"Secrets" as suppressed or repressed threatening information in the somatizer's autonomic nervous system: Problems with implementing the somatization model not with the model per se

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I see no need to abandon the model of somatization, since it is consistent with current empirically validated knowledge in basic cognitive and affective neuroscience (Damasio 1994, 1999; Davidson 1994; Kihlstrom 1987; Roediger 1990). Incidentally, it is also consistent with many salient clinical observations in Dr. McWhinney and colleagues' introduction to "Rethinking somatization." For example, they state "healing may require expression of suppressed emotions so that the memory enters consciousness and integration is restored." What McWhinney et al calls "integration" in the language of current cognitive neuroscience is what I have called congruence (Wickramasekera 1998) between implicit and explicit perceptions and memories (Damasio 1999; Kihlstrom 1987; Kihlstrom, Barnhardt & Tataryn 1992).

What has been missing in the domain of somatization to date is a model bridging accurate clinical observations and basic cognitive and affective neuroscience. We have needed a comprehensive model that links basic cognitive and affective neuroscience (Damasio 1999; Davidson 1994) to those scattered salient clinical observations in McWhinney et al on the conditions of "integration," "healing," and "alexithymia." My predisposing triggering and buffering High Risk Model of Threat Perception (HRMTP) (Wickramasekera 1979, 1988, 1998) provides operational definitions of salient clinical observations in somatization and also provides a reliable and valid method of quantifying these clinical observations for clinical practice and research in somatization.

It appears that McWhinney et al took too literally the metaphorical title of my paper "Secrets kept from the mind but not from the body and behavior." They did not realize that my conceptualization of somatization and stress-related psychophysiological disease (it appears to be all diseases) is based on current empirically validated concepts in cognitive and affective neuroscience and not on Freudian theory or psychiatric nosology (Diagnostic and Statistical Manual of Mental Disorders-IV). For example, my predisposing risk factors are operational definitions of certain well-established measurable personality factors that the extensive empirical research I reviewed has shown to increase the probability that emotions and perceptions, in the words of McWhinney et al, "may lie beneath the level of consciousness." Technically, in current cognitive neuroscience, this is the distinction between implicit ("lie beneath the level of consciousness," as McWhinney et al write) and explicit ("the memory enters consciousness," as they write) perception, memory, and emotion (Kihlstrom, Barnhardt & Tataryn 1992). That there can be incongruencies (Wickramasekera 1993, 1998) between implicit and explicit perceptions, memory, and mood that are manifested in autonomic nervous system physiology and/or
behavior but not in conscious awareness and verbal report, is empirically well established in the clinic and laboratory (Damasio 1999; Davidson 1994; Kihlstrom 1987). It appears that people and patients can have autonomic nervous system responses and behavioral memories and perceptions that are conditioned responses that are automatically triggered by specific situations without any conscious awareness of the trigger or conscious awareness of the perception or memory (Wickramasekera 1968, 1971, 1972, 1974a,b, 1976a,b, 1994a,b, 2000; Wickramasekera & Wickramasekera 1997; Wickramasekera et al. 1998).

At no point in my paper did I explicitly invoke the concept of a “self” much less, as McWhinney et al. write, a “disembodied self” because the concept of the unity of self is controversial on both logical and empirical grounds (Hilgard 1977). In fact, I am clear all through the paper and particularly in the case study of the “two million dollar man” that the “secrets” in this instance are emotions in the patient’s body of implicit rage at his wife, and more specifically in the patient’s blood pressure (implicit emotion), that have not become explicit or reached conscious awareness. Hence, “the secrets” are those emotions or cognitions that have been repressed or inhibited in the body of the patient.

According to McWhinney et al., a “trusting committed relationship with a healer who has self-knowledge” (in terms of cognitive and affective neuroscience this is congruence between implicit and explicit memory and perception in the healer) may be an essential condition to “heal” or reduce the incongruence between implicit and explicit perception in the patient. But as I have stated in my High Risk Model of Threat Perception, congruence in the healer is an insufficient condition for healing in the somatizer (Wickramasekera 1979, 1998). The predisposing risk factors in the somatizing patient that maintain the incongruence between implicit and explicit perception need to be reduced or altered by specific interventions like the “Trojan Horse Role Induction” (Wickramasekera 1988, 1998).

In the final analysis, the high risk factors (Wickramasekera 1979, 1998) are an effort to operationalize the following important clinical observations of Sir William Osler, “Sometimes it is better to know what kind of person has a disease rather than to know what kind of disease the person has” (Wickramasekera 1988). It is not simply the nature of the virus or the amount of tissue damage that determines the number, duration, and intensity of clinical symptoms but also certain psychosocial features of the host. I have attempted to operationalize in my High Risk Model clinically relevant psychosocial features of the host as anticipated by Osler. My model specifically operationalizes those features of “the host” or the healer that can amplify or reduce the probability of incongruence between implicit or explicit perception or, in McWhinney’s term, “self-knowledge.” I was explicit in summarizing the empirical evidence supporting my predisposing risk factors (Wickramasekera 1988, 1998). I also hypothesized why these predisposing psychosocial risk factors may increase or reduce the probability that physiological reactions do not reach conscious awareness, producing a mind-body disconnect (Wickramasekera 1998). The empirical evidence has grown (Crawford et al. 1993; Kosslyn et al. 2000; Szechtman et al. 1998) that trait hypnotic ability, particularly when it interacts with negative emotions, may be implicated in dysregulation of the sympathetic and parasympathetic arms of the autonomic nervous system (Wickramasekera 1994a,b, 1998b, 2000; Wickramasekera & Wickramasekera 1997). In fact, I have hypothesized that high trait hypnotic ability will be associated with hypersensitivity to threat perception and will impede mainly the sympathetic nervous system and that low trait hypnotic ability will be associated with hyposensitivity to threat perception and will impair mainly the parasympathetic nervous system (Wickramasekera 1998).

Yes, somatization is a normal process, but there appear to be large and stable individual differences in the degree to which normal people are prone to amplify or inhibit negative emotions associated with somatic symptoms that are organic or functional in origin. Yes, negative emotions (for example, fear, anger) can be associated in a
primary way with reducing immunocompetence (Senior 2001), or in a secondary way (for example, amplifying the clinical symptoms of a cold) without significant viral infections (Cohen et al 1991) and perhaps with all autonomic nervous system dysfunctions and even tissue damage. But certain psychosocial features of the host (the patient), like the use or lack of social support, can reduce or amplify the magnitude of somatic symptoms (Cohen et al. 1997) and the probability that these negative emotions are blocked or amplified in conscious awareness and verbal expression (Wickramasekera 1979, 1998). The important clinical action, as Osler anticipated, is often in the interaction between the person and the disease (Wickramasekera 1988). For example, the trait of negative affectivity or neuroticism (which is a risk factor in my High Risk Model) is simply a psychological label for typical ways in which certain alterations, like higher level functions of the neuroendocrine-immunological axis, alter the basic psychological functions of perception, memory, and mood. This is a level-of-analysis issue, not a denial that in biology “top down” (Sperry 1980) and “bottom up” factors interact.

Openness to an integrated approach to treating somatizing patients, McWhinney et al write, should “start in the hearts and minds” of primary care physicians and medical school. But historically, this has not gone very far to date, even in family medicine much less in internal medicine. Because medical schools appear to select students who are skilled at repression, according to my risk factors (low on absorption and high on the Marlowe-Crowne scale) (Wickramasekera 1994b, Palsson, Wickramasekera, Rutledge, Davies & Dowling 1997), this situation is not likely to change. To integrate the exploding body of empirically-validated information in psychometrics, cognitive neuroscience, and psychophysiology with the exploding corpus of information in basic biomedical science will require too many years of medical school and too many alterations in medical education. Further, how cost effective is it to have a primary care MD who can rapidly and effectively treat acute problems do long-term “psychoeducation,” psychotherapy, and psychophysiological monitoring (Wickramasekera 1988, 1998) with chronic highly resistant (“difficult patients”) somatic symptoms? The late twenty-first century clinical psychophysiologists and primary care MDs will work together inside primary care settings (not in mental health settings), perhaps using a Trojan Horse Role Induction (Wickramasekera 1988, 1998), to help these difficult and expensive patients bring their implicit distress expressed in somatic symptoms into explicit perception and conscious awareness. After their distress has been brought into conscious awareness (explicit perception) and their somatic symptoms are reduced and expressed mainly as anxiety or depression, then referral to the mental health sector may work. But the bulk of the hard-core somatizers will reject referral to the mental health sector and treatment outside of primary care medicine (De Gruy 1996).

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McWhinney, Epstein & Freeman respond

An adequate cosmology will only begin to be written
when an adequate philosophy of mind has appeared.
E. A. Burtt, The Metaphysical Foundations of Modern
Physical Science.

No wonder that medicine has been unable to make
any serious contribution to understanding of the
psychosomatic aspect of illness...it would be truer to say
that it has prevented us from reaching an understanding.
J. Hoffmeyer, Signs of Meaning in the Universe.

Few of the opponents of dualism have given proper
recognition to the likelihood that [a] gigantic effort might
be required to reconstruct the edifice of science after
introducing the subject [emphasis added]. L. J. Rather,
Mind and Body in Eighteenth Century Medicine.

We very much appreciate the thoughtful
responses to our article and accompanying
introduction. They have encouraged us to believe
that there may be an emerging consensus among
those who have thought about these issues, and