Secrets Kept from the Mind, but Not the Body and Behavior: Somatoform Disorders and Primary Care Medicine

by Ian Wickramasekera, Ph.D.

Somatoform (DSM-IV) patients seen in primary care medicine (Family practice, Internal Medicine, etc.) are less aware of psychosocial factors driving their somatic symptoms than somatoform patients seen in the mental health sector (Wickramasekera, 1993; Saxon & Wickramasekera, 1994). These patients may present somatic symptoms like chronic fatigue, chronic allergic reactions, muscular and vascular headache, irritable bowel syndrome, primary insomnia, and primary hypertension. Emotional distress seen in primary care typically is presented as a somatic complaint (De Gruy, 1996). Remarkably, in cases of somatization disorder, the rate of medical utilization is as high as 9 times the national norm (Smith, 1994)! Further, 1/3 to 1/2 of primary care patients will refuse referral to mental health professionals (De Gruy, 1996). The above facts are a major problem for primary care M.D.’s; hence, somatization has been called medicine’s “blind spot” (Quill, 1985) and medicine’s “unsolved problem” (Lipowski, 1987).

Somatization is the conversion of threatening psychological information into somatic symptoms (Wickramasekera, 1979, 1983; Wickramasekera, Pope, & Kolm, 1996) and maladaptive behavior (Wickramasekera, 1976). Threaten neuroendocrine based emotional (National Academy of Sciences, 1989) information kept secret from consciousness, may disrupt adaptive behavior and biology (Wickramasekera, 1988, 1993a,b, 1994a,b). In a group of 83 somatoform patients, it was found (Wickramasekera, 1995) that those who scored high on a measure of hypnotic ability presented their distress both in psychological (e.g., anxiety, depression) and somatic (e.g., irritable bowel syndrome, chronic pain) symptoms. But that those who scored low in hypnotic ability presented their emotional distress mainly in somatic symptoms (e.g., chronic pain, irritable bowel syndrome, etc.). It is proposed that the exclusively somatic presentation of emotional distress can be more lethal (Wickramasekera, 1986a) as recently documented in the case of 70 morbidly obese (BMI=40) patients candidates for gastric exclusion surgery (Wickramasekera & Price, 1997).

Patients presenting somatic complaints without organic findings are likely to have one or more of 3 predisposing psychometric risks factors (Wickramasekera, 1988, 1993). These 3 risk factors enable them to not only keep threatening secrets from others but more lethally from themselves. These “secrets” may pertain to recent painful perceptions or old traumatic memories of “unfinished” business. These predisposing risk factors are: (1) High hypnotic ability (Harvard 12-9), (2) Low hypnotic ability (Harvard 3-0), and (3) having a high (17+) Marlowe-Crowne score (Crowne and Marlowe, 1960). These are orthogonal or unrelated measures. These 3 risk factors can induce an incongruence between psychological measures (e.g., no perception or memory of negative emotions) and physiological (e.g., but strong sympathetic activation e.g., high skin conductance or high heart rate or high blood pressure, etc.) measures of threat perception. For example, somatizers may be angry or fearful as indicated by sympathetic activation (e.g., cold hands, wet hands, etc.) but will have no conscious perception or memory of anger or fear.

Accessing these “secrets” requires what I have called a Trojan Horse Role Induction (Wickramasekera, 1988, 1989a). This strategy begins by first putting out the “fire” of chronic distressing somatic symptoms (e.g., chronic headaches, irritable bowel syndrome, chronic insomnia, etc.) with a variety of empirically effective techniques like biofeedback, hypnosis, or cognitive behavior therapy (NIH-TAP Report, 1996; Ollens, 1996; Wickramasekera, 1976; Wickramasekera & Kenkel, 1996). At the same time we use psychophysiological monitoring techniques to identify, track, and explore the physiological changes associated with approaching (Wickramasekera, 1993, 1994) the “matches” or the “secrets” blocked from consciousness. In the final analysis, these secrets drive the...
somatic symptoms. This is not lie detection, but truth detection. The Trojan Horse Role Induction and psychophysiological monitoring appear to, at least temporarily, enable the risk factors maintaining mind-body incongruence. Thus they improve psychological self-regulation in somatoform patients. There is strong and growing empirical evidence from cognitive neuroscience, neuropsychology, and experimental hypnosis that psychosomatic factors (cognitive and emotional) can conflict consciousness in both normal people and patients (Shedler et al., 1993; Shevlin et al., 1996; Weintgerer, 1990; Wickrasmasekera, 1988).

I have proposed that specifically under conditions of psychosocial threat or trauma the operation of these 3 risk factors increase in probability (Wickrasmasekera, 1988, 1993).

In summary then, I have proposed that all patients who present chronic somatoform symptoms in primary care medicine, without obvious organic disease and even without DSM-IV diagnosable psychopathology, be routinely tested for at least the above 3 risk factors while their medical investigation for organic factors continues. People with one or more of these 3 risk factors may have unblocked or reduced important, negative, emotional, information (e.g., rage, depression, shame) from consciousness. Lack of important negative emotional information can impair judgment (Damasio, 1994) and adaptive behavior. The chronic failure to detect this potent source of information from reflexive emotional states (Damasio, 1994) can have several important behavioral and health consequences. It can block the conscious processing of such potent neuroendocrine based emotional information (e.g., rage, shame, etc.), which on one hand could (a) dysregulate adaptive ANS and immune functions, (b) while constricting the scope of cognitive choices and the range of behavioral coping responses to threatening but inevitable human predicaments (e.g., failures, unhappy marriages, loss of support systems, etc.).

The measurement of hypnotic ability with the Harvard or Stanford Scales requires specialized training and skills. Hence, I have suggested that the 34 item Absorption Scale (Tellegen & Atkinson, 1974) which correlates modestly with hypnotic ability, independent of context effects (Nandon et al., 1991) be used at least for initial screening along with the 33 item Marlowe-Crowne Scale to identify these 3 psychometric risk factors. This testing should take less than 20 minutes. If one or more of these 3 risk factors is identified, it is possible that negative emotions or trauma blocked from consciousness is driving the somatic symptoms. A somatoform diagnosis should be seriously considered, particularly before further dangerous medical tests or exploratory surgery is done.

The Trojan Horse Role Induction and psychophysiological monitoring with psychotherapy (Wickrasmasekera, 1988, 1994a,b; Wickrasmasekera, Davies, & Davies, 1996) will convert a somatizer into a curious psychotherapy patient who regards somatic symptoms as information from the cognitive or emotional unconscious (Kihlstrom, 1987; Shedler et al., 1993; Shevlin et al., 1996; Wickrasmasekera, 1988, 1994b). Such a patient can be engaged in a therapeutic alliance that does not simply use biofeedback, cognitive behavior therapy or hypnosis (Wickrasmasekera, 1976, 1988, NIH-TAP, 1996) to self-soothe and to put out somatic “fires” but also to find the “matches” flickering or blocked from consciousness (Wickrasmasekera, 1988, 1994; Wickrasmasekera, Davies & Davies, 1996).

A Case Illustration

C.M. went to her doctor complaining of shortness of breath during the night, frequent chest pains and insomnia. Twice she had taken herself to the emergency room, thinking that she was having a heart attack. Exhaustive tests by her physician and four specialists yielded nothing and she was referred for evaluation. Psychophysiological assessment revealed high hypnotic ability (Harvard 10) and high (20) Marlowe-Crowne score. Her cognitive stress profile showed an inhibited respiratory pattern and labile heart rate with delayed recovery from cognitive stress. But, all other psychological tests (e.g., MMPI) were within normal limits.

During her initial interview, C.M. had mentioned that she had dated the same boyfriend for four years. She wanted to get married and start a family, but each time she suggested this he offered a different excuse. He had kept her in a “holding pattern” for 4 years. C.M. made it clear that although this was not an arrangement she would choose, she denied that she was not happy with it.

Most somatizing patients are skeptical of psychological explanations of their somatic symptoms and need to be shown, not told, about what bothers them. While her physiological reactions were being monitored C.M. was asked to hypnosis to visualize and talk about her relationship with her boyfriend. Her physiological reactions during this procedure showed the previous inhibited respiratory pattern and elevated heart rate response, but to a greatly amplified degree.

The patient’s verbal report on a pre-post subjective units of distress scale indicated no perception of these large heart rate and respiratory changes. Previous research with hypnotic surgical analgesia and experimental pain have shown that high hypnotizable and high Marlowe-Crowne people can have poor fear and pain perception.

It appeared that her relationship with her boyfriend was the major stressful stimulus acting upon her “window of vulnerability.” When C.M. was told this she was at first incredulous. The next step was to show her, on the instruments, the heart rate and respiratory changes her thoughts and emotions about her boyfriend produced, and then to help her through psychotherapy to see and
recognize her frustrations and anger at her boyfriend. Soon her symptoms became infrequent and she was able to phase out all psychotropic and sleep medications. She was followed for two years with a temporary onset of psychological symptoms (e.g., depression) but no relapse of her somatic symptoms and eventually a significant change in her social relationships.

Most cases are not this simple. Many patients are addicted to pain, sleep, or psychotropic medications or have had multiple unsuccessful surgeries for their somatic symptoms. They are angry and bitter and continue to press for a strictly medical solution to their somatic symptoms. Often, it is not difficult for the therapist to determine the “window of physiological vulnerability.” The difficult part is finding the unconscious factors driving the physiological stress response and showing the patient how these unconscious perceptions and memories drive their somatic symptoms.

References:


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