certain degree of flexibility both at the cognitive and emotional levels of relating to the client. When one perspective doesn’t generate questions which are meaningful to the client or yield feasible problem solutions, one has to quickly shift one’s way of looking at the problem, generate different questions and problem solutions. Given the limits of any specific theoretical perspective, the therapist who is narrowly trained in only one perspective and set of techniques is likely to be effective with only a narrow range of presenting problems.

As this paper suggests, identifying a problem focus that is relevant to the initial complaints, that enlists the client’s active cooperation and results in a parsimonious course of treatment is not a simple process. It often requires the integration of an awesome and complex mixture of personal qualities and clinical skills, a deep understanding of human nature as it is expressed in both intra and interpersonal process and a extensive exposure to diverse perspectives and techniques of facilitating human change.

References


Secrets Kept from the Mind, But not the Body and Behavior

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At least 50% of patients with somatic complaints seen in primary care medicine are less aware of psychosocial factors driving their somatic symptoms than somatoform patients seen in the mental health sector (Wickramasekera, 1993a; Saxon & Wickramasekera, 1994). These patients may present somatic symptoms such as 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; Kirmayer et al., 1993). The underlying emotional distress is identified only 50% of the time when somatically presented but is identified in 90% of the cases when psychologically presented (De Gruy, 1996). The rate of medical utilization for such disorders is 9 times the national norm (Smith, 1994)! Because these distressing somatic symptoms persist, and perhaps because of the fear of malpractice lawsuits, patients presenting chronic somatic complaints without significant organic findings or psychopathology are eventually referred to medical specialists or subspecialists (Wickramasekera, 1988). Specialists order expensive and invasive tests and procedures, sometimes with iatrogenic consequences. Further, 1/3 to 1/2 of primary care patients will refuse referral to mental health professionals (De Gruy; Orleans et al., 1985; Von Korff & Myer, 1987). It is no surprise then that somatization has been called medicines’ “blind spot” (Quill, 1985) and medicines “unsolved problem” (Lipowski, 1987).

Somatization is the conversion of threatening psychological information into somatic symptoms (Wickramasekera, 1988) and maladaptive behavior (Wickramasekera, 1976). Threatening neuroendocrine-based (National Academy of Sciences, 1989), emotional information kept secret from consciousness can disrupt normal behavior and biology (Wickramasekera, 1988, 1994a,b; 1996b). It is also proposed (Wickramasekera, 1988, 1994b) that somatizers are at greater risk for such disruptions than patients who present their emotional distress psychologically (e.g. depression, anxiety). For example, in a group of 83 somatoform patients, it was found 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. Those who scored low in hypnotic ability, however, presented their emotional distress mainly in somatic symptoms (e.g. chronic pain, irritable bowel syndrome, etc) (Wickramasekera, 1995). Moreover, the somatic presentation of emotional distress can be more lethal (Wickramasekera, 1986, 1988, 1993a) as recently documented in the case of 70 morbidly obese (Body Mass Index = 40) patients who were candidates for gastric exclusion surgery (Wickramasekera & Price, 1997).

Patients presenting somatic complaints without organi-
ic findings and who are unaware of emotional distress, or refuse referral to the mental health sector are likely to have one or more of 3 predisposing psychometric risks factors (Wickramasekera, 1988, 1993a,b; 1996a,b). These 3 risk factors enable them to not only keep threatening secrets from others but 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. sympathetic activation, high skin conductance, high heart rate, high blood pressure) measures of threat perception. For example, somatizers may be angry, anxious, 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. The common feature of these 3 predisposing risk factors is that they reduce or block negative emotions from consciousness (verbal report) but not from behavior (e.g. behavioral violence, avoidance of certain situations, self-soothing substance abuse, etc) or physiology (e.g. migraines, ANS dysregulation, immunosuppression, etc). In other words, these 3 risks factors appear to enable a person to “keep distressing secrets from Self” (Wickramasekera, 1993a, 1994a,b).

Accessing these “secrets” requires what I have called a Trojan Horse Role Induction (Wickramasekera, 1988, 1989a,b). This strategy begins by first putting out the “fire” of chronic distressing somatic symptoms with a variety of empirically effective techniques such as biofeedback, hypnosis, or cognitive behavior therapy (NIH-TAP Report, 1996; Oliness, 1996; Wickramasekera & Kenkel, 1996) which substitute skills for pills. Psychophysiological monitoring techniques can identify and track the autonomic nervous system changes that accompany the approach (Wickramasekera, 1993, 1994a,b) to the “secrets” blocked from consciousness, which drive somatic symptoms. This is not lie detection, but truth detection. When the primary focus of therapists’ attention is first on the effective reduction of the patient’s chronic distressing somatic symptoms (e.g. pain, insomnia, etc), a powerful positive transference relationship develops that bypasses typical security operations and enables the patient to talk about threatening “secrets kept from Self”. The Trojan Horse Role Induction and psychophysiological monitoring appears to, at least temporarily, disable the risk factors maintaining mind-body incongruence or self-deception and improves psychophysiological Self-regulation in somatoform patients.

I have proposed that specifically under conditions of psychosocial threat or trauma the operation of these 3 risk factors is intensified. In fact, there is empirical evidence for the association of these 3 risk factors with the following disorders. (1) Primary insomnia, with EEG definition (Wickramasekara et al., 1992), chronic somatoform complaints like functional muscular & vascular headache, TMJ, vasovagal syncopy, low back pain, primary dysmenorrhea, primary hypertension, idiopathic flushing, hyperhydrosis, (Wickramasekera, 1994b, 1995), Irritable Bowel Syndrome (Toner et al., 1992), morbid obesity (Wickramasekara & Price, 1997), moderate obesity (Wickramasekara & Atkinsons, 1993c), chest pain (Saxon & Wickramasekara, 1994), chronic pain (Remler 1990; Stann et al., 1986), chronic urticaria (Sherzter & Lookingbill, 1987), PTSD symptom intensity (Spiegel et al., 1988; Stutman & Bliss, 1985), nightmares (Belicki & Belicki, 1986), bulimia and substance abuse (Pettinati et al., 1985; Pettinati et al., 1990).

In summary then, I propose 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 the above 3 risk factors as part of their medical examination. People with one or more of these 3 risk factors may have blocked or reduced negative emotional information (e.g. rage, depression, shame) from consciousness. Lack of important negative emotional information can impair judgment (Damasio, 1994) and adaptive behavior as illustrated in the case study below. The chronic failure to detect this potent source of information from reflexive emotional states (Damasio, 1994) can have several serious behavioral and health consequences. It can block the conscious processing of such neuro-endocrine based emotional information (e.g. rage, shame, etc), which on one hand could (a) dysregulate (Pennebaker et al., 1988) adaptive ANS and immune functions (b) while constricting the scope of cognitive choices and the range of behavioral coping responses (Wickramasekera, 1994b; Wickramasekara et al., 1996b) 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 can take less than 20 minutes and if one or more of the risk factors are present, a somatoform diagnosis should be seriously considered, particularly before further dangerous medical tests or exploratory surgery is done. A more complete investigation of the patient with other components of the High Risk Model (Wickramasekera, 1979, 1988, 1995) may provide a
specific psychological direction to intervention with a distressing somatic symptom (e.g. GI pain).

The Trojan Horse Role Induction and psychophysiological monitoring with psychotherapy (Wickramasekera, 1988, 1994a,b; Wickramasekera et al., 1996b) is designed to convert the somatizers into a curiously psychotherapy patient who regards somatic symptoms as information from the cognitive or emotional unconscious (Kihlstrom, 1987; Shedler et al., 1993; Shevrin et al., 1966; Wickramasekera, 1988, 1994b). Such a patient is engaged in a therapeutic alliance that does not simply use biofeedback, cognitive behavior therapy or hypnosis (Wickramasekera, 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 (Wickramasekera, 1994b, 1996b).

Case Study

The following abbreviated case study illustrates briefly the Trojan Horse Role Induction and Psychophysiological therapy (Wickramasekera, 1988, 1993a). K.C. is a 35 year old white married male, father of 2 children who in the last 5 years had developed several somatic symptoms including uncontrolled hypertension, severe idiopathic flushing, severe headaches, and mild depression. K.C. was studied over 20 times for extensive periods (on both an inpatient and outpatient basis) at 2 prestigious Medical School Centers in the mid-west and one famous medical center in the south. His health insurance company had spent over 2 million dollars over 3 years on hightech biomedical studies that had moderately improved only his headaches with a combination of several drugs. The other somatic symptoms were unaltered or worse after 3 years of negative findings on multiple invasive biomedical tests and specialized medical consultations. Psychiatric interviews and conventional psychological testing at the three major academic medical centers found no evidence of any significant psychopathology. Because of his failure to respond to all blood pressure medication on the market and his unpredictable episodic surges of blood pressure, his internist considered his situation life threatening and referred him for a series of rare and highly specialized neuroendocrine tests done only at my previous medical school. When this series of tests was also negative, the medical neuroendocrinologist, who knew of my work with the psychophysiology of somatization, referred the patient to me for evaluation.

History revealed that because of his uncontrolled somatic symptoms, the patient had quit work 3 years ago and progressively became an invalid limited to housekeeping and child care activities. He had also gained weight and increased his alcohol intake. Pre-morbidly, the patient had been an excellent student and leader in college and a very successful salesman on the fast track to a top executive position with a major national corporation. The patient’s chronic somatic symptoms, doctor shopping, and invalid status enabled his wife to resuscitate her own promising professional career which had been interrupted by the birth of the children. The patient reported some mild marital stress secondary to his lack of employment, weight gain, and increased alcohol intake but denied any recent or remote significant distress or trauma at home, work, or in any social relationships. The patient reported he missed seeing his parents, who lived several hundred miles away, but he saw his in-laws, who lived close to him very frequently. The patient stated that if his somatic symptoms were controlled, he could return to work and his depression would resolve.

Psychological testing indicated that the patient was high on both (1) hypnotic ability (Harvard Test = 9, Stanford Form, C = 9, Absorption 70%) and (2) the Marlowe-Crowne test = 20). Because he had 2 psychometric risk factors for somatization, as discussed above, I suspected that his verbal report data, and conventional psychological testing (SCL-90) would be relatively uninformative. In fact, his SCL-90 scales were all in the normal range except depression which was elevated T=74 and hostility which was his lowest score T=41. In spite of the adversities of the last several years, the patient appeared cheerful, humorous, and socially out-going, but he had a cold and wet hand shake. His psychophysiological stress profile (Wickramasekera, 1976, 1988) confirmed the source of his cold and wet hands. Even resting baseline measures indicated a sympathetically activated body. His most reactive systems were cardiovascular (low resting baseline hand temperature 73.6 F (normal is 88 F), moderately high resting heart rate = 86.08 BPM, and low Blood Volume Pulse = 4.85), high skin conductance 17.74umho and high frontal EMG 11.78uv. Hence, even under resting baseline conditions, the patient’s body was on a “red alert” status. But this was apparently a “secret kept from his mind”, because he reported feeling calm during these measurements on a visual analogue Subjective Units of Distress Scale (SUDS).

This incongruence between his low level of verbally reported subjective distress and his cheerful manner on one hand, and the strong physiological baseline indicators of chronic sympathetic activation (“Fight and Flight Response”), suggested that most of his stress was outside of consciousness and a “secret” from even him. Hence, any productive clinical-verbal investigation of this patient would require concurrent physiological monitoring. Because of his stress profile data, I chose to monitor his blood pressure B/P continuously (Critikon-Dinamap Johnson & Johnson) first under baseline conditions (eyes open 3 minutes and eyes closed 3 minutes) and later while he was talking about several topics (e.g. his parents, children, wife, job, friends, etc) Figure 1 illustrates his blood pressure response under several conditions.
It is clear that his strongest response is to talking about his wife. I decided to change to a neutral topic and replicated this B/P response 3 times before I showed the patient the data. He acknowledged the reliability of his B/P response to the topic of his wife, but he denied any conscious perception of blood pressure increase or any associated emotion. Because he was visiting our Medical Center, he spoke daily from his motel room to his wife on the phone. I asked him to measure and record his blood pressure twice before, during, and after speaking to his wife from his room. Two records indicated the same strong B/P elevation while talking to his wife and a delay in B/P recovery after the conversation, plus the flushing across his face and chest and back. He also noticed a feeling of sadness and irritation during this "in vivo" conversational stimulation.

In the course of 3 weeks of intensive (3 times per week) psychophysiological psychotherapy, K.C. became aware of intense rage towards his wife who he perceived as "jealous" of his prior professional success, which left her "trapped" as a housewife and "jealous" of his relationship to his parents. He perceived her as very domineering and seeking to separate him from his children and his parents. He felt she blamed him for the pregnancies that had interrupted her promising professional career that was now slowly prospering during his illness. At the conclusion of the third week of therapy, the patient's physician had withdrawn him from all blood pressure medications and his systolic and diastolic B/P levels were within the normal range. His blood pressure "surges" were very infrequent and the flushing had stopped. The patient recognized that he had very frustrated and angry feelings toward his wife. He also realized that he had always had ambivalent sexual feelings towards other men about which he felt shame, and he felt profoundly ashamed of what had become of his promising career, and his present life.

When he left the area, I referred him to a skilled psychotherapist back in the mid-west to continue to work on his personal and marital problems and specifically his sexual conflicts. When he returned for a 3 month medical-psychological follow-up, all his somatic symptoms had declined in frequency and intensity by over 80%, and he reported that his headaches had dropped to zero, and he was off all pain medications. His flushing had improved over 95% and his episodic blood pressure surges had become very infrequent even without any blood pressure medication. He had separated from his wife, built a closer relationship with his kids and parents, and was contemplating divorce and another adult relationship. But he had not reduced his weight or his alcohol intake. He had visited his parents twice for the first time in his marriage with his children, but without his wife, and felt supported by his family. He reported using his self-hypnosis skills to self-soothe his negative emotions (fear, anxiety, etc) on an erratic basis. He also reported that the hypnotic state enabled him to see old situations "freshly”.

This case study illustrates how the identification of two psychometric risk factors that block threatening emotions from consciousness influenced the selection of techniques of therapy in this case and the surprising short term psychosocial and somatic outcomes. The patient's unconscious emotional reactions of rage (driving hypertension and headaches) and shame (driving idiopathic flushing or blushing) were associated with hormonal-neuroendocrine responses which are hypothesized, at least in part, to have driven his somatic symptoms and may have occluded his coronary arteries. I hypothesize that the chronic occlusion or blocking from consciousness of salient cognitive and correlated pharmacological information can have lethal consequences. For example, this lack of information about his emotions, is hypothesized to have impaired his judgement and behavioral choices in everyday life. This blocking of the information about his emotions from consciousness is hypothesized to amplify the pharmacological component of emotion, that drove his somatic symptoms. It is proposed that the delivery of this information (feelings of rage, shame, etc) to consciousness will reduce the intensity of the pharmacological component of the rage-shame response and provide the patient with more behavioral options in living. Mann and Delon (1994) recently described a similar case. Pennebaker et al (1988) have proposed that psychological inhibition is extra work for the autonomic nervous system and appears to have negative immune consequences.

References

Wickramasekera, I. (1979). A model of the patient at high risk for chronic stress related disorders: Do beliefs have biological
BOOK REVIEW


Review By Alice F. Chang, Ph.D.

Editor’s note: Dr. Chang is currently a candidate for APA President.

The MMPI and MMPI-2 are not only the most widely used of all objective measures of personality assessment, but they are also consistently the bedrock of forensic assessments and testimony. Ackerman (1997) reported that in a sampling of 201 child custody assessors, the MMPI-2—or occasionally the original MMPI—was included in 91% of all parental assessments done, with lesser frequencies for all other tests used.

Articles on the forensic use of the MMPI and MMPI-2 have consistently started from the view of the court: what does the court need to know from personality assessment and what parts of that need can tests such as the MMPI answer? Starting from the MMPI rather than from the perspective of the court, Caldwell has provided a brief and concise set of answers as to what the MMPI can demonstrate—what questions can be asked of the MMPI and what answers it can provide.

The book is entirely in a question and answer format, the standard question and answer approach of legal discourse. Each chapter poses a series of questions with answers ranging from one paragraph to two or three pages. Caldwell asserts that he wrote the book for attorneys as well as psychologists. The first chapter, “The Test,” is correspondingly basic—although his simple-sounding descriptions of the scales could well be used to communicate their meaning to a jury. He uses “MMPI/MMPI-2” to designate the instrument as a whole, regardless of which form is being used.

Caldwell’s second chapter on Test-Taking Attitude depends in part on the extra validity scales scored by the