominated the disease of ulcers. Today however, both sexes are about evenly susceptible. The current ratio is 2.8 males to 1 female.¹⁹

Ingestion of drugs has also been attributed to the etiology of ulcers. "The British Journal of Medicine" has stated that 50% of ulcer patients were alcoholics²⁰. One Danish study by W. Hojer-Pederson²¹ has shown 18% drug addiction in peptic ulcer patients. Aspirin addicts were noted as having a high incidence of peptic ulcers.

Thus one begins to sense the multicausality of peptic ulcers,

whether it be the inbalance of the entire nervous system, hereditary factors, drugs or other diseases of the gastrointestinal tract that weaken the stomach. The psychological causes will be discussed later in this section. There is simply no single causal agent in the etiology of this syndrom.²²

Statistically, peptic ulcers in the United States has been a wide spread phenomenon. It has affected twenty million or approximately 10% of the population. Annually it kills ten thousand. Operative intervention is necessary in 15-20% of the cases; eventually four million will have surgery.²³ From 1957-1965 there was a 40% increase in the estimated number of persons affected.²⁴ Mortality rates have been reported as high as 58%.²⁵

The total costs due to peptic ulcers nearly exceeded one billion dollars in a Rand study done in 1960;²⁶

total disability costs	\$463 million
total death costs	\$355 million
total medical costs	\$186 million

200,000 per year have been totally disabled for more than one week.²⁷ In 1965, peptic ulcers were the twelfth most frequent cause of absenteeism and the fifteenth most frequent cause of death. Ulcers have been a frequent subject for humorous inference. It clearly deserves more serious attention.

III. Peptic Ulcers- Psychological Factors

Due to the very nature of the human mind, the psychological factors involved in peptic ulcers are highly complex and research findings contradictory. Since the emphasis of this paper is on

psychological concepts and methods concerning the psychic processes involved in peptic ulcers, this particular section will deal primarily with recent research into the factors.

Chronic peptic ulcers are peculiar to one species, the homo sapiens, and even here does not occur with any frequency until subjected to the influence of civilization.²⁸ Dr. M. Franz has felt that the rise of ulcers in the large cities has been due to modern culture dissolving many existing social structures.²⁹ Sussner has felt that it has been a disease of the beginning of urbanization.³⁰ Stress, however has seemed to be the main theme.

Fortunately, ulcers have been induced in animals for research purposes. In a recent "Scientific American", Weiss³¹ had devised a means of assessing the importance of psychological variables apart from the impact of the physical stressors on the organism. For those rats that could predict the shocks received little ulceration. Those that could not, did. Therefore, in higher cognitive processes, feedback affects bodily stress reactions.

In another rat experiment, A. Mikhail and H.C. Holland³² have found that active rats developed ulcers three times less frequently than caged rats. This finding has tended to give Sussner's hypothesis regarding ulcers and the rise of urbanization some sustenance.

Psychological testing has come up with several stereotypes for ulcer patients. M. Hamilton³³ found his experimental group scoring higher on the anxiety-guilt and dependency scales and lower on the obsessional than the control. In two separate studies, one by Silverstone and Kissinger³⁴, the other by M. Brown et al³⁵, the two research teams concluded that peptic ulcer patients were gen-

erally passive-aggressive with dependent leanings. In 1956, Weiss³⁶, in a study of the psychodynamics of peptic ulcers found conflicts associated with suppressed resentment, anger, guilt and fear of helplessness. F.A. Jones³⁷ concluded the patients with peptic ulcer "have a tendency to worry inwardly."

In another study, this time of 120 women with ulcers, the researchers had found 25% depressed and holding in their anger and 10% cheerful and holding in their anger.³⁸ Still another team,³⁹ concluded that the common emotional factor is a threatened or real loss (support, financial or emotional security) leading to depression, repressed rage, diffuse anxiety or denial.

Even the Rorschach test has been utilized:⁴⁰

88% of ulcer patients vs 26% of control	had passive-oral
	tendencies
92% of ulcer patients vs 56% of control	had father fear
92% of ulcer patients vs 32% of control	had strong repression

Finally, in a Swedish test, A.I. Steinback⁴¹ found of 30 patients, all had experienced anxiety reactions in the last three months before seeking medical help for their ulcers.

From all these findings, one might conclude that anxiety has been the most indicated mental state.⁴² It should be noted that the typical emotional constellations found in patients suffering from ulcers have also been observed in patients who do not suffer from ulcers, for instance those with heart disease.⁴³

As strong as the arguments have been for a stereotyped personality, typified by the hard driving executive who pushes himself too hard, restrains his emotions⁴⁵ and wears his peptic ulcer as a

badge of success, there are equally strong arguments that there is no stereotype. Both G.F. Balen⁴⁵ and M.I. Grossman⁴⁶ have shown quite conclusively that peptic ulcers are not restricted to any definite age or that any definite personality type or personality typical of peptic ulcers have been established. Michael Rutter concludes in this manner:

"It appears clear that in spite of many claims to the contrary, patients with peptic ulcers do not have a specific personality pattern. However, it is probable that anxiety traits are commonly associated with the presence of peptic ulcer than would be expected."⁴⁷

All of the aforementioned personality characteristics could be categorized under mental dysfunctioning. Here again the family has come into the etiological picture. In the "Journal of Psychosomatic Medicine", Gerdt Wretmark⁴⁸ has reported that 78.9% of his ulcer patients vs. 54.7% of the control group had one or more siblings and/or parents with mental disease. Fathers had a great frequency of alcoholism and mothers were commonly found to be neurotics in the experimental group.

Thus, due to the present confusion and the difficulty of defining and measuring psychological aspects of an ulcer, it has been hard to tell what roles the personality plays in ulcers. It has been consequently difficult to establish a psychotherapy to treat all ulcer patients. It has been the belief of this author that Re-evaluation co-counseling could well be the answer to this dilemma. This particular therapy will be discussed at length in a subsequent chapter.

IV. Present Treatment for Peptic Ulcers

Due to the vagaries of peptic ulcer, particularly when one has been trying to appraise the value of any facet of medical treatment have been such that dogmatism on the part of this author has been avoided. This section merely has spoken to the common method(s) of treatment utilized by modern medicine.⁴⁹

Dr. Sequin⁵⁰ has listed the four basic goals of treatment for ulcer patients in order of priority:

1. Decrease gastric juices
2. Influence the upper center of neurovegetative control
3. Act upon neurovegetative imbalance
4. Handle the basic emotional conflicts

These four goals have been widely accepted in the medical field. Usually there is little question of when a patient has an ulcer for the use of the X-ray and endoscope have brought the accuracy of a correct diagnosis to greater than 90%.⁵¹ An examination of each of the current four goals is useful in understanding today's medical practice.

1. Decrease gastric juices

Currently this has been done in three ways: diet, antacids, and X-ray therapy. Since 20 A.D. when Celsus prescribed bland diets for patients with gastric distress, diet has been the routine recommendation by physicians to their patients with peptic ulcers. Today the diet is termed Sippy after the doctor who created it in 1915.⁵² The essential part of an ulcer has been the frequency of meals rather than the type of food which centers around milk products. This diet is questionable for there has been a subsequent high incidence of atherosclerosis and the diet itself is environmentally frustrating in and of itself, causing undesirable extra tension.⁵⁴

Antacids are the mainstays of therapy.⁵⁵ All have their drawbacks. Calcium carbonate (Tums) has been the most effective but has carried a danger of renal calculi. Aluminum hydroxide (Maalox) has had the danger of phosphate depletion syndrome or silicate stones. Licorice glycoside has had the effect of stimulating the secretion of protective mucus but has had no effect on decreasing gastric secretion.

X-rays do not reduce acidity, but there has been a danger of cancer.⁵⁶ Peptic ulcer treatment has also been faced with many ephemeral cures. One such cure that has been recently popular and suddenly unpopular, has been the freezing of the stomach with -20°C alcohol.⁵⁷ Another has been done on the part of Dr. David Sandweiss⁵⁸ who injected distilled water into his patients with great enthusiasm for the drug and got a 70% cure rate. Vitamin A has been also tested for it maintains the integrity of mucus secreting cells.⁵⁹

2. Influence the Autonomous Nervous System

This portion of the general therapy has usually utilized such psychotropic drugs as bromides, barbiturates and the popular anticholinergic drugs. The latter decreases the release of gastric juices from the antrum and decreases gastric mobility, but some individuals will develop blurring of vision and dryness of the mouth.⁶⁰

Thus the common route for an ulcer patient has been a Sippy diet, antacids, and anticholinergic drugs.

3. Neuro-vegetative imbalances

This has called for surgical treatment; either a hemigastrec-

tomy which removes 40-60% of the portion of the stomach which has the acid secreting parietal cells⁶¹, or vagotomy which is a resection of the bundle of nerves that control stomach functioning. There has been a greater chance of death in gastrectomy than vagotomy and less recurrence in gastrectomy than vagotomy.⁶² Naturally, surgery has done little good without the removal of the underlying anxiety.

4. Handling the basic emotional conflict

It would appear the extensive application of psychiatric treatment has been awaiting a generally accepted theory of ulcer causation. One study in 1952 showed that 80% of psychoanalysts had had no ulcer patients.⁶⁴ Analysis has been of course an expensive and lengthy proposition. One thousand hours of analysis has not been unusual for cure.⁶⁵ Dr. E. Palmer treated 400 patients with psychotherapy alone, no diet or drugs.⁶⁶ 300 were cured, 95 required further treatment and 5 dropped from therapy. Apparently the time and expense may be worthwhile.

Another means of handling the conflict has simply been hospitalization. This has indeed removed the patient from his or her source of anxiety and has generally healed the sore. However, it has been an expensive process and upon discharge, the patient must return to the original anxiety producing environment. Medical doctors also have seen their own actions as substitute mothers (i.e. milk diet prescriptions) allowing the patient to yield to his passive-oral tendencies without an internal or external struggle.

CHAPTER 2 - THEORIES OF PSYCHOLOGICAL ETIOLOGY

In the last sixty years, perhaps as many as one hundred theories concerning psychological circumstances related to the development of peptic ulcers have emerged. They all have shown conflictual and unconvincing evidence, for research in psychotherapy is at best a difficult and discouraging endeavor. The more respected and followed theories are discussed in this chapter.

S. Freud

The fathers of all the aforementioned theories were Joseph Breuer and Sigmund Freud, who in 1936 presented the theory of conversion in their Studies in Hysteria.⁶⁸ Prior to this research team, the only significant findings came from Pavlov and Darwin. Pavlov had shown that stress situations produced reactions of a highly individualized nature in dogs based on the character and experience of that canine.⁶⁹ Darwin had drawn attention to the similarities of humans and animals during flight or fight in regards to heart pulse, blood sugar, respiration and et cetera.⁷⁰

Perhaps with the aforementioned foundation, Freud formulated his concept of hysterical conversion: "In hysteria, the unbearable idea is rendered innocuous by the quantity of excitation attached to it being transmitted into some bodily form of expression, a pro-

cess for which I should like to propose the name of conversion."⁷¹ He had further seen this as a "mysterious leap from the psychic into the somatic." Modern medicine has taken objection to the latter part, feeling that this leap is no more mysterious than any other motor innervations, such as voluntary movements or expressive movements such as laughter or weeping.⁷²

In discussion of this topic, Freud had been very definite on two counts: one, that a conversion was a symbolic substitute for an unbearable emotion, a kind of physical abreaction or equivalent of an unconscious emotional tension, and two, that all of the repressed emotion can be retraced to sexual tension. In Studies in Hysteria, Breuer and Freud have cited case after case supporting these two hypotheses, though none dealt with ulcers specifically.

Furthermore, Freud had seen that these substitute innervations never brought full relief; they were only attempts at relief. The remnant tension that was not relieved showed up in a pathological condition.⁷³ The important issue, naturally was that the emotional tension itself was partially relieved by the symptom itself.

Freud has presented a model of cathartic psychotherapy (with an overwhelming analytical base) that allegedly rids the clients of not only the remaining tension, but also the tension that initially caused the pathological condition. Of course, this model was drawn from his observation that when emotions were not expressed through normal channels by voluntary activity, i.e. rage, weeping, that they became a source of chronic psychic and physical

disorders. In making an analogy with cathartic and analytical psychotherapy with the surgical removal of a pus pocket, Freud had stated, "Such an analogy finds its justification not so much in the removal of the morbid material as in the production of better curative conditions for the issue of the process."⁷⁴

This paper has assumed that the reader has had an understanding of cathartic and analytic psychotherapy, so it has not dealt with description of the techniques at this time. However, the following chapter dealing with Re-evaluation co-counseling has presented a discussion of Freud's techniques relative to co-counseling.

F. Alexander

Soon after Freud's clarification of psychosomatic disease, the field was entered by Dr. Franz Alexander, whose widely published works including the establishment of the "Journal of Psychosomatic Medicine" have earned him the title of the "founder" of this field. Alexander took Freud as a starting point in creating a second manner besides conversion in which mechanisms of integration may become pathogenic; vegetative neurosis.⁷⁵

Alexander has restricted conversion phenomena as presented by Freud to symptoms of the voluntary neuromuscular and sensory perceptive systems and differentiated them from psychogenic symptoms in the vegetative organ systems, those operated by the autonomous nervous system explained previously.

Alexander's rationale for this distinction has been that conversion symptoms were substitute expressions, abreactions or unexpressed emotional tensions. This mechanism has been restricted to

the voluntary neuromuscular or sensory perceptive systems whose function has been to relieve and express emotions. An example would be paralysis of the larynx of a person who cannot find expression of rage through yelling, accusing or hitting. On the other hand, Alexander has shown a vegetative neurosis consists of a dysfunction of a vegetative organ, controlled by the autonomic nervous system, not the voluntary neuromuscular system. Thus the vegetative symptom is not a substitute expression of the emotion but its normal physiological concomitant.

Alexander has assumed that for every emotional state, there has been a certain distribution of vegetative innervations. For instance, Pavlov found in his dogs that the attitude accompanying and preceding food intake and digestion was accompanied by a vegetative tonus. If these emotional states were chronically sustained, then the vegetative innervations (i.e. in the stomach - hypermotility, hyperacidity, etc.) also became chronic.

Interestingly enough, Alexander has deemed a peptic ulcer as being "neither a conversion symptom nor a vegetative neurosis. In some cases it has been the somatic end result of a long standing neurotic stomach dysfunction, but in itself has nothing whatever to do with any emotion. It has not been the symbolic expression of a wish or self-punishment. It has been a secondary physiological end result of a psychogenic functional disturbance, a vegetative neurosis of the stomach."⁷⁶

Another of Alexander's guiding principles has been that physiologic change itself has been related to a particular "emotional constellation". For instance, he stated that an ulcer patient is

commonly diagnosed as having "frustration of the dependent, help seeking, love demanding desires". That the patient is further characterized as a dependent person who must do nothing to lose approval of those he is or might be dependent. He therefore restrains himself from any show of anger, and consequently inhibits expression of his natural feelings and wishes.⁷⁷

Utilizing a Freudian framework, Alexander has had the opinion that an ulcer patient has strong oral-receptive tendencies. He desires love and security. When a wish is not satisfied, these oral cravings become frustrated and that increases gastric secretion. One would think this would also increase ones' appetite. however, as A.J. Sullivan has pointed out in Personality in Peptic Ulcers ⁷⁸, there has been no statistically significant gain in appetite/ weight in patients with peptic ulcers.

V.S. Baugh's⁷⁹ studies have afforded Alexander's guiding principle some substance. He has found that in repression of emotions, the diaphragm dies (arrests), thereby causing mucosa of that area (the stomach) to have low vitality and low resistance to increased activity from anticipated love or its conditional equivalent - food.

A third guiding principle of Alexander's in regards to the psychosomatic dimensions of gastrointestinal and other disturbances has been the theory of specificity. Alexander and his colleagues at the Chicago Psychoanalytic Institute have favored the concept that different personality types and thus emotional tension affect different specific organs. Again, this has related back to his holistic assumption that the physiological responses to different tensions are varied; that, consequently, vegetative dysfunctions

result from specific emotional constellations. Thus the symptom has only been one part of a neurotic disturbance of that personality.⁸⁰

Therefore, Alexander's general theoretical model may be expressed in the following terse manner:⁸¹

1. All healthy and sick human functions are psychosomatic.
2. Emotions are always associated with concomitant action expressed through a portion of the autonomous nervous system and its innervated organs.
3. For specific emotions there are appropriate concomitant vegetative patterns.
4. Those portions of the anatomy controlled by voluntary action are subject to the conversion phenomenon as opposed to the autonomic system which falls under the category of vegetative neurosis.
5. Emotions repressed from overt expression lead to chronic tensions, thus intensifying in degree and prolonging the concomitant vegetative innervation in time.
6. The resulting excessive organ innervation leads to disturbance of function which may eventually end in morphological changes in the tissues.

F. Dunbar

Concurrent with Alexander's publications was Dr. Dunbar's Mind and Body⁸², a volume of epic proportions that has covered all diseases in an annotated bibliographical form. She has, however, presented her brand of a conceptual model. It has been highly mechanistic, dealing in variable distribution of energy which has often been disturbed by internal difficulties preventing adequate expression of feelings stirred up by life situations (again Freud's effect on conceptual models). Like Pavlov, she has believed that without more direct expression of action, the organ of preparation for such action must carry the task of dealing with the resulting

tension or accumulation of energy, discharging it in dysfunction or succumbing to it in the form of morphological change and wasting it.⁸³

More current researchers have found fault with this short-circuit theory. Items such as the reversability of tissue damage, specificity and the organ as a total psychosomatic process have gone without mention in Dr. Dunbar's theoretical presentation.⁸⁴ However her aforementioned laws of emotional thermodynamics as well as her development of psychological profiles of specific disease syndroms still have held weight in setting current research directions.

Much of her investigations into psychological profiles centered on disease of the gastro-intestinal tract. Specifically regarding peptic ulcers, Dr. Dunbar found the stereotype of the ulcer patient as being the go-getter was true. However she also found some interesting stereotyped psychodynamics underlying that facade:

"The ulcer patient in his childhood usually is devoted to his mother, and yet he cannot be satisfied with the dependence which that devotion implies. As he grows older, he is continually torn between his impulse to lean upon his mother, wife, friend or employer and his compulsion to assert his own independence. It is his desire to escape from his own fear of being a clinging vine which causes him to reach out for responsibility and gives him the appearance of the go-getter - and often causes him to climb quite high in the ladder of worldly success.

There is not in this personality the drive to excel which characterizes others, the coronary type for example. The ulcer patient's ambition and activity are merely a cloak for his dependent pull. He wants only to be active and escape from his own suspicion of inferiority; he does not necessarily seek to rival others, to climb over them, to impress his superior abilities upon them.⁸⁵"

Like the research of others, Dr. Dunbar's stereotype, based upon years of practice has supported Alexander's argument in that there

has been a hurt, the dependence-independence conflict, that has a natural somatic concomitant - gastric irritability.

H. Wolff

Harold Wolff, whose distinct theoretical position constituted a special position in the field, has borrowed somewhat from Pavlov's findings. Wolff⁸⁶ has pointed out that stresses which affect man arise not only from his biological and physical environment, but also from threats and symbols of past dangers, from failures and frustrations of his needs and aspirations, and from cultural pressures and rapid social change.

To these stresses, the body assumes what Wolff has termed a "protective reaction pattern." Innately, humans have created emergency protective patterns, preparing the body for mobilization by giving it extra fuel. When the crisis is offensive, stated Wolff, the stomach prepares by secreting added gastric juices to digest the food or symbolic item that will be consumed after the "kill." Along with these body preparations go certain feelings and attitudes, which, stemming from the same needs have the same goals and same somatic results. Thus in later life, when one is restimulated by a here and now emotional or environmental situation, he or she reacts by a patterned physical and psychological response. Thus the go-getter businessman is always out for the "kill" and consequently develops an ulcer.

C. Sequin

In an attempt to consolidate Wolff, Dunbar, Alexander, and Freud, Charles Sequin has left out any points of controversy from these other four researchers and has remained fairly middle of the

road. He has felt that events that had interfered with natural maturation and progress tend to make an individual escape from the struggle and take refuge in dependence. Unconsciously that person would like to become the child whose mother takes care, feeds and protects him. Due to social tenets, he cannot admit this to himself and creates a reaction formation, causing him to act over-aggressive and independent. If the repressed desire for dependence continues, it will transform (conversion) itself into a desire to be fed. The stomach acts as if it is expecting food and develops an ulcer. To the two mechanisms of integration which may become pathogenic, namely conversion and vegetative neurosis, Sequin adds a third, designated as "secondary effect" which basically is the culture and patient's own reaction to the disease itself. For example, many patients have ulcers that will heal in hospital and stay that way despite a return to the same hostile environment that caused it.

F. Deutsch

Felix Deutsch gained acceptance as a viable theoretician in the field of psychosomatic medicine in 1962 with the publication of Body, Mind and the Sensory Pathways⁸⁸. His thesis has been that the real or imagined loss of an object leads to symbolization of that object. Sometimes, the sensory pathways will reunify with the lost object (or symbol) and place in onto (i.e. skin disease) or into parts of the body. This leads to an alteration of physiologic functions in the body such as ulcers.

S. Lachman

Most recently, psychosomatic disorders have come under the

study of behaviorists, most notably Sheldon Lachman.⁸⁹ Although most of his presentation has been a rewording in behavioral terms of the aforementioned theories, Lachman has presented a new set of theoretical perspectives collectively termed autonomic learning theory.

The essence of this theory has been that "psychosomatic manifestations result from frequent or prolonged or intense implicit reactions elicited via stimulation of receptors."⁹⁰ A more simple statement would be that the role of learning of the development of psychosomatic aberrations is emphasized without minimizing the role of genetic or non-genetic predisposing factors.

Lachman has gone on to divide psychosomatic phenomena into three categories: The first was constructive psychosomatic reactions; those efforts on the part of the organism to combat illness or disease processes, i.e. the increased blood pressure in those patients with low blood pressure. The second was destructive or pathological psychosomatic reactions. These might be those intense physiological changes induced by persistent emotional stimulation that are dysfunctional, i.e. asthmatic attacks. The third and last was simply psychosomatic disease; those organic pathologies resulting from sustained, repeated or intense reactions to emotional stimulation. In other words, Lachman was addressing such permanent structural damage as ulcers and colitis. Furthermore, any structure or bodily function can be the end focus of psychosomatic phenomena, but Lachman has stressed, like Alexander's vegetative neurosis, those that are directly innervated and regulated by the autonomous nervous system.

Since emotions involve the viscera and since the autonomous nervous system has been the major mechanism for mediating emotional behavior, and since emotional reactions may be learned, and last, since it has been these reactions, where sufficiently intense or sustained can cause pathology then according to Lachman, these emotional reactions can be unlearned or eliminated. He therefore has proposed as one of the goals of psychotherapy for patients with psychosomatic complaints that the patient learn via behavior modification to gain control in so far as possible, over his own autonomous nervous system functioning and also the emotion arousing situations and conflicts that disrupt the patient's homeostasis. Also included in Lachman's brand of psychotherapy was educating the patient in the role of emotions in any and in his particular illness and training him to avoid or constructively deal with emotional situations or conflicts that have operated negatively for him.

Finally, Lachman has arrived at an equation that represents a figure for psychosomatic breakdown:

$$BT = \frac{\text{Emotional activation}}{\text{Biological assets}}$$

BT refers to breakdown threshold. Emotional activation refers to the value (duration, intensity and frequency) of the emotional arousal. And biological assets of course refers to the degree of biological strength or resistance to pathology.

Generally speaking, this formula has tied all theories of psychosomatic disorder in that it represents the holistic view: all biological disorders have psychological components

and all psychological disorders have biological disorders that must be considered in both diagnosis and treatment. In other words, the human organism has been a psycho-socio-bio-physical unit.

CHAPTER 3 - RE-EVALUATION: CO-COUNSELING

This chapter has been developed to present the reader with an overview of re-evaluation co-counseling and its possible application in the field of psychosomatic medicine. It has done so by first presenting the basic theoretical framework, then by a discussion of how re-evaluation co-counseling might explain psychosomatic disease and also by a presentation of the present practice of this peer cathartic therapy. Furthermore, this chapter has compared re-evaluation co-counseling to the theories presented in the last chapter; a proposed re-evaluation co-counseling for peptic ulcer patients to the therapies popular today, and finally proposes further research in this field.

Theoretical Framework

The theory of re-evaluation co-counseling was originated by Harvey Jackins in 1950 and in the last decade has been published by its mentor in The Human Side of Human Beings.⁹¹ This framework has served as a basis of practice that has become increasingly established in self-help groups in the United States and a dozen foreign nations.

The theory has essentially three concepts: rationality, patterns and discharge. Jackins sees man as inherently having the characteristics of vast intelligence, zestful enjoyment of living and loving, and having a co-cooperative interpersonal relationships. Furthermore, any behaviors other than these three innate characteristics is representative of something having gone wrong. That something gone wrong, says Jackins, is that people get hurt, either physically or emotionally and this shuts down the flexible human intelligence: rationality. This is reflected in expressions such as "scared out of my wits" or "so mad I couldn't think straight." Specifically, a rational act is one exactly created to suit a new situation, one that is unlike any other.

The opposite of a rational response to a new situation, the theory argues, is a patterned, repetitive response. One does not utilize his full intelligence by attempting to solve a brand new problem or situation with a past response to a similar situation, for he is not taking into account the new elements. Addictions, panics, and neuroses are extreme examples of patterns. Stage fright, the infinite number of phobias, and sex roles are everyday examples of humans behaving in a patterned manner. He is unaware of any dysfunctioning and unable to fully control that situation.

The theory further presents discharge of emotional distress as the cure-all for the removal of patterns and irrational responses. Hurtful experiences can be subdivided into six categories with six corresponding innate discharge processes.

<u>hurts</u>	<u>discharge mechanisms</u>
1. grief	crying
2. fear	cold sweat and shaking
3. anger	warm sweat and stomping (tantrum)
4. embarrassment	laughter
5. boredom	non-repetitive talk
6. physical	stretching, scratching and yawning

The theory further postulates that discharge is not part of the pain of the hurt as today's culture tends to believe. "Don't cry, everything will be OK." or "Stop shaking, get a hold of yourself, have one of my valiums, or a stiff drink, etc." Because society lays so many stigmas on these discharge processes ("big boys don't cry; stop crying or I'll really give you something to cry about; young ladies aren't supposed to show their anger.") people establish non-discharge patterns; in other words, repression-internalization. Furthermore, when discharge is allowed to happen, present or previously accumulated distress will be removed, rationality will be restored and the rigid behaviors such as phobias will be overcome.

Re-evaluation co-counseling explanation of psychosomatic disease

Re-evaluation co-counseling theory, though it does not deal specifically with psychosomatic disease, might well explain this phenomena in the following manner. As was mentioned previously, when one experiences physical (tension or injury) or emotional hurt, the flexible intelligence ceases to function. All inputs to the mind, whether internal or external, during these traumas are mistored unless discharge frees the storage mechanism. This mistorage can show up at any point in the body. Re-evaluation

co-counseling theory would go onto explain that discharge would decrease and eventually cure the physical sign of mistorage. For those that have experienced discharge of a heavier level of hurt such as fear, anger or grief, they recall a sense of physical well being. Obviously, this parallels the theories of Wolff and Dunbar.

Present application of theory

The practice of re-evaluation co-counseling involves recovering through removal of internal and external impediments and utilizing the natural discharge process. In the classes, students are trained to be sufficiently present for their clients so that he will feel safe to discharge. This entails being an attentive and supportive listener, one who refrains from making interpretations, evaluations, criticisms, comparisons and giving advise. The counselors are also trained to break those internal impediments to discharge, control patterns (i.e. the grown man who is unable to cry because he was reared on maintaining a stiff upper lip).

Meeting outside of class, two students take turns counseling and being counseled. The one acting as counselor listens, draws the other out and permits, encourages and assists emotional discharge. The one acting as client gets in touch with the hurts, past and present, discharges and consequently re-evaluates the stressful situation. With growing experience, confidence and trust, the process works increasingly better.

Thus one sees that the practice of re-evaluation co-counseling

does fill the mental health needs of America in that it is inexpensive, requires minimal facilities and training, is applicable to all ages, sexes, races and nationalities and is readily available.

Comparison with other theories

Although Harvey Jackins (a math major) had minimal knowledge of psychological theory, his re-evaluation co-counseling theory does have many similarities with the theories discussed in Chapter 2. The following discussion has dealt solely with theory, not practice, for this has been discussed in a later portion of this chapter.

Anna Freud spoke of Sigmund Freud's belief that the cathartic method as he used it led to a "restored nervous system".⁹² This restoration, thought Freud, would prevent the "mysterious leap from the psychic into the somatic," in other words, conversion phenomena. He had felt that there would be no need for a symbolic substitution of an unbearable emotion if that emotion were, in re-evaluation terms, discharged. Freud thus had relied heavily on catharsis, seeing it both as a symptomatic and causal therapy.⁹³

Alexander has disagreed somewhat with the values of catharsis, seeing weeping as having no utility.⁹⁴ He has seen psychosomatic disease such as hypertension arising not from repressed but unexpressed emotions. Re-evaluation co-counseling would say that both cause pathology. However, Alexander has not seen Freud's conversion as valuable.

"One of the most important discoveries of Freud was that when emotion cannot be expressed and relieved through normal channels

by voluntary activity, it may become the source of chronic psychic and physical disorders. Whenever emotions are repressed because of psychic conflicts - that is to say, excluded from consciousness and thus cut off from adequate discharge - they provide the source of chronic tension which is the cause of the hysterical symptoms."⁹⁵

Regarding the peptic ulcer stereotype, Dunbar has stated, "The ulcer patient's trouble is that he seldom realizes the true state of his emotions." She also has seen that when the person struggling with such conflicts as dependency-independency has brought the essential conflict to the surface of their mind and has begun to grapple with it intelligently, then the ulcer will come under control. In other words, in re-evaluation language, the person gets hurt, deals with it in the innate discharge manner and feels better."⁹⁶

Many other psychosomatic researchers have unknowingly supported re-evaluation theory. For instance, I. J. Sharvon⁹⁷ has seen that abreaction as a release and relief of affect at the revival and reliving with intensity of a past traumatic event whether forgotten or remembered leads to a lessening of tension, a breaking up of abnormal patterns, uncovering of other repressed or forgotten material and facilitation of transference. Sharvon has differed from re-evaluation practice in that he utilized drugs to break through the chronic control patterns, whereas re-evaluation co-counseling utilizes what is termed a "spectrum of techniques." Furthermore, Sharvon has done nothing for his clients in removing the guilt or anxiety that stem from such control patterns as "big boys don't cry."

I.J. Harris⁹⁸, in his study of depressed women has found that

there is a close correlation between inability to express feelings of resentment and somatic dysfunctioning. He further has supported the pattern concept of re-evaluation co-counseling by stating that the perception of stress depends on the constitutional endowment and previous experiences of the individual. Moreover, he has stated, "A feeling of good health is dependent upon a gratification of basic needs and upon an ability to discharge anger externally and rather completely."⁹⁹

Greenacre,¹⁰⁰ from the psychological studies of children, has found that the early polymorphous discharge of tension leaves these channels available for discharge in later life. Then, during periods of heightened anxiety, frustration and danger, the flow of activity is conducted over old channels reviving the overflow responses of early life; therefore breaking patterns of control before they become chronic.

J.B. Kirsner in his research on duodenal ulcers has shown that the removal of a source of irritation plus encouragement to express anger, frustration, resentment and tension may be more helpful than drugs in the control of ulcers.

Finally, Percival Symonds¹⁰², in a study of successful psychotherapy in 68 cases, has found "59 followed abreaactions, 7 followed interpretations by the therapist and 2 were related to change in perception which may or may not have been caused by the therapist's comments." He has gone on to say that, "It is quite possible that in the 9 cases in which the changes apparently followed the therapist's interpretation or were related to changes in the client's perception, the changes actually followed

an abreaction that was not noted or recorded by the therapist, and it is possible that the abreaction might not even have been observable but might have been more in the nature of an internal reaction."

Symonds even has paralleled the re-evaluation co-counseling concepts of free attention as a necessity for discharge ("Insight I") and re-evaluation of a distressful event of the past ("Insight II"). Symonds has stated, "Before abreaction can take place, the client must perceive the situation in a different way than he is accustomed to perceiving it, that is non-threatening (note: what re-evaluation terms balance of attention, which is a balance between the awareness of the here and now with the therapist and the heaviness of the client's material)...Insight II depends upon a preceding abreaction which reduces tension, removes threats, and makes the change in perception possible. Insight II paves the way for further abreaction (note: what re-evaluation therapy terms breaking of control patterns) which helps the therapeutic process to proceed until the therapeutic goal is reached." It would seem therefore, that both Symonds data and his interpretations support the practice of re-evaluation co-counseling psychotherapy for those clients with psychosomatic disease.

Proposed Re-evaluation Co-counseling for Peptic Ulcer Patients

Due to the fact that re-evaluation co-counseling has been tested and perfected over the past twenty years in thousands of cases in nearly a hundred separate communities, this author has found attempts to change the present structure of re-evaluation co-counseling unworthwhile. The Elementary Counselors Manual

has presented a concise guide to the do's and don't's in the art of being both a client and co-counselor.¹⁰³ This handbook combined with elementary classes in co-counseling can afford virtually any lay person the ability to counsel and be counselled by a person with peptic ulcers; with little expense and theoretically - maximum efficacy.

In normal organization of groups, therapists attempt to have group composition of like people, for instance obesity, adolescent, cancer or married couples groups. It is suggested that this not be the case for a class in re-evaluation co-counseling for people with peptic ulcers. Since these classes have been for class members to re-evaluate their own material where the teacher plays only a minor role as therapist (per se), then the ulcer patients would only feed into each other's patterns rather than breaking that pattern (i.e. control pattern of repression of emotion). Therefore, if any ulcer patient found himself in a mixed group, he would have a high chance of getting a co-counselor who would perceive that pattern and aid that client in breaking it. One must be aware in co-counseling that a pattern, like a drug addiction, will fight off all attempts to cure that pattern or addiction.

Therefore the proposed treatment for peptic ulcer patients utilizing re-evaluation co-counseling differs in no way from the status quo use of this therapy as outlined in the Elementary Counselors Manual. Also, the Spring issue of the Journal of Humanistic Psychology (1972) has presented two excellent articles by Dr.

Thomas Scheff¹⁰⁴ and Dr. Bernard Somers¹⁰⁵ dealing with re-evaluation co-counseling. Both have afforded a terse outline of this therapy.

Comparison of Re-evaluation Co-counseling and other treatments

Contemporary psychoanalysts stress interpretation and insight and tend to disregard catharsis.¹⁰⁶ They believe that Freud and Breuer¹⁰⁷ tried cathartic therapy and found it wanting. In his work, Freud did indeed see abreaction as affording only temporary relief from somatic dysfunctional symptoms. From the re-evaluation counseling perspective, this was due to the incompleteness of Freud's methods.

In treating his patients, Freud, as in re-evaluation co-counseling, aided them in getting in touch with a traumatic event. Cured, he felt, came "with appropriate affect..The patient is, as it were, getting rid of it by turning it into words. The patient only gets free from hysterical symptom by reproducing the pathogenic impressions that caused it by giving utterance to them with an expression of affect." Therefore, he and re-evaluation therapy both consider verbalization of a trauma as essential, however, the latter would see that words are a trigger for the discharge of emotions, not an end in itself. As was aforementioned, patterns such as those associated with peptic ulcers, are driven by a great reservoir of emotional distress, distress requiring tens or even hundreds of hours of discharge.¹⁰⁸

From this point of view, then, it would seem that Freud and those therapists who have followed his model have been only skimming the surface of the emotional distress of their clients.

Re-evaluation co-counseling sees Freud as further erring in encouraging the patient to forget the trauma that he had discussed; thus leaving the material still undischarged and probably recidivistic.

In a footnote to his discussion of the technique of abreaction of arrears (discharge), Freud had stated "I once learnt to my surprise that an abreaction of arrears of this kind can form the subject of an otherwise puzzling neurosis."¹⁰⁹ He continued by describing a case in which the patient cried continuously under hypnosis. He then went on to say that the depression from which she was suffering left, bringing himself what he ironically termed "credit of a great therapeutic success by hypnosis," when in actuality he was allowing the innate discharge mechanisms to operate.

Thus the central error made by Freud and his contemporary followers has been to focus on the verbal aspect of the cathartic experience, elicit discharge but then interfere with the very discharge process they had elicited by interpretation and steering the client to verbalization of feelings. A secondary error according to re-evaluation counseling would be that the psychoanalytic therapist interprets the patient's own material for him or her in an authoritarian position, rather than allowing the client to gain sufficient free attention via discharge to re-evaluate his or her own material by himself or herself.

Re-evaluation counseling differs greatly from the behaviorist's approach. Behavioristic techniques do not take into account the re-evaluation counseling tenets of man's nature, rather treat

man as a programmed machine. Behaviorists only change the overt signs of a pattern and like an iceberg leave the great majority of the pattern untouched, only to resurface later in another psychosomatic pathology. However, behavior modification is used tacitly in re-evaluation classes where clients who discharge are given strokes for that act. On the other hand, behaviorists would have to admit that non-discharge due to control patterns is also treated with warmth.

Another in-vogue therapy that also deals with catharsis has been that of Arthur Janov's "Primal Scream" therapy.¹¹⁰ Although emphasis is on screaming, Janov has recognized other forms of discharge: "No two primals are alike even for the same person. There are angry and violent ones, fearful ones, and quiet and sad ones. Whatever form it takes, the therapy is aimed at old unresolved feelings."¹¹¹

But like Freud, Janov has made the error of cutting off discharge. "I began to cry more and Janov waited and then said, 'say what you're feeling, don't cry it away.' I stopped crying eventually and grew quiet."¹¹²

Thomas Scheff¹¹³ has seen two fundamental differences in the approaches between re-evaluation and Primal Scream. In the former therapy, the client is in charge and therefore is allowed to go at his own pace and not be forced into areas for which he is not ready. In Primal Scream, the therapist is clearly in an authoritative position and uses considerable force and coercion to meet the therapist's expectations.

The second difference lies in Janov's opinion that the defenses constitute a system which must be overthrown all at once. Re-evaluation co-counseling makes a contrary assumption that patterns constitute systems that may be breached one at a time, so that the therapy can be seen as a protracted, gradual and relatively undisruptive process.

This paper will not attempt to deal with transactional analysis. However, from what this author has seen of this therapy, it does share the humanistic characteristic of re-evaluation co-counseling, but the therapist, not the client, is again in charge.

Proposed research

As in any research into a psychotherapy approach to the cure of peptic ulcers, conclusions are at best guarded due to the highly individualized character of therapy. Treatment of patients with peptic ulcers by re-evaluation co-counseling would, however, provide "cleaner" research due to the commonality in the practice of it.

Some variables that might be tested would be placing several similar cases in re-evaluation, behavior modification, psychoanalytic or primal therapies and compare cure rates. Added factors might be using or not using antacids, psychotropic drugs or surgery.

Finally, it would be interesting to measure stomach activity during emotional discharge. As was mentioned in the first chapter, this has been done with the measurement of acidity or motility of stomachs of patients in stress situations, but never while discharging.

CHAPTER 4 - SUMMARY AND CONCLUSION

This paper has served to discuss the present status of psychosomatic disease, specifically peptic ulcers and the the psychotherapies for them, specifically introducing Re-evaluation co-counseling into this field as a viable, inexpensive, humanistic alternative. In a disease such as peptic ulcers that is plagued by ephemeral and vogue cures, one looks very carefully at any innovation. Re-evaluation co-counseling comes to this field and brings with it compassion, a significant theory and successful methods at achieving control of the hurts that might lead to peptic ulcers.

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