

## **The person in/behind the diagnosis**

Lars Thorgaard. M.D. Psychiatric Department Herning and DNS, Denmark

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## **A dimensional sub-classification of schizophrenia based partially on empathy i.e.: How is schizophrenia experienced from inside the patient?**

**LTH-5 s.**

### **Adknowledgements**

I shall express my debts to the psychiatry in Herning, Denmark and to the psychiatry in Stavanger, Norway from where I have had support to my work the last many years. Thanks to Bent Rosenbaum for our co-work in the DNS with the manuals. My work in the DNS also resulted in the work about processnotes for both the psychotherapists and the supervisors from which the material new research will be generated. Birgitte Døssing will present some of this work tomorrow at her workshop.

### **Introduction**

It is my intention to present my model of a dynamic classification of schizophrenia based on attempts at empathy – on empathising. It is intended as a tool, developed for individualised dimensional classification in order to map out just how each unique individual lives with *his/her* disorder.

### **Man is moulded for a great deal by his mastering, his attempts of mastery and mastering-strategies, for instance mastering of self-coherence, self-protection, self-preservation etc.**

We humans – whether healthy or sick – are moulded for a great part by the results of our mastering-strategies – successful as well as failed - which we have used or use in our lives, by the way we live our lives, and the consequences herein. These strategies can be creative and/or destructive in varying degrees. They may be conscious, unconscious, and/or instinctive self-preserving in their intension. They can provide the basis for growth and development, yet they may also be disruptive and create new problems. When they operate in the

aforementioned way, it is frequently in order to undertake the task – and most often instinctively – to attempt to ‘kill’ or to soothe a large and unbearable pain or feeling.

### **About psychosis**

On the one hand, psychosis can be understood as something which arises when mastering is no longer possible: When ones attempts at mastering an extremely painful life situation and the consequences thereof, and/or an intolerable mental state, necessitates giving up, either temporarily or indefinitely.

A psychotic state can, in itself, be understood as an attempt at mastering - albeit on an entirely different level, in an entirely different way. It cannot be emphasised enough, that the more vulnerability factors there are in a persons constitution and environment, the greater the necessity for dealing with them with self-created attempts of mastering and mastering-strategies. It is, therefore, necessary to look for these attempts at/of mastering in the subjective experiences of the psychosis: in the phenomenology (in the classical central-european sense of the concept). By doing this, one has the possibility to empathise more precisely that, which the person is really up against: That which the person in / behind the diagnosis is trying to deal with and master. The symptoms, as they are considered traditionally from the outside, can be seen as signs/as icons as to how the person is trying to master with inner and outer problems.

There are at least two areas of vulnerability: The individual vulnerability, and vulnerabilities in the environment around the person. The more cumulative traumas on top of a individual vulnerability - the more detrimental to the patient’s position - and consequently - a further need for self-created mastering-strategies ! Unfortunately and tragically they often prove inadequate and in themselves becomes problematic: A solution creates new problems ! Life and living – in itself - can, in the case of the vulnerable and sensitive person, be primary experienced as trauma’s. This is one end of the continuum. At the opposing end we see that the population of psychotic persons (with schizophrenia) are at the very least just as totally traumatised as the so called ‘background population’ of healthy and robust are (Read, 2004, 2005). It is quite understandable, when clinical work and research today shows an increasing eye for considering many schizophrenic symptoms in the light of traumatisation and disassociation. Ross (1990, 2000, 2006) speaks of the existence of a so-called ‘dissociative’

schizophrenic with a considerably more favourable prognosis, and where there is an indication for psychotherapy (relationship treatment). He operates with a continuum extending from (what he calls) non-dissociative schizophrenia to dissociative schizophrenia, to what he terms dissociative identity disorder. In my dynamic psychosis understanding the dichotomy of non-dissociative and dissociative schizophrenia is unnecessary. There is always the crucial influence of splitting processes because of the mentioned vulnerabilities in their co-work. These splitting-processes express themselves in the positive symptoms amongst other things.

I would advise precise observation in order to identify the patient's own mastering-strategies in the subjective experience of the psychosis, as well as their manifestations/consequences. In this way you may gain insight into the forces the patient is struggling against, and therein enable the possibility to empathise with that which is attempted too be mastered. The symptoms by which we make diagnosis will comprise, to a large extent, the person and the person's attempt to master. They express the manifestations of the mastering-strategies and "What it is 'the person in the diagnosis' is trying to – and forced to - deal with?".

### **Existential conditions/predicaments and dimensions**

The dimensions in my classification system are general in-that any one here could diagnose themselves with, what I call LTH 5-s (in the beginning and still for fun and in order to bring associations to DSM and ID). The dimensions reflect general life conditions. That which one can gain insight into with the help of my dimensions, is to which degree each individual has special or pronounced difficulties with one or more of the dimensions. Some people will have particular problems with one aspect whilst others will experience alternative difficulties in another area. Those who are especially vulnerable are similar in this respect, although they have added unique difficulties which, as described earlier, means they strive for particular mastery-resources. As chance would have it, though, these mastery-resources are all too frequently unavailable.

### **Empathy work**

The classification system LTH-5 s. has its origin in the attempts the 'uninitiated' can make to really try for a moment to put himself in the other's situation. This underpins how we accept that which each unique individual experiences from within, and how he/she has to live with

precisely his/her schizophrenia. Using the system requires that we try to create our empathy for just how it is experienced and which mastering-strategies the individual seeks. It also requires a good deal of empathising work from us, although the dimensions of the system can help to make this a little/a good bit easier. We have indeed some dimensions, which we can peruse (løbe igennem) as aids, when we attempt to attain an overview with the help of empathy.

The classification system should be used with the following guidance:

The relationship-worker/ care-worker must study the history of the ailment thoroughly (Itstorroly) and with respect. Furthermore one should be able to give a detailed description of the symptomatology corresponding to traditional diagnostic systems. An added importance is attributed to the life history, which unfortunately is all too often only told in part. It is also, supplementary to the story, sought to identify even more through empathising with active imagination in order to establish hypotheses and context about/with the life history. One does this as a substitute/proxy for the patient. A further priority is the observation and description of the patient's relationship-abilities: Of the ways in which the patient relates to and has related to, both now and in the past, and in particular how the patient is relating with others - and vice versa - including care-workers, therapists and other psychiatric professionals.

It is important to catch elements of resonance through empathic feeling and understanding of how the disorder is experienced from within the patient and how the patient instinctively and unconsciously relates to his/ her disorder; how on the whole we think the patient believes the disorder can be controlled. Knowledge of the classification system can, as mentioned in itself, be beneficial in this respect.

### **The 'diagnostic' exercise:**

- 1) Try to differentiate between the following possibilities in the classification system. This is done in relation to a specific patient, at a given time, and under the actual circumstances in his/her life. That is to say: In the relationships, in the patient's disorder-processes and the treatment-processes.

- 2) Next, answer the following question: Which dimension fits best to your attempt at empathy, and which is second- best. You must have a first choice and a second.

It is thus, that none of the dimensions discussed exclude one another. All of them can be found in all of the patients, and each patient has difficulties with every dimension although one or two are most prevalent for this unique patient, in this relationship, at this time in his/her life. Also in the development of this disorder and of this treatment process. As mentioned all the elements can be found in every case of schizophrenia, but there is always something which is more to the fore, whilst other elements are in the background. For the sake of convenience, one could imagine that all of the dimensions are foremost on the screen of the computer and that they are on top of one another. The object of the exercise now, is to select and make a priority of what is most in the foreground and what is secondary in the foreground.

Sometimes we do this to the advantage in the team. Everyone deliberates the question quietly for a while - 5 minutes is suitable. Now the supervisor asks each in turn and notes the successive suggestions on a flip-over. Each team member shares his/her ideas, and we discuss until reaching a consensus. Eventually common ground is reached ( inter-rater-reliability) about how the system works.

### **Options of action and treatment options present themselves.**

When the diagnosis is complete, the process and especially the result gives options for action concerning a more precise mapping out of which problems the patient is particularly struggling to try to master and/or what particular need for help to self-to-self-help is required. Moreover - and not least - important information about action or treatment plans can be exacted.

### **The schematical working form.**

Allow me first to describe the classification system in a schematical form. Before I do this, I would like to point out that no developmental psychology is intended as part of the system. Neither should one think of cause/effect models between each dimension. One may have a

tendency to do this, and it can be said, that there might be a connection with developmental psychology, aetiology and pathogenesis. Despite that this may be very tempting, one should avoid the connection or 'kinship' if you like, between for example attachment-disturbance, relationship-disturbance and trust-disturbance (one could indeed argue that fundamental confidence/trust is a pre-requisite for safe attachment and the ability to form relationships, or whatever comes first- the chicken or the egg?)

The important thing is to consider the dimensions as an attempt to attain empathy with - and herein form hypotheses about - the experience oriented: the subjective which sometimes can be seen and felt by others (also in symptoms and the behaviour). One can also certainly begin to think of dynamic connection in between each dimension. It can be very useful later, when treatment is in progress. It is however ill-advised in the early stage.

### **LTH – 5. s**

Schizophrenia is experienced as a disorder of:

#### **Attachment/separation**

A disturbance dominated by fear of, and incapacity to, attach and to separate.

#### **Trust/Confidence**

A disturbance dominated by an incapacity to have confidence in.

#### **Relationships**

A disturbance where relationships with others are felt as painfully impossible

#### **Identity**

A disturbance characterized by a more or less constant feeling and experience of disintegration of the self and/or weak or no differentiation between self and others.

**Self-esteem / Self-confidence and Self-contempt (selvforagt) / Self-abasement (selvnedvurdering) / Self-hate**

A disturbance/disorder characterized by more or less loss of self-esteem and self-confidence. Self-contempt, self-abasement and self-hate is instead prominent.

### **Body, Life, World, Globe, Universe-disintegration**

The Body, Life, World, Globe or Universe are falling apart and/or The Body, Life, World, Globe or Universe are dissolving, disintegrating and/or putrefying.

A disturbance characterized by experiencing that the body or parts of the body are changed, are falling apart, dissolving or putrefying.

The same experiences can be related to life and living, to other people, to the world, the globe or the universe.

### **Control /Loss of control/ Fear of Loosing of Control**

A disorder characterized by trying to have control, loosing of control or having fear of loosing control.

### **Paroxysms / Relapse / Fear of Relapse**

A disorder characterized by what is experienced as psychotic “fits”, by relapses and fear of relapses.

### **Selfcare-failing / Care-failing**

A disorder where failing to take care of oneself is prominent - and very often met by care-failing from the surroundings and even caretakers.

### **Loss of energy / spark of life**

A disorder characterized by the loss of energy, `spark` and initiative.

### **LTH-5 s. : The separate dimensions**

In the following I shall go through each of the dimensions in turn. After that I will illustrate the system and utilisation of the classification system with the aid of an example from

treatment and supervision work. In a concluding section some of the system's practical ways of being used will be summarised.

### **Attachment/separation**

By this we understand a disturbance which is mostly experienced as a powerful fear of, and an inadequate capacity to, attach and/or separate.

This may be experienced internally as a painful feeling of "separation is difficult or impossible" and as "attachment is something that I dare not risk and/ or am incapable of" -experience. The subjective experience will also be marked by the consequences of this insufficient capacity and thus but how it is tackled- with varying degrees of success.

The problems and sufferings involved in the incapacity to separate in the predicament of schizophrenia are enormous. Being unable to bear, endure and contain separation seem to be the most fundamental deficit in schizophrenia which results in an incapacity to attach and vice versa

(Benedetti et al). In many cases you will find, that the consequences of this double incapacity is the most prominent problem the patient experiences in the predicament. This double incapacity can be found in the patient's life history and all of its consequences. It is especially advisable to look out for this in the therapeutic relationship. Whilst it includes an incapacity to be alone, it also- at the same time- involves an incapacity to be in the relationship and to be intimate- a disastrous dilemma.

Treatment aims are: In cases where this is the most prominent consequence, the patient may begin to understand the need to work together, as creatively as possible, to endure, to master, to cope with and combat this disturbance and its consequences, i.e. the incapacity to separate and attach, whilst working together to improve other capacities.

### **A disorder of trust/confidence**

We often find a disturbance of trust when a certain patient's schizophrenia - experienced from within - is dominated by problems and conflicts concerning "to- be- able" or "to dare to have

trust” or to dare to run the risk involved in committing to this trust. This dimension naturally includes all of the paranoid modes of experience in schizophrenia.

This should be observed in the life history. It is also recommended- as it generally is with all the dimensions- to look for this disturbance and to investigate the circumstances surrounding it.

This could be in the patient’s relationships to important people in their lives, and especially in the case of any care- workers.

Professionals can, for example, feel excluded and kept at a distance. There may be a constant discreet loss of trust or a manifest paranoid lack of trust. A trust disturbance may express itself by way of the aforementioned lack of trust, often in reality, as a way of testing whether or not the relationship-treatment-worker / care-worker is in fact worth investing trust in (running the risk).

Loss of confidence can be seen, for example, in relation to the offer of care, good and well-meant treatment and useful/helpful form of medication. Sometimes the loss of trust is so great, that food may be experienced as poisoned, and good treatment as harmful - as a punishment or an attempt to kill. Try to feel how terrible it is not to dare to have trust. We all know the pain and anxiety involved, when losing the trust in for example family, friends or colleagues. Imagine then, if the loss of trust is so penetrating and the anxiety so debilitating for the patient whose schizophrenia is primarily experienced as - and is - an all embracing “loss of trust-disorder”.

Loss of trust is unavoidably connected to loss of self-confidence and self-doubt. Those with fundamental loss of trust-disorders do not have enough self-confidence - and vice versa.

If one suspects others, then it is probably due to self-doubt. Self-confidence disorders are related to:

“Self-esteem, self-confidence, self-contempt and/or self-hate-disorders”, which we will look at shortly.

Remember though that we must try not to think of the inter-relatedness between the different dimensions. Here we shall only decide whether or not we experience and believe that the loss of trust is the most prominent in the patient's experience, or that we think it is a self-confidence loss that is more to the fore. In case of the latter we have to look to the next dimension in order to classify.

When it is a question of trust and loss of trust disorder, the joint therapeutic objective for both parties - patient and relationship-treatment-worker / care-worker together - is to try to create the optimal conditions for fostering trust and self-confidence. It is of extreme importance to discuss the work to be done and that which is done, especially when encountering obstacles. It is best to avoid expressions like 'paranoid' and 'mistrust' in conversation with, and referring to the patient. It does little to create security / safety, and will be considered/heard as criticism.

### **Identity disorder**

Schizophrenia is experienced internally as an identity disorder with a largely constant feeling and experience of disintegration of the self and diffuse differentiation between the self and other selves. Indeed on the whole between self and the surroundings. The patient experiences the self as unstable and falling apart. Other people seem to penetrate/dissolve/enforce into the patient and vice versa.

The inner world is constantly dominated by and experienced with feelings of disintegration. This happens both in the case of primary disintegration ( expressed by the so called 'ich-störungen) as well as manifestations of the secondary multiple splittings: Secondary disintegration which may also be experienced in the positive symptoms.

Questions such as: Who am I?, Who is whom? And Who does what to whom ? can never be taken for granted. One's thoughts are not one's own. Thoughts and actions are unclear or are experienced as enforced or disappear. This is also true of the will. One is no longer "master in one's own house". This would also be true having a secure and relative non-problematic sexual identity, where one is chronically doubting one's sexual identity.

The incoherence and instability of identity is reflected in shifting feelings of inferiority and grandiosity - and when at its worst it is a try of mastering predominant feelings of “not existing”.

In all therapeutic relationships the patient is offered the possibility of a suitable and stable person and stable frames and other factors to identify with.

### **Relationship disorder**

Being in a relationship with others is felt as painfully difficult, even impossible.

The patient often withdraws from contact in order to minimize feelings of inadequacy, the sense of lack of vitality and the experience of being unable to live a normal life. The intense longing for relationships, closeness and intimacy are desperately kept at a distance. Behind these intense longings often lies a hidden, though considerable and painful vulnerability to narcissistic affronts. The latter often encourages a further withdrawal from relationships, into an often grandiose, paranoid, autistic world inhabited by avengers and fantasies of revenge.

In the therapeutic work – relationship-treatment – the patient is offered the possibility to be in, work in and contain trying to master being in relations. The remaining capacity is cared for, stimulated and developed.

### **Self- esteem/ self- confidence disorder- with self- contempt, self- abasement and self-hatred**

These disorders are found in many cases as the most pronounced feature of the ailment. One should observe for the prominent feelings of inferiority and insignificance which is often compensated for by grandiosity in an inner withdrawal. Observe too, the imperative voices prompting contempt, hate and abasement. The task for the therapist is to discover, through empathy, the ‘terroristic’ elements of the super-ego , and work together in an attempt to counter-attack with, for example, the words: “Nobody deserves to be as full of self-contempt as you are”.

### **Body, Life, World, Globe, Universe-disintegration**

A disorder characterised by experiencing the body as changing, falling apart, dissolving or rotting. These experiences can also be felt in relation to life, other people, the world or universe. This is the predicament of living with a disorder where the self-destructuralising processes are instinctively attempted to be mastered-with by means of projections to the body, to life, the world, the globe and/ or the universe. When the de-structuralizing is experienced within, the same is experienced of the world around.

In the treatment relationship the patient is offered time and space to develop different mastering-strategies to get both body and mind to hang better together.

### **Control/ Loss of control/ Fear of Loss of Control**

Try to empathise with having to live with an ailment dominated by constantly trying to preserve

a vulnerable control of the feelings involved in, and the demands of expression of and obtaining satisfaction from, love, anger, hate, sexuality etc.

Alternatively try to imagine the enormity of constantly trying to control or resist the urge or commands to commit suicide. Another example might be controlling the expressions of the body - or being controlled by something or someone else. What might be considered worst of all must be the fear of not having any control at all ! When loss of control has happened once, the anxiety of/in waiting for it to happen again is enormous.

Treatment offers help to self-to self-help to better control, and to gradually developing more and more control and realistic mastering of the fears of losing control.

### **Paroxysms/ attacks- Relapse/ Fear of relapse**

In this instance we are dealing with a disorder that is recognised by the experience of psychotic episodes, relapses or fears of relapse. In order to diagnose, empathise into, how

horrific it must be to suffer a disorder, where there is no control, what-so-ever, over the future. When will it happen again? When will it return? How is it possible to live with such uncertainties?

The patient will often instinctively and/or unconsciously develop unsuitable mastering-strategies, and in certain instances be literally afraid to even move. The patient creates hypotheses about what triggers new attacks and then hypotheses about relapse prevention. These hypotheses are seldom revealed by the patient and are often false solutions (Balint 1965). False solutions about what triggers and prevents relapses.

### **Self- care failure/ Care- failure disorder**

When schizophrenia is experienced as self-care failure and care failure, the disorder is characterised by failure in self-care.

This self- care failure is often met by care failure from others - including professionals! The aspects of this disorder are experienced in a good deal of the symptomatology, particularly in many of the negative symptoms, but also in a great many self-destructive and self-harm episodes.

Imagine just some of the defensive-/instinctive mastery-aspects of self-care symptoms: not to feel anything, not to experience anything at all, not to feel ones own needs. Where there is no feeling there is no longing!

Most importantly, however, is that most self-care failure is often met by care-failure from both community and professionals alike. Care-failure is a common response to the self-care failure of schizophrenia.

### **Loss of energy/ spark of life**

When schizophrenia is experienced as a loss of energy disorder, there is a necessity for continual and constant input of energy. This could be facilitated through a good relationship: Relational treatment.

There is almost always a necessity for constant stimulation, activating and engaging. Nobody must let up. Certainly not the relationship-treatment-workers/care-workers and neither should the politicians and administration, who otherwise might easily begin to think, that it may be for a limited period only. It is not !!It is crucial that everybody involved recognises that a limited course of action will simply not do! That, in fact, it may even make things worse, in that a new attachment will be replaced by a painful separation.

### **Clinical example: Inga**

A case whereby we first and foremost consider:

- 1) “My body changes and are falling apart-disorder”
- 2) “Separation and attachment-disorder”

And finally I here include the 3` most prominent

- 3) “Control and fear of loss of control-disorder”

Inga was 20 years old. From early childhood she was apprehensive, delicate and touchy. She didn't like school, had few friends and only limited interests.

Inga began to use hash and speed in puberty. For a couple of years she lived in an inner city ghetto in the capital, where she in fact was also born and raised. Her use of hash was considerable when admitted to hospital.

Inga's parents were divorced when she was 3-4 years old. Inga has not seen her father since. Following the divorce, Inga was cared for by an aunt and uncle. Why this was is uncertain, but it may have been, that her mother was ill? Mentally ill? one could ask.

Inga failed to commence any study or employment. Her network was very limited.

Inga worried a great deal about her physical health. She was intensely anxious about physical diseases and constantly felt that she was ill, that she was being consumed by a malignant illness. She checked everything bodily – also doors and windows! She heard voices that spoke about her in the 3<sup>rd</sup> person. They commented and discussed her world and her behaviour. She was constantly restless and uneasy.

Inga felt isolated - as different from all other people - and experienced that her body changed. Her ears and nose seemed to get smaller and smaller - very slowly. She feared that they would fall off. Inga also felt that her arms and legs were coming loose. She felt that her teeth were changing and was often showing them to people.

Inga had a local psychiatric care-worker who visited her 4 times weekly. A male district nurse visited her every 14 days. Inga stayed mostly with her mother or aunt and seldom in her own apartment. She was dependant on her mother.

Inga had previously been admitted to psychiatric hospital 3 times. Recently she was admitted whilst her care- worker was on holiday. She became more isolated and was only able to leave home to buy hash.

During this hospitalisation Inga was sectioned (forcibly detained by law) due to a suicide attempt. She attempted repeatedly to run away, but was always brought back.

Inga paced back and forth on the ward, calling her mother frequently - and cried a good deal of the time. This was something Inga had not done previously. During a single home visit, Inga obtained some hash or speed. On returning to the ward she was in a terrible state which became worse over the next couple of days. The symptoms increased, and she told how hash and speed always helped when she experienced body changes. It helped her feel more connected and whole. After a day or so, however, it became worse. Much worse! She couldn't sleep and became more and more obsessed with physical symptoms becoming increasingly restless and agitated.

In the ward everybody felt (Inga too of course) powerless. What would become of her?

In supervision the question was posed- what could be offered to Inga to replace her drug abuse? There was also an interest in learning more about Inga, and her strong ties to her mother.

### **LTH 5-s diagnoses**

Supervisor shared his thoughts with the team. He suggested that first and foremost calling Inga's disorder: "My body (and my self) falls apart and changes-disorder".

Supervisor suggested Inga's anxiety of being consumed by physical disease and the bodily changes. The supervisor said that it was in this way that Inga experienced her schizophrenia, and also that we should assume that this type of psychosis is about revealing the patient's experience of, that the the self is disintegrating, through the bodily expressions.

The supervisor also suggested that we could classify Inga's disturbance as a "Separation is difficult- disorder". And possibly even better: an "I don't dare to attach-, and can't bear separation-disorder". The supervisor mentioned that Inga clearly could not deal with separation from her mother or her care-worker. She became more ill, when her care- worker was on holiday. Inga tried to deal with separation from her mother by calling her all the time, in an attempt to master with the separation.

The divorce when Inga was 3-4 years old was highlighted. The hypothesis was formed, that Inga became ill after she was re-united with her mother. Could it be that Inga became extremely anxious after this re-union, because she was afraid of losing her yet again? Could the renewed contact have triggered this "anxiety of loosing"-nightmare. This is not to say, that Inga's schizophrenia was caused by the divorce - but rather that her vulnerability has to be investigated very carefully in the context of these traumatic events.

One of the team-members re-called Inga's self harm-episodes on the very first admission, and said that the staff at that time had spoken about, that Inga could be offered a photograph of her mother and/or a recording of the mothers voice just to retain an inner image of her. This idea was rejected however, as it was felt it might infantilise Inga. The idea here is, that the diagnosis 'Attachment and separation-disorder' could then have been applied. But why be

afraid of helping Inga with such possible (unstable) mastering-strategies - after all many people relate to loss and threats of loss with the aid of photos - at least always in the form of “inner photos” and “inner `voices” !

### **Inga´s own mastering-strategies**

The team discussed Inga´s body delusions. She had on her own developed mastering-strategies to deal with her “My body is changing and falling apart-disorder”. This was in part her use of drugs, which must be regarded - even though effective in the short term - as a particularly inappropriate mastering-strategy.

Another strategy was more effective. Inga moved back and forth on the ward and felt best, when she went for walks.

### **Action and Treatment using LTH 5-s**

With regard to the detainment order where Inga, as always during short admissions, felt craving for drugs, the supervisor was of the opinion that restraint was correct. The term is used in a broader context here in that when dealing with a “falling- apart- disorder” it logically follows, that it must be helped by “holding together” or “restraining the parts”. A “My body is changing and falling apart-disorder” and the “Separation and attachment is difficult-disorder”, can easily be considered to be closely related.

The treatment must be based on holding both mind and body together. This could involve helping Inga to achieve some small success in her life- metaphorically - to “put something together” or “get something to work or stand on its own”.

In the individual relationship treatment it might have a decisive effect if both the care-worker and the district nurse visited Inga more frequently and were constant in their contact at all costs. Covering for each other during their vacations for example.

Inga´s own mastering-strategies are equally important, when revealed, acknowledged to her and especially accepted. It was discussed just, how it would be to talk to Inga about all of

these things: To begin to refer to her ailment/illness as a “I feel my body is changing and falling apart- ailment”. Those who knew Inga best felt, that she would respond well and perhaps feel more understood. The next step might be to recognise her own self-created successful mastering-strategies, and show her and support her by, that she had herself developed / invented really good strategies with which to combat and master her experiences. She made her body move, she activated it, and tried to keep it from falling apart by that. This could be build on!

We should also mention here, that medication could play an integral part in helping Inga’s sense of holding her body/herself together. It could be said to Inga that one previously had met patients with similar experiences, and that these persons had often feared, that medication might be more harmful than helpful: That medication could affect the struggle to maintain and control a balance, in a negative direction. The relationship-treatment-worker could then say, that this is a misunderstanding! That the chosen medication in correct doses helps to have control and regain control. The psychiatric worker really recognised and expressed the value of some of Inga’s coping strategies, for example Inga’s resistance to taking medication which was motivated by a loss of control anxiety, since she didn’t know the effects of the medication and risked losing control entirely.

The relationship-treatment-worker had, in conclusion, then also observed Inga’s “Attempts to preserve control” and her great “Fear of losing control”.

### **General observations of the practical use of the LTH 5-s**

First and foremost, the relationship-treatment-worker can use this system to gain insight into the extensive and varied difficulties and needs in each and every patient. Difficulties and needs vary from patient to patient, from one phase of life to another, and between course of treatment and phases of the disorder and treatment. Primarily there is a need for help and support aimed at :

- Tolerate and endure the consequences of a diminished capacity for mastery with separation and attachment as well as helping to consolidate and develop the existing capacity in such a way as not to risk running aground.

- Daring to trust.

- Being in, coping with and tolerating a relationship.

- Developing a more stable sense of identity.

- Through help to self-to-self-help enable body, mind and/or surroundings to feel more connected. To create this connection and develop mastery-strategies that gather and shape meaning and continuity.

- To tolerate and bear the consequences of having a “Paroxysm-disorder” and “Relapse-disorder” and a “Fear of relapse-disorder” and to develop more purposeful mastering-strategies in dealing with these.

- Gaining increased control of ones “Loss-of-control-disorder”, “Control-disorder” and “Fear-of-losing-control-disorder” and gradually develop more creative and realistic adjustments and ways of dealing with the fear.

- Prevention of loss of self-care and to counter the complexities that lie between self-care failure and care-failure.

- Together combat loss of energy and supply energy/spark.

**The LTH- 5 system offers itself as an aid.**

The classification system offers a meaningful aid in organisation and implementation of :

- An individually organised empathy-orientated treatment plan in co-operation with the patient. As a thorough LTH 5-s diagnosis has been made the treatment goal is becoming evident; when for example the issue is a “Loss of control-disturbance” and a “Fear of loosing control-disturbance”, there is a need for help to self to self-help at controlling.

- Individual psycho-education. Much psycho-education is uniform and generalised. There is a need for supplementary individualised education. Experience shows that the dimensions of the LTH 5-system give meaning to the patients experience and contribute to consensus and co-operation.

- Individual prevention of relapse.

- Individualised relationship treatment based on empathy and with the aim to develop - amongst other - individualised mastering-strategies with resultant improvement in management of problems, symptoms and illness.

- As an aid to map out dysfunctional thoughts and behaviour and thus remedial to planning and implementation of cognitive therapy and social (skills) training within the cognitive treatment framework (CBT).

- As an aid in making a relationship diagnosis.

- As an aid and pointer in dynamic psychotherapeutic work, and as an aid in expressing relevant issues and foci in the dynamic psychotherapy.

### **Concluding remarks**

In my experience the language that develops and unfolds, reflecting on the thinking behind the LTH 5-system becomes meaningful both to patients and psychiatric workers. Patients comprehend and use the language. The language becomes corporal.

As previously described many care-workers use the system when mapping out treatment with the patients with discussion and explanation similar to the ones conducted in the team-work.

This procedure is very useful and is a highly individualised form of psycho-education and basis for relationship-treatment.

Furthermore my experience tells me that certain underlined points evolve, when implementing the system and that these will offer clear, concise and meaningful guidelines for treatment, useful to everyone involved - but especially to the patients.

Individual variations occur under the heading of the LTH 5 a-system dimensions.

Development of metaphors and word-play are often better at expressing the issues, which need worked with, than countless words. These underlined points, punch-lines, metaphors and word-play are especially helpful to the care-worker in mobilising empathy with the individual patient and not least assist in regaining lost empathy.

Regained empathy and added empathy will aid compliance. Improved compliance offers - in my way of thinking - an opportunity to offer the patient a continuous and responsible professional relationship. In the least it offers an opportunity to the patient to enter into such a relationship- which will offer chances of betterment and an opportunity to enter into a process of recovery with help to self to self-help. Hence you support the patient in developing even better mastering-strategies - that the self-developed - according to the specific disorder of the patient.

### **LTH 5-a. Dimension for some other “syndromes”**

#### **Borderline disorder:**

- Failure to care for one- self
- Self-contempt and self-hatred
- Loss of control and fear of loosing control
- Unstable identity and vulnerability of identity
- Disturbance in attachment / separation

#### **Depressive illness and affective disorder:**

- Loss of self-worth, self-esteem and self-confidence

- Self- hatred
- Self- contempt
- Loss of delight and glow
- or: Self over- estimation
  
- Relapse and Fear of relapse
- Disturbance in separation / attachment
- Loss of energy
- or: Noticable excess of energy

**Anxiety disorders:**

- Loss of trust/confidence
- Control, loss of control and/or fear of loosing control
- Paroxysms/attacks and fear of relapse
- Disturbance of separation / attachment

**Obsessive- compulsive disorders:**

- Control and fear of loosing control
- Loss of trust/confidence
- Disturbance of separation / attachment

**Somatisation / Histrionic pd / Dissociation /PTSD:**

- Loss of trust/confidence
- Powerlessness and impotence
- Helplessness
- Disturbance of separation and attachment

**Eating disorders:**

- Control, losing control and/or fear of loosing control
- Self-contempt
- Self-hatred
- Unstable identity and vulnerability of identity

- Disturbance of attachment / separation

**Thank you very much for your attention!**

Lars Thorgaard, m.d., Consultant psychiatrist and psychotherapist  
Psychiatric Department Herning  
The County of Ringkjøbing  
Gl. Landevej  
DK-7400 Herning

Private practice with psychoanalytic psychotherapy and supervision  
Merianvej 20  
DK-8240 Risskov

Email: [lthorgaard@dadlnet.dk](mailto:lthorgaard@dadlnet.dk)

[www.lars-thorgaard.dk](http://www.lars-thorgaard.dk)

tel 0045 – 8617 7435

### **References**

please see the Powerpointpresentation at this site.