This exchange continues the discussion of Brian Campbell Broom's "Metaphor and story: A novel clinical panorama arising from a unitary mind/body approach to physical illness," which appeared in the Summer 2000 issue.

Salient observations and concepts but dubious methodology

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Dr Broom's paper focuses boldly on the major theoretical issues in mind–body medicine—for example, the "natural reciprocity between physical disease and story," the concept of psychogenesis in the initiation even of cancer, the inadequacy of the concept of somatization and somatoform disease in the Diagnostic and Statistical Manual of Mental Disorders IV, the commonness and the normality of the mind–body transduction in humans, and the three dimensions of what I have called psychophysiological disease. In general terms, these dimensions are: (1) "subjective" (or, in Broom's term "story"), (2) "somatic," and (3) "action" dimensions. I am in general agreement with Broom's views on all the above major points.

However, I prefer to call all disease, from cancer to the common cold, psychophysiological because this label seems most consistent with current knowledge in basic cognitive neuroscience and biological science. The issue of how much of the variance in the initiation of organic disease (for example, cancer) is "top-down" (psychosocial factors causing organic changes) as opposed to "bottom-up" (biomedical model) is an empirical issue that I think is probably specific to the disease and the specific patient who has this disease. Further, I believe that this empirical issue will be most fruitfully examined in the future in the context of the individual differences that I have specified in my High Risk Model of Threat Perception (Wickramasekera 1988, 1998). I believe that this model, which I describe in some detail in an earlier issue of Advances (Wickramasekera 1998), carves the most relevant psychophysiological phenomena described by Broom at its natural joints, doing the least amount of violence to the psychophysiological domain and without carving it into "bits and pieces" (Broom's phrase). I think further that the High Risk Model of Threat Perception encompasses the most relevant psychosocial dimensions of mind–body disease that can be usefully differentiated for assessment, therapy, and prevention.

In reading Broom's description of the nitty gritty details of the multiple challenges in working with "difficult patients" in the trenches (the "non-ready" patients, enduring "the skepticism of patients and colleagues," holding oneself "calm on an uncertain journey," etc.), I was impressed with the richness of his clinical observations and skills. Most psychotherapists avoid these patients like the plague, and most medical doctors become impatient and angry with these patients and regard them as "crockes." Eventually, in response, many such patients come to regard their medical doctors and psychotherapists as "quacks." For a description of the meaning-eroding and potentially destructive interactions between psychiatrists, internists, and "difficult" patients, I refer the reader to the chapter "Crockes, Quacks, and Shrinks," in my book Clinical Behavioral.
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Broom's approach to the assessment and therapy of "difficult" patients covers many of the most relevant dimensions of individual differences for mind-body research, but he also misses several important dimensions. In his assessment of patients, he asks us to target: (1) the language of the patient; (2) the meaning of events to the patient; (3) the patient's imagination; (4) major life changes; (5) "micro life events"; (6) the indirect expression of feelings; (7) "love"; (8) "friendship"; (9) "pursuit of the particular"; (10) "faultlines"; (11) the denial of negative affect; and (12) the limited access of these patients to any "affect states." Now, many of these 12 issues can be theoretically or empirically reduced to a smaller number of nonoverlapping or independent factors specified in my High Risk Model of Threat Perception (Wickramasekera 1988, 1995, 1998). Why does this matter? In a busy clinical practice nothing is so "practical as a good theory." A good theory can quickly focus our attention on what factors drive the bulk of the variance controlling clinical symptoms. This focused work can increase the efficacy of therapy and save time and money.

Broom appears unaware that a number of constructs from the High Risk Model (Wickramasekera 1988, 1995, 1998) have already been shown to amplify all somatic symptoms, even those based on organic findings (as in diabetes or the common cold) or to transduce psychosocial perceptions of threat into somatic symptoms. For example, both (1) high and (2) low-hypnotic ability (a very stable and partly genetically based personality trait) have been shown empirically to have major implications for the construction of meaning, for cognitive rigidity and flexibility, for "surplus pattern recognition" (the ability to see meaning in events that appear to others to be randomly distributed), for empathy, poor interpersonal boundaries, and for hyper- and hypo-sensitivity to interpersonal and transpersonal events. Further, people who score (3) high on catastrophizing are prone to amplify all clinical presentations (for example, chronic pain, acute pain, and psychological symptoms like depression and panic). In addition, (4) self-deception or repression of negative affect (which appears to be a trait) has been shown to amplify the progression of somatic symptoms, from chronic pain (Deshields et al. 1995) to breast cancer (Jensen 1987). Further, (5) a high propensity to negative affectivity (believed to be a trait) and high negative affect (a state into which people who are high or low in negative affectivity can temporarily enter), a propensity that seemingly is the reverse of self-deception or repression of negative affect, has also been shown empirically to amplify all somatic symptoms (Costa & McCrae 1985), including the common cold (Cohen et al. 1991).

Broom appears unaware that many of the psychosocial variables he asks us to target (including friendship, love, indirect or lack of access to negative feelings, major life changes, and minor hassles) have already been operationally defined and psychometrically quantified so that we are not totally dependent on the subjectivity of the clinical interview. For example, major life changes, minor hassles, social support, the degree of satisfaction with social support, and the denial of negative affect all have operational definitions and have psychometric measures of known validity and reliability. As one instance, poor awareness of feelings or alexithymia is empirically known to overlap with low hypnotic ability (Frankel et al. 1977). Both in the general population and in chronic medical samples, there are normative data on these individual-difference variables relevant to psychophysiological disease.

Since many dimensions of "story" have been operationally defined and psychometrically quantified, we do not have to reinvent the wheel. I would ask Broom to specify and explicate any clinical observations and concepts missing from my High Risk Model after he has read these comments and had an opportunity to review more carefully the empirical evidence supporting my 1998 Advances paper.

It is my opinion that several important dimensions of story are unconscious or implicit (Kihlstrom 1987) and hence cannot be accessed by Broom's apparently sole reliance on verbal interview methods. For example, many perceptions of threat are manifested in patient behaviors and in patient autonomic nervous system responses (Wickramasekera 1988, 1995, 1998). The indirect expression of feelings (Wickramasekera 1988, 1995, 1998) can go completely unnoticed by the examiner (uncorrelated with reported verbal behavior).

The indirect expression of "unconscious" feelings (Wickramasekera 1988, 1995, 1998) avoids direct exposure to threat, perceived or actual. Hence, insufficient interpretation of these variables is necessary.

The development of the "story" notion (Wickramasekera 1988, 1995, 1998) has purely exploratory value with respect to the symptom of syncope. The interplay of verbally interpreted elements is relevant to the "story" of the patient. A fine verbal narrative is easy to construct for understandable reasons (Wickramasekera 1988, 1995, 1998). But how do we know that this is a meaningful story? Or, at least, one that is "true"? The "story" of the patient may provide insights into these dimensions of "story" specific to the context of family, culture, and illness, the "clinical milieu."
system reactivity to threat but are outside the patient's verbal report and language (Wickramasekera et al. 1996, 1998; Wickramasekera & Wickramasekera 1997; Wickramasekera 1993, 1994a,b, 1998). Put another way, there are often large discrepancies between the explicit (language) story and the implicit (unconscious) story in which the patient is living. The implicit story may be manifest in a patient's behaviors (for example, threat approach and/or avoidance behaviors) and in the pattern of autonomic nervous system reactivity to specific threatening memories, moods, and perceptions (Wickramasekera 1998). In a sense, the patient's behavior and body is driven by "secrets kept from the mind but not from the body and behavior.

Hence, access to story may be an essential but is an insufficient basis to plan assessment, intervention, prediction, and prevention of somatic symptoms.

There are also some methods that I have developed, like the Trojan Horse Role Induction (Wickramasekera 1988, 1993), to reduce the notorious resistances of a group of the patients with purely somatic symptoms to any psychosocial self-exploration and introspection. Because their symptoms are often purely somatic (for example, syncope, pain, diarrhea, constipation) or organic, psychosocial testing and psychosocial interventions have zero face validity or apparent relevance to such patients.

A further point: The phenomenological and verbal report dimension of clinical problems (the story in which the patient lives) is certainly crucial for understanding the patient and for the establishment of rapport and during therapy. But how do you connect with a patient looking for "a mechanism for his body, when you look and talk like a monk." Wickramasekera 1988? The perceptions, memories, moods, and beliefs in which people live and how deeply they live in these "stories" have been psychophysiological specified as in my High Risk Model and can have consequences for their behavior. And therefore indirectly and in some cases directly for their physiology (Wickramasekera 1998, 1999a,b; Wickramasekera et al. 1998). The promising mechanisms mediating these transactions of meaning into neuroendocrine and immune changes are being specified by basic scientists even as we write. It appears that the normal mechanisms of the human learning of hope and fear (operant and respondent conditioning) are implicated in all psychophysiological disease. In particular, it is clear that the perception of threat to stable perceptions of the self and its mental and physical integrity, can trigger profound and far-reaching physiological changes that can initiate functional and eventually organic disease (Wickramasekera 1988, 1998; Wickramasekera et al. 1998).

Broom's clinical observations are salient but his methodology needs further refinement.

References


Costa Jr PT, McCrae RR 1985 Hypochondriasis, neuroticism, and aging: When are somatic complaints unfounded? American Psychologist 40:19–28


Wickramasekera I 1994a Somatic to psychological symptoms and information transfer from implicit to explicit memory: A controlled case study with predictions from the High Risk Model of Threat Perception. Dissociation 7(3):153–166

Wickramasekera I 1994b On the interaction of two orthogonal risk factors, 1) hypnotic ability and 2) negative affectivity (threat perception) for psychophysiological disregulation in somatization. II Symposium on Suggestion and Suggestibility, University of Rome, Italy

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Wickramasekera I 1999a How does biofeedback reduce clinical symptoms and do memories and beliefs have biological consequences? Toward a model of mind-body healing. Applied Psychophysiology and Biofeedback 24(2):91–105

Wickramasekera I 1999b Secrets kept from the mind but not the body: Commentary on Elihu Segal’s “Medical psychological observations during the Holocaust: Escape into health.” Advances in Mind–Body Medicine 15:75–77


difficult to grasp. Wickramasekera’s response provides me a further opportunity to try and make the issues clear.

For example, when it comes to an understanding of the bodily aspects of mind–body issues, Wickramasekera says he means “more specifically the autonomic nervous and neuroendocrine systems dimension.” Around this statement the fundamental issues of our differences become clear. I am asserting that the clinical phenomenon of somatic metaphor is real (and common), and it is this phenomenon that is addressed in my article. Wickramasekera appears to ignore this, and at the same time slips in “psychophysiological,” as if what he means by that and what I am approaching via the example of somatic metaphor are pretty well the same. But this is not so.

“Somatic metaphor” conveys the notion that “meaning” is expressed in the body in a way that is symbolic—and manifestly symbolic (there may of course be illnesses that are symbolic where the symbolism is not so manifest—see below). Assuming for the moment Wickramasekera accepts that some illnesses do express such symbolic meaning, then, in his view, how would these meanings get transduced into bodily figuring? Apparently via the autonomic nervous system and the neuroendocrine system. In view of the fact that many of the “somatic” illnesses we see are inflammation or immunological. I note in passing that I do not understand why he left out the parasitic/immune system. But the argument

Broom responds

My first reading of Dr Wickramasekera’s comments on my article reminds me of how hard it is for us as integrationists, in our discussions together, not to be tripped up by the perennial problem of “not seeing the wood for the trees.” Moreover, even if we can agree that the wood and the trees can be distinguished, it appears we may differ as to which is which. The “wood” in my article is the assertion of a need for a unitary paradigm of personhood, and this need arises from the peculiar phenomenon of somatic metaphor, which Wickramasekera does not address. The “trees” are the issues of methodology raised by the latter part of my article, which highlighted our ways of going about getting “story.” Clearly I have much to learn from Wickramasekera in this respect. Nevertheless, I would have been very interested in what his response would have been if I had left the distracting “trees” out of the article.

There are a variety of issues I want to respond to. Firstly, the implications of a number of Wickramasekera’s terms such as “psychophysiological,” “top-down,” and “bottom-up,” which, I contend, have a strong dualistic and linear flavor. Wickramasekera and I both assert a very significant role for subjectivity in a physical disease, but the linearity implied by these terms is not adequate to the cases I describe in my paper. I argued at length that these cases require a more
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A publication of the Fetzer Institute