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KNOWING THE UNSPEAKABLE: AFFECTIVITY, OBJECT RELATEDNESS AND THE PROCESSES OF SOMATIZATION IN INDIVIDUALS SUFFERING WITH CHRONIC SOMATIC DISTRESS

By

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A dissertation submitted to the Graduate Faculty in Psychology
in partial fulfillment of the requirements for the degree of
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Abstract

KNOWING THE UNSPEAKABLE:
AFFECTIVITY, OBJECT RELATEDNESS AND THE PROCESSES OF SOMATIZATION IN INDIVIDUALS SUFFERING WITH CHRONIC SOMATIC DISTRESS

by

Jeanne Patz Blaustein

Advisor: Professor Steven B. Tuber

This study explores the fluctuating capacities for affectivity and object relatedness in three individuals suffering with unexplained chronic distress. This study contributes to the field of psychosomatic medicine and to psychoanalytic theory of somatization by linking the processes of somatization with recent work in the areas of affect regulation and the internalization processes of object representation.

A time-series analysis with a multiple case-study design was chosen in order to examine the unpredictability of remissions and eruptions of chronic unexplained somatic distress in the context of a design into which time and change were meaningfully incorporated.

The principal instruments used in the study include the Epigenetic Assessment Rating Scale (EARS) (Wilson et al., 1988), a psychoanalytic rating scale designed to score narrative material; the Recent Experience Memory Test (Blaustein, 1994), a variation of Mayman's Early Memory Test designed to be administered weekly; the Symptom Checklist 90-Revised (Derogatis, 1977); and the Illness Narratives Interview-II (Blaustein, 1994), a semi-structured questionnaire designed to elicit ratings and descriptions of illness experiences.

Shifts in object relatedness were more strongly associated with shifts in somatic symptomatology than were shifts in affectivity. These differences were significant in most cases. Higher levels of empathic understanding and mutuality were generally associated with lower weekly levels of somatic distress. Complex relationships between shifts in object relatedness and the onset of somatic symptoms were identified. Significant differences among subjects were found.

These findings strongly point to the possible importance of disturbed early interpersonal experiences in the etiology of the processes of somatization. The existence of various temporal relationships between factors is of clinical interest as it may begin to shed light on the often unpredictable patterns of somatic distress reported by so many patients. These findings point to the need for psychoanalytically-oriented psychotherapy with somatizing individuals in order to rework and rebuild problematic self- and object representations resulting from experiences of early and profound empathic failures.

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My experiences working with my entire dissertation committee have been delightful, enlivening and challenging. I wish to acknowledge and thank each of them for their contributions. Throughout this entire process, my chair, Dr. Steven B. Tuber, was enthusiastic and unremitting in his ability to offer thoughtful criticisms, and practical assistance and suggestions. His humor, his warmth and his ability to bring great clinical sensitivity to the challenge of designing a study helped make the task of working on this project not only manageable, but enjoyable, and I thank him most especially for these gifts. Dr. Diana Diamond brought sensitivity and wisdom to the theoretical questions I was grappling with, and offered unflagging assistance in pursuing various methodological avenues. Dr. Arietta Slade was especially instrumental in helping me focus on the clinical and idiosyncratic nature of each woman's experience. Her comments restored for me, at a critical moment in the process of designing the study, my aim of learning how to listen to the clinical nuances of qualitative material. I feel privileged to have had the opportunity to work so closely with these three members of the faculty at City College.

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Dr. Wilson, the primary author of the EARS scale used in this study, gave freely and generously of his time over the last two years as the leader of a training group of new coders for the scale and as an advisor to me on this study. He was consistently supportive and helpful in his suggestions. His keen appreciation of the merits of time-series analyses was instrumental in the early stages of the project design.

As a member of the EARS coding group, I have been privileged to work and become friends with four graduate school colleagues, Lan Chin, Heidi Kling, Stephanie Lewin and Susan Schaek. Together, and after many hours of tea, seltzer and cookies, we have indeed become a group, able to share clinical impressions and challenge each others' thinking. They each scored the Recent Experience Memory narratives with clinical sensitivity, care and interest.

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My thinking about the relationship between bodily experience and emotional life has grown from my own very personal explorations of myself.

Marcia Lesser has taught me a great deal about the subtle ways in which the body carries our emotional secrets. Dr. Frances S. Anderson has been an invaluable

guide and partner in the often difficult and elusive process of my own psychoanalysis. I thank her for her capacity to persistently and patiently explore with me that which has been unspeakable in my own life, and to help bring to light the complex relationships between those experiences and my own struggles with somatic distress.

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to our lively conversations about the dynamics of somatization. My sister Susan and her husband Alan have weathered my ups and downs with good humor and love. Their personal triumphs with the arduous writing process have, in turn, helped me weather the seemingly unending nature of completing a dissertation.

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Lastly, I want to acknowledge the extraordinary contributions from my husband, Peter E. Bokor. It is not simply that he has supported with empathy and enthusiasm my work on the dissertation. He has, unflaggingly, read drafts, helped me talk my way out of the theoretical tangles I so often get into, and so on. What I am ultimately most grateful for, however, is Peter's own commitment to speak that which is true, to resist the simple and easy way out, and for his remarkable ability to continue learning about himself. His love and support mean the world to me, and I dedicate this dissertation to him.

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CHAPTER ONE

INTRODUCTION

> He who has eyes to see and ears to hear becomes convinced that mortals can keep no secret. If their lips are silent, they gossip with their fingertips; betrayal forces its way through every pore.
>
> -Sigmund Freud[1]

> People often experience themselves, at any given moment, as containing or being a "self" that is complete in the present; a "sense of self" often comes with a feeling of substantiality, presence, integrity, and fullness. Yet selves change and are transformed continually over time; no version of self is fully present at any instant, and a single life is composed of many selves.
>
> -Stephen Mitchell, 1993.

This study explores the fluctuating capacities for affectivity and object relatedness in individuals suffering with unexplained chronic somatic distress. The aim of the study is to understand more deeply the relationship between the eruptions of physical symptoms and the subtle shifts which can occur rapidly and erratically throughout one's life between relatively sophisticated, verbal and flexible modes of functioning in the areas of affectivity and object relatedness and more primitive, enactive and rigid modes in these two realms of psychic life.

The theoretical framework for this study is based on several bodies of theory and research. Most broadly defined, psychoanalytic and epigenetic theories of human development, and a general consensus among psychoanalytic theorists and clinicians that somatic symptoms are psychologically meaningful expressions of psychic distress, together constitute the central theoretical pillars on which the research is based.

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[1] Cited in Mitchell (1993).

There is considerable debate among contemporary theorists regarding the specific nature of the relationship between early stress and somatization. Nevertheless, there is general agreement that early developmental disturbances are implicated in psychosomatic symptomatology.

More specifically, empirical findings in the fields of affect and attachment theory, object relations theory, psychobiology and developmental psychology suggest that early trauma and/or chronic emotional stress can have profound psychological and physiological consequences.

Affect states which are intolerable, and unremittingly either ignored or exacerbated by inadequately sensitive caregivers may drive an infant to "respond to this experience by an inhibition of reflective self function" (Fonagy, et al., 1983). As Peter Fonagy puts it,

> "The capacity to conceive of the contents of one's own mind, as well as of the object's mind, is an important prerequisite for normal object relations. In its absence, the analytic patient, faced with the task of self-reflection, is prone to experience meaninglessness, chaos and nameless dread, as his own and others' feelings and intentions can only be represented at a primary (the immediately accessible) level and cannot be reflected upon or thought about" (Fonagy, 1991, p. 650.)

Instead, affect may be dissociated before it is represented, with the result that infants never adequately internalize the capacity to experience, represent and regulate their own affect states (See, for example, Krystal, 1979; Krystal, 1982-1983; Krystal, 1988; McDougall, 1974; McDougall, 1978/1992; McDougall, 1982-83; McDougall, 1989).

Stimulation of an emotional sort quickly becomes overstimulation for these infants. Children and adults with histories of childhood trauma may repeatedly ward off

affective tension by responding to negative affect on a bodily, enactive and behavioral level rather than on a symbolic and verbal level (Fonagy, et al., 1983; Horowitz, 1978). A tendency to somatize psychic distress as a result of an inability to represent both the existence and meaning of internal mental processes such as affect states, thoughts, desires and fantasies may result (Fonagy, 1991).

Further, an inability to represent and thereby integrate painful affects as a result of exposure to cumulative emotional trauma may reflect an inability to connect in meaningful, stable and mutual ways to others. Severe disruptions and deprivations in early relationships with primary caregivers may prevent the consolidation of basic psychic capacities to represent one's own (and others') internal emotional states (Fonagy, Steel, Steel, Leigh, Kennedy, & Target, 1983).

Previous explorations of the psychological functioning of somatizing patients have found an inability to tolerate and express affect. Also noted is a paucity of fantasy life, flat and superficial styles of relating to others, and a tendency toward operational and concrete cognitive styles (McDougall, 1989; Nemiah & Sifneos, 1970; Salisbury, 1990; Taylor, 1987). Little systematic work has been done, however, to explore the ways in which periodic shifts in affectivity and relatedness correspond to the vicissitudes of psychic life as manifest through somatic processes.

And yet, symptoms come and go. How do we understand this fact in the context of object relational theories and developmental models which posit the stability of character structure and internal representations? Perhaps, as Mitchell suggests in the passage quoted above, each of us is both a multiplicity of selves and a more singular, layered and stable self. We may have access to more or less flexible and variegated

ways of experiencing ourselves in our lives at various moments, on different days. It is the aim of this study to explore how the complex relationship between the psyche and the soma bears witness to this changeability.

This study builds on prior work which documents difficulties in the realms of affectivity and object relatedness often experienced by somatizing patients. More specifically, findings from empirical research, clinical observations and theory suggest that disturbances in early relationships may be implicated in the etiology of these impairments in psychological functioning, and of the psychosomatic symptoms, themselves. In this study, I explore the hypothesis that somatization may be effectively understood in a developmental context as an adaptive response to early and cumulative traumatic experiences which overwhelmed at times one's ability to subjectively represent experience (Khan, 1991; Fonagy, et al., 1983; Herman, 1992a; Herman, 1992b; Khan, 1983).

I am linking, here, the idea of fluctuating levels of subjectivity to the dynamics of somatization. In doing so, I am hypothesizing that somatic symptoms may represent a split (which is more, or less, enduring) between psyche and soma (Winnicott, 1970/1992). This split, I am going to argue, results from an inability to internalize a consistent ability to represent and regulate affect and thereby assign meaning to one's experience of self and others.

In order to explore this hypothesis empirically, this study examines the fluctuating capacities for Affect Tolerance, Affect Expression, Use of an Object, and Empathic Knowledge of Others in three individuals suffering with chronic somatic distress in the context of the fluctuations in the somatic symptoms which these same

individuals report weekly over a twenty-week period. The aim of the study is to elucidate further the relationship between the early developmental achievements of affectivity and object relatedness, and the defensive shift to somatic functioning.

Greater insight into the developmental substrate of somatization may assist theorists and clinicians seeking to understand the complex psychodynamic impediments to effective psychotherapeutic interventions with somatizing patients and thereby improve the treatment approaches to which we turn when working with this group of individuals. I hope that this exploratory investigation contributes to the operationalization of clinical observations and theoretical speculations about the psychological meanings of somatic functioning. Finally, I hope to deepen our understanding of the ways in which the body expresses, only indirectly, and partially, the various experiences of the self.

CHAPTER TWO

REVIEW OF THE LITERATURE

Her pure and eloquent blood
Spoke in her cheeks, and so distinctly wrought,
That one might almost say, her body thought.

-John Donne,
The Second Anniversary[2]

A. Background

Attempts to understand the connections between the body and the mind have a long history in the evolution of Western philosophical and scientific thought. Aristotle wrote that pain is an emotion (Salisbury, 1990). Hippocrates believed that the humors affected both body and soul (Hippocrates, 1955). Centuries later, Descartes declared that the mind and body are separate. Western medicine, maturing in the shadow of Cartesian dualism, has traditionally accepted the notion that it is possible to cure the body with little regard for the state of the spirit (Perrone, Stockel & Krueger, 1989).

From its inception, psychoanalysis has been invoked to explain, mend and heal the perceived rift between mind and body. A product of the intellectual tension between nineteenth-century biological materialism and a twentieth-century appreciation for a more skeptical and hermeneutic approach to "reality," Freud himself was caught between his respect for the powerful but elusive nature of unconscious conflict and his belief in the biologically driven substrate of consciousness itself. He sincerely hoped that his Project for a Scientific Psychology (1895) would presage the eventual discovery of the biological bases of the psyche. Psyche and soma were intimately yet

mysteriously connected for Freud, and the impingement of one on the other was a theme with which he wrestled throughout his long career as he tried to unravel the relationship between drives, cultural and family influences, and the life of the body as its instinctual needs were thwarted or gratified by society.

In recent years, it has become fashionable in numerous and varied circles to speak of the "mind-body" connection. The psychological impact of disease (Holland, 1993), and the medically curative effects of psychological well-being are increasingly acknowledged throughout the medical, psychiatric and psychological communities (Pennebaker & Beall, 1986) as vital components of the health sciences. Bill Moyers' much touted PBS series, Healing and the Mind (Moyers, 1993) brought the question into American living rooms and popularized, anew, the idea that psyche and soma are inextricably linked. From stress-management clinics in hospitals to New Age centers for holistic healing, Americans seem to be rediscovering what ancient healers and philosophers understood centuries ago.

Based on our own experience, few of us would deny that our feelings are connected to our bodies. Who has not felt the racing pulse in a moment filled with fear? Or the irrepressible smile in a moment of joy or great pride? One might even suggest that we often only know our emotions through their physiological manifestations (Welch, 1993).

Expressions such as "I've got butterflies in my stomach" resonate for all of us as translations into a physical idiom of various and complex feeling states; the emotions

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[2] Cited in Erskine and Judd (1994).

are expressed as physical symptoms and as symbolic metaphors. With scrutiny, however, most of us can usually give words to that which we experience initially as a physical symptom, words which we consensually recognize as relatively transparent expressions of our emotional state.

Yet some people suffer with unexplained chronic somatic distress (see below for full definition). Symptoms come and go, without adequate medical explanation. For these individuals, the interaction between mind, emotions and the body may occupy not only a central, but a debilitating place in their lives. Bodily distress regularly takes the place of overt or conscious psychological processes and manifestations. The rather fluid translation process in which most people engage, from thought and feeling, to body, and back again, to an affectively-laden cognition, is one which individuals suffering from psychosomatic symptoms are unable to employ. They are often unable to name feeling states. They do not experience or express their emotions directly, but through their bodies (McDougall, 1989; Krystal, 1982-1983).

In the opening to her eloquent discussion of the impact of chronic trauma on psychological development and functioning, Judith Herman writes:

> The ordinary response to atrocities is to banish them from consciousness. Certain violations of the social compact are too terrible to utter aloud: this is the meaning of the word unspeakable.
>
> Atrocities, however, refuse to be buried. Equally as powerful as the desire to deny atrocities is the conviction that denial does not work ...
>
> The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma (Herman, 1992b, p. 1).

It is the premise of this study that somatic symptoms represent, for many people, the "unspeakable" aspects of their emotional lives. Symptoms may even serve as signposts, as poignantly disguised evidence of "the obliteration of the significance of

things whilst retaining their perception" (Fonagy, 1991, p. 651). This is not to say that every somatic symptom represents a direct translation of a specific horror or trauma. What I am suggesting, instead, is that the cumulative effects of chronic emotional trauma[3] - especially in childhood, but perhaps in adulthood as well - may seal off from consciousness experiences known through the body nevertheless.

B. Somatization: The Problem of Definition

The symptom picture of somatizing individuals is complex. At its most extreme, somatization is viewed as a full-blown psychiatric disorder. Grouped together with the related Somatoform Disorders, Somatization Disorder (SD), as defined by the DSM-IV, is "a pattern of recurring, multiple, clinically significant somatic complaints" (1994). Somatization Disorder patients have a chronic history of multiple pain complaints, and additional gastrointestinal, sexual and pseudoneurological symptoms which begin before the age of thirty. The distinguishing features of SD include an inability to adequately explain the cause of somatic symptoms with general medical knowledge and/or the recognition that the resulting impairments are in excess of what would be expected based on the symptoms and medical history.

Individuals with Somatization Disorder (or its subclinical counterpart, Undifferentiated Somatoform Disorder) frequently seek numerous medical opinions for their various and changing physical problems and often undergo repeated and

[3] "Chronic emotional trauma" is meant to suggest a range of traumatic experiences. Thus, I am including not only the most obvious and extreme examples of physical and sexual abuse, and catastrophic loss, but less obvious types of traumatic experiences such as neglect, emotional deprivation, and chronic exposure to empathic failures on the part of significant figures in one's life.

unnecessary medical procedures. The combined effects of symptoms and related help-seeking behaviors result in significant impairment in "social, occupational or other important areas of functioning" (1994).[4]

In practice, however, "somatization is a term used to cover a broad range of common clinical situations" (Kirmayer & Robbins, 1991). In addition to the patients described above, individuals with isolated medical problems such as asthma, coronary disease, ulcerative and diabetic conditions have been described as "somatizers." The rationale for this was based on the argument that psychogenic factors played a large role in the etiology and maintenance of these ailments.

Likewise, psychoanalysts have long reported on cases of individuals who, lacking a formal psychiatric diagnosis in this area, nevertheless experience increased somatic distress during particularly difficult emotional periods in their lives.

In this study, I have treated somatization in this broader clinical context. I have therefore included in the study individuals who experience unexplained chronic somatic symptoms which precipitate help seeking and/or cause disability (Kirmayer & Robbins, 1991(1987)). The organic sources for their distress remain obscure, however. The working assumption here is that these patients are neither malingering nor hypochondriacal, but, that they are, in fact, experiencing great physical distress. Thus, their symptom pictures are similar to those individuals receiving one of the Somatoform

[4] Of note is the fact that Somatization Disorder is more frequently found among women than men, with prevalence rates ranging from .2% to 2% in women and less than .2% in men (DSM-IV, 1994). Numerous recent studies have linked the relatively high incidence of Somatization Disorders in women to the emotional sequelae of sexual abuse among female children, (Morrison, 1989; Briere & Runtz, 1988; Fry, 1993), the incidence of which has been found in various studies to be significantly higher than among males (For a review, see Fry, 1993).

Disorder diagnoses outlined in the DSM-IV such as Somatization Disorder, Undifferentiated Somatoform Disorder, or Somatoform Pain Disorder.

The DSM-IV eschews developmental and etiological considerations and emphasizes manifest symptoms and behaviors of somatization. The manual notes that Anxiety, Depressive and Substance-Related Disorders frequently co-occur in patients with multiple somatic symptoms, and that Somatization Disorders are often associated with Histrionic, Borderline and Antisocial Disorders (1994). The DSM-IV draws no developmental conclusions from these findings of co-morbidity, however. Consequently, in spite of the new diagnostic criteria laboriously arrived at, and deliberately set forth in the DSM-IV, considerable debate continues over the meaning, identity and etiology of somatization.

In fact, a prickly diagnostic dilemma is posed by those individuals who manifest extensive somatic problems in the context of extreme co-morbid personality problems, such as the self-mutilating behaviors often observed among persons diagnosed with Borderline Personality Disorders. Although this study focuses on those individuals without concomitant Axis II diagnoses, it will be clear from the theoretical discussion which follows that these groups share numerous clinical features, and that the etiologies may have considerable overlap. (On related psychopathology of personality organization, see, for example, Jacobson, 1986; Kernberg, 1984; Kernberg, 1984/1976.)

Some recent studies suggest that there may be a "common diathesis" underlying some cases of Affective, Anxiety and Somatization Disorders (Ironstone, 1989). Psychiatrists Blumer and Heilbronn, for example, have suggested that chronic pain, one of the key somatic complaints of patients presenting with any one of a number of the

Somatoform Disorders, is more accurately diagnosed as a form of masked depression (Blumer & Heilbronn, 1982). This assessment would make treatment for the symptoms of depression rather than for those related to somatization more likely. Such patients would carry a psychiatric diagnosis of depression, and their psychological functioning as it relates to psychosomatic processes per se would remain largely unexplored.

By contrast, Otto Kernberg links somatic symptoms and the problem of hypochondriasis to the etiology of severe character pathology such as that found in individuals diagnosed with Borderline Personality Disorders (Kernberg, 1985/1975, p. 10). Kernberg does not generally explore the somatic symptom for its underlying symbolic or psychodynamic meanings. Instead, he believes that somatic symptoms reflect underlying structural weaknesses in the ego stemming from problematic internalization of early object relations (Kernberg, 1984). Manifestations of bodily-related disorders are understood, in Kernberg's schema, as manifestations of splitting, one of the principle defenses employed by people with structurally weak ego and superego formations.

Blumer, Kernberg, and the latest versions of the DSM have aimed to link somatic symptomatology with primary psychiatric, usually major affective and/or personality disorders. Herman's impassioned contribution to the debate over the definition and etiology of somatization can be understood, in part, as a reaction to these latest trends in psychiatric morphology.

Herman suggests, by contrast, that somatization is best understood in the more inclusive (and less pejorative) context of trauma reactions. Rather than subsuming somatization within a more "primary" psychiatric diagnosis, Herman argues that the

symptoms of somatization are themselves meaningful within the historical context of the patient's life and need to be understood as "primary" reactions to chronic stress and abuse. This view emphasizes the consequences of traumatic victimization rather than psychopathology.

In her effort to reconstruct the diagnostic categories applied to survivors of trauma, Herman describes three common reactions to traumatic stress, including psychosomatic symptoms, dissociation and disturbances in identity formation. Herman maintains that these symptoms are currently misdiagnosed as Somatization Disorder, Multiple Personality Disorder and Borderline Personality Disorder respectively. She argues that these symptoms properly belong instead under the more general (and less socially pejorative) new diagnostic rubric of "complex trauma reactions" (Herman, 1992b, p. 120).

The trauma reaction pattern described by Herman which is most relevant to this study is the syndrome she characterizes as "hyperarousal." This is a complex response to trauma in which "physiological arousal continues unabated ... Their bodies are always on the alert or danger" (Herman, 1992b, p. 35-36). She writes elsewhere:

> The normal regulation of bodily states is disrupted by chronic hyperarousal. Bodily self-regulation ... may be chaotically disrupted or minutely overcontrolled (Herman, 1992b, p. 108).

The hasty and defensive retreat from potential overstimulation of affect, the inability to maintain stable and differentiated representations of self and others, and chronic somatization are features consistent with clinical observations of trauma survivors. Herman argues that trauma survivors who regularly suffer with these symptoms are currently misdiagnosed as having long-standing psychiatric and/or

personality disorders without regard for the diagnostic relevance of their personal (in her view, traumatic) histories (Herman, 1992b; see also, for example, Salisbury, 1990; McDougall, 1989; Taylor, 1987).

In her effort to reshape the diagnostic categories and psychiatric assessment of somatic processes, Herman challenges those within psychiatric communities who accept somatization as a discrete clinical entity (Acklin & Alexander, 1988; Krystal, 1988; Taylor, 1987). In addition, she challenges both those who view somatization problems as secondary to other psychiatric disorders (Blumer & Heilbronn, 1982), as well as theorists working within the psychoanalytic tradition who have understood somatization within a developmental framework (Khan, 1991; Winnicott, 1964/1992; Fonagy, 1991; McDougall, 1974). It is to the work of these last theorists that I now turn in order to explicate more fully the developmental substrate of psychosomatic illness in general and the processes of somatization in particular.

First, I will give a brief review of the early psychoanalytic attempts to understand somatic symptoms. Then, I will explore the ideas of more contemporary psychoanalytic theorists who have expanded and revised earlier models in order to include more recent findings from infant development and the relationship between physiology and the mind. I will argue, then, that somatization can best be understood when set in a conceptual framework based on the principles of contemporary psychoanalytic and epigenetic theories of development. Finally, I will discuss relevant theoretical and empirical contributions from the fields of affect, object relations, and attachment theories as they relate specifically to the etiology of somatization.

C. Early Psychoanalytic Theories of Somatization

Psychoanalytic theorists for over a century have tried to explicate the underlying psychodynamics of psychosomatic symptoms and the processes of somatization. As noted above, the general understanding of this diagnosis in medical and psychiatric circles is that "the medically unexplained symptom represents a somatic idiom for the expression of psychological distress" (Escobar, Swartz, Rubio-Stipec & Manu, 1991, p. 63).

This view has a long history. In his Treatise on Hysteria (1859), Paul Briquet wrote that hysteria (the term the Greeks originally associated with the physical manifestations of emotionality in women), is "a neurosis of the brain in which the observed phenomena consist chiefly of a perturbation of vital activities, which serve as the manifestation of affective feeling and passions" (p. 3, cited in Mai & Merskey, 1980). Briquet noted that the syndrome was more commonly found in women because they "are more sensitive, impressionistic, and more easily distressed." Anticipating the etiological speculations of the next century, Briquet noted that one third of all of the children he studied had been "habitually maltreated or held constantly in fear or had been directed harshly by their parents" (cited in Mai, 1980).

A complete understanding of the syndrome which came to be known after 1859 as 'Briquet's Syndrome', or, more popularly, as hysteria, continued to elude psychoanalytic thinkers in the decades immediately following the publication of Briquet's Treatise.

The next major explication of the nature and causes of hysterical symptoms came from Jean-Martin Charcot, working in Paris in the 1870's and 1880's. Charcot

focussed on disturbances in the sensory nervous system in the patients he treated at the Salpetriere, in Paris. Dubbing the syndromes as "hysterical neuroses," Charcot "observed" and treated, with hypnosis, hundreds of female patients.[5] His work at the Salpetriere lead him to formulate his "laws of hysteria" in which he characterized hysteria as "an inherited, lifelong, functional nervous disease whose underlying existence was signified by sensory and motor stigmata; it was a disease that could erupt at any time in fits ... "(Shorter, 1992). Hypnosis, in Charcot's view, was the appropriate treatment.

Charcot's legacy was not lost on two of his most able students, Pierre Janet in Paris, and Sigmund Freud, working with Joseph Breuer in Vienna during the last two decades of the nineteenth century. Like Charcot, Freud and Breuer originally described hysterical symptomatology as the result of the "stimulation of a hysterogenic zone" which would produce neurological symptoms similar to the ones Charcot was "recording" in Paris (Shorter, 1992). Breaking from Charcot, however, both Janet and Freud understood the symptoms of the "hysterics" as evidence of "a condition caused by psychological trauma" (Herman, 1992b) rather than genetic disposition.

With words Freud would later come to regret, and recant, he wrote with Breuer, in their Studies in Hysteria, that "hysterics suffer mainly from reminiscences" (Breuer & Freud, 1893-1895, cited also in Herman, 1992b). Initially convinced that such

[5] In fact, it seems now that many of the women Charcot "treated" suffered from epilepsy and/or other medical ailments. Nevertheless, his work with these patients, and his formulations on the nature of hysteria were central to the development of Freud's conceptualization of hysteria over the course of the next two decades.

reminiscences referred to sexual events in each patient's history, Freud came to view the hysterical symptom as a neurotic compromise, i.e., as a partial expression of unconscious material that the ego represses from conscious awareness due to its sexual nature (Breuer & Freud, 1893-1895). Symptoms, in Freud's view, had direct symbolic significance. Hysterical outbursts, like dreams or parapraxes, were thought to be thinly, but cleverly disguised expressions of "strangulated affect" and unconscious conflict.

By 1910, however, Freud had retreated from his earlier claim that such reminiscences were based on actual events and from the notion that hysterical symptoms were reality-based. Instead, he shifted psychoanalysis to the study of intra-psychic phenomena. It was at this point, Herman argues, that "The study of psychological trauma came to a halt" (Herman, 1992b, p. 15).

In fact, however, trauma has always held an important place in the evolution of psychoanalytic thought (Khan, 1991). In his eloquent paper on The Concept of Cumulative Trauma (1991), M. Masud Khan explicates the shifts in Freud's thinking on the general problem of trauma (not, however, as it relates to conversion symptoms per se). Khan argues, persuasively, that by 1926, with the publication of Inhibitions, Symptoms and Anxiety, Freud had reintegrated the "intrapsychic, intersystemic and environmental sources of trauma into a unitary frame of reference." With this paper, Freud set the stage for the recognition, in more recent decades, of the mother-infant relationship as a crucial site for potential growth and/or traumatization (Khan, 1991). Khan quotes Freud:

> The fundamental determinant of automatic anxiety is the occurrence of a traumatic situation; and the essence of this is an experience of helplessness on the part of the ego in the face of an accumulation of excitation... the various

> specific dangers of which are liable to precipitate a traumatic situation at different times of life (Khan, 1991, p. 119).

When renewed interest in psychogenic somatic symptoms emerged in the 1940's and 1950's, psychosomaticists like Alexander (Alexander, 1950), Deutsch (Deutsch, 1959) and Schur (Schur, 1955) sought to refashion the dynamic features of Freud and Breuer's early hypotheses. During these decades, theories of personality were on the rise, and, in the spirit of the age, some psychosomaticists sought to link specific personality styles with specific symptoms and illnesses.

Alexander, for instance, devised a list of the seven classical psychosomatic diseases including ulcerative colitis, asthma and other ailments. Each of these conditions was associated with a particular personality type. Those individuals suffering from ulcerative colitis, for example, were thought to have constitutionally restrictive personality styles, and so on (Alexander, 1950).

Although he departed from both the early dynamic theories of hysteria and from Freud's later integration of the idea of trauma and anxiety, Alexander retained Freud's later recognition of the importance of environmental factors as essential precipitants for the eruption of psychosomatic illness. Alexander wrote:

> A patient with vulnerability of a specific organ or somatic system and a characteristic psychodynamic constellation develops the corresponding disease when the turn of events in his life is suited to mobilize his earlier established central conflict and break down his primary defenses. In other words, if the precipitating event never occurs, a patient may, in spite of the presence of the predisposing emotional patterns and of organ vulnerability, never develop the disease (Alexander, French & Pollock, 1968, p. 11 cited in Taylor, 1987, p. 18).

Nevertheless, the developmental substrate of Alexander's "characteristic psychodynamic constellation" remained obscure.

Max Schur's contribution to the field of psychosomatic medicine represents a transitional moment in the field. Relying more explicitly than Alexander on Freud's economic and energic model of the mind, Schur tried to specify what the specific somatic manifestations of given affects -- anxiety, or aggression, for example -- might look like vis-a-vis the transformations of psychic energy. In 1955, Schur wrote of his ideas regarding psychosomatic illness:

> My hypothesis assumes the interdependence of the ego's faculty to use secondary processes and to neutralize energy, and the desomatization of responses. It assumes, on the other hand, that resomatization of responses is tied up with the prevalence of primary process thinking and the use of deneutralized energy (Schur, 1955, p. 124).

The shift noted here, from secondary to primary processes, represents, Schur suggested, a "physiological regression" (Schur, 1955, p. 126). Precipitants of illness include, according to Schur, "certain types of libidinal and ego endowment and development, a certain genetic and developmental setup of organs and organ systems, related to certain environmental influences," by which he means various sorts of "traumatization" (Schur, 1955, p. 157).

Most contemporary psychoanalytic theorists continue to recognize somatic symptoms as painful bearers of hidden knowledge from a past long buried in an individual's unconscious. Psychoanalysts generally agree, in addition, that psychosomatic symptoms are the result of a more complex, non-linear sequence of events than that envisioned by Freud and the early psychosomaticists. Although the debate over the specific etiology of psychosomatic illness continues, a number of theorists, working from different directions, have contributed fruitfully in recent years

to our understanding of the complex problem of psychosomatic illness and the processes of somatization.

D. Contemporary Psychoanalytic Theories of Somatization

Winnicott has provided us with perhaps one of the most comprehensive and moving explications of the disruptions in the basic "maturational processes" of childhood which can lead to profound and debilitating disturbances in an individual's relationship to his or her body. A fundamental tendency in human development, Winnicott suggests, is the push from a primary unintegrated state towards integration. Central to this challenge of integration is the establishment of a robust "indwelling" of the psyche in the soma (Winnicott, 1964/1992, p. 113). "Indwelling" consists in large measure in the developmental achievement of what Winnicott calls "personalization" (Winnicott, 1970/1992), the making of one's own one's "body self."[6]

It is from the mirroring and reinforcing behaviors of the mother/caretaker toward both the ego and the body of the infant, Winnicott asserts, that the infant "gains a foothold in the "I AM" or "king of the castle" position in emotional development. From then on, not only does the enjoyment of body functioning reinforce ego development, but also ego development reinforces body functioning..." (1964, p. 113). It is this unfolding and mutual interaction and reinforcement between mother and baby,

[6] By this, Winnicott means to suggest "a kind of positive form of depersonalization" which involves a reversal of "a loss of contact with the body and body functioning" (1970, p. 261) such as that indicated by the more widely known term, depersonalization.

and between ego and body, which gradually enable the growing child to consolidate a coherent sense of his/her own "body ego organization" (Khan, 1991, p. 131)[7].

When Winnicott speaks of the depersonalization involved in the psyche-soma split and the manifestations of psychosomatic illness, he is referring to the consequences of the infant's early experiences with caretakers where inadequate "mothering," with "nothing to contain the interweaving of forces in the inner psychic reality, and in practical terms, no one to hold the baby," created an "unthinkable anxiety" in the dependent infant (Winnicott, 1969/1992, p. 115). Psychosomatic illness, Winnicott suggests, represents a defensive split in the link between psyche and soma in the face of the "threat of depersonalization and a loss of body boundaries and of the unthinkable almost physical anxiety which belongs to the reverse process of that which is called integration" (1969, p. 115). The state of illness, in other words, is a "split in the ego-organization." This split acts as a defense "against the dangers that arise out of integration and out of the achievement of a unified personality" (1964, p. 111).

Building on the ideas of Winnicott and Freud, Masud Khan elaborates more fully the specific maternal failures which can impede the development of an individual's stable and cohesive "body ego organization." Khan returns to Freud's idea that every living organism develops a "protective shield" which regulates the reception of stimuli, both internal and external. With Freud's image in mind, Khan then proceeds to integrate

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[7] Throughout the psychoanalytic literature, the "mother" is invoked as the primary caretaker responsible for the nurturance and regulating of the infant. It is my feeling, however, that while the infant needs consistency in his/her caretakers so that stable regulatory, attachment and object relational patterns may be established, this role need not, necessarily, be fulfilled by the child's mother. Throughout this discussion, therefore, "mother" will be used somewhat metaphorically to invoke the personage of a consistent caretaker without implying that the child's biological mother must be the person to meet these needs.

this idea with Winnicott's notion that "the infant in care has for his protective shield the caretaking mother" (Khan, 1991, p. 122).

It is, Khan argues, the mother's role to "dose and regulate stimuli" for her infant. When she fails in this role, the infant experiences what Winnicott has dubbed "impingements" on his/her organism. Repeated and excessive impingements of this sort, Khan suggests, constitute a kind of invisible, "cumulative trauma." He writes:

> Cumulative trauma thus derives from the strains and stresses that an infant-child experiences in the context of his ego-dependence on the mother as his protective shield and auxiliary ego..... If [the mother's] personal conflicts intrude here, the result is a shift from the protective-shield role to that of symbiosis or rejective withdrawal. How an infant will react to these failures depends upon the nature, intensity, duration, and repetitiveness of the trauma (Khan, 1991, p. 122/127).

There are several key points embedded in these lines which link Khan's ideas to the etiology of psychosomatic processes. First, Khan anticipates the current debate over early trauma and the healing value of specific recovered memories when he notes that "the use of the word trauma in the concept of cumulative trauma should not mislead us into considering such breaches in the mother's role as traumatic at the time or in the context in which they happen. They achieve the value of trauma only cumulatively and in retrospect ... One treacherous aspect of cumulative trauma is that it operates and builds up silently throughout childhood right up to adolescence" (Khan, 1991, p. 123/133). By emphasizing the cumulative and invisible nature of these traumatic insults to the body and ego integrity of the child as they occur in the ongoing relationship between infant and caretaker, Khan, like Freud, allows for the interplay between environmental, constitutional and intrapsychic factors and points to the possible psychosomatic derivatives of cumulative trauma.

Second, in representing the mother as the child's "auxiliary ego," Khan raises the related issues of dependency and identification as they might relate to a somatizing tendency. In addition to the developmental trend toward integration noted above, a second maturational tendency, Winnicott argued, is the movement from "absolute dependence" to "relative dependence" toward independence (Winnicott, 1963/1965). During early childhood, the infant must be able to experience both the safety to be dependent, and even to return to the state of absolute dependence when necessary, as well as the "integrative tendencies," "in the matter of indwelling or the inhabitation of the body and the body functioning" (Winnicott, 1970/1992). By positing the mother as the "auxiliary ego," Khan underlines the important function she serves in reflecting back and containing for the infant his/her body ego and providing a safe and harmonious environment in which the child can both grow into his/her body self and regress as needed. He suggests, too, her importance as an object of identification for how the child might view and relate to his or her emergent self and its inner processes. There is, in other words, a critical process of identification at work implicit and embedded in the containing and regulating functions of the caretaker. Khan writes:

> The mother's role as protective shield is not a passive one but an alert, adaptive and organizing one. (Khan, 1991, p. 127).

The child must be able to identify with this "alert, adaptive and organizing" quality of the caretaker in order to develop both the capacity for and the tolerance of his/her own reflective inner processes.[8]

Henry Krystal, Joyce McDougall and Peter Fonagy, three contemporary psychoanalytic theorists working in separate traditions, have also placed impaired regulatory and/or faulty identificatory processes at the heart of psychosomatic disturbances.

Krystal, who has written extensively on the subject of alexithymia and affective development in general suggests that a predisposition to psychosomatic disease can be conceptualized as a consequence of either a massive "regression in affective expression consisting of affect dedifferentiation, deverbalization, and resomatization" following a trauma in adulthood or as an "arrest in the genetic development of affect" in early childhood (Krystal, 1982-1983, p. 365). Krystal writes:

> Possibly the most crucial aspect of mothering consists of permitting the child to bear increasing intensity of affective tension, but stepping in and comforting the child before emotions overwhelm him or her ... If the mothering parent fails to prevent the infant's affect from reaching an unbearable intensity ... a state of psychic trauma may develop ... {resulting in} global distress occasioned by the total, unregulated flooding with the undifferentiated, somatic, preverbal, timeless, ur-affects [sic] of a young child (Krystal, 1982-1983, p. 366).

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[8] M. Masud Khan and other theorists associated with the British Independent School of Psychoanalysis have written beautifully on the ways in which both psychosomatic symptoms and secrets can serve as transitional objects. Like a bodily symptom, the act of having a secret connected to harboring, hiding, or burying an object, Khan writes, enables the person to split off and thereby protect an important part of the self. By doing so, however, the individual is unable to "elaborate or correct it in terms of new experience (Khan, 1978). It is precisely at the moment of experiencing a traumatic break in the connection with the caretaker that an effort to create, or preserve the connection in the form of a transitional object, or a psychosomatic symptom, may be employed (Gaddini, 1978; Khan, 1978). I am grateful to Suzanne Little for bringing the work of these thinkers to my attention.

For Krystal, a regression back to this early level of affective functioning in a time of crisis signals that the individual's affect was not sufficiently managed or contained during childhood, and that the individual's psyche remains vulnerable to over-stimulation.

Like Krystal, McDougall, writing in the tradition of the French school of psychosomaticists (see, for example, (M'Uzan, 1974), suggests that disturbances in early interpersonal experiences may give rise to a style of mental functioning which "increases psychosomatic vulnerability" (McDougall, 1989). Although McDougall, too, points to problems in early mother-child relationships as the source of alexithymic tendencies and psychosomatic vulnerabilities, she does not see somatization as a regressive process as Krystal does. She argues, instead, that these individuals suffer from an impairment in affectivity and object relatedness due to psychological conflict around the identification with the maternal figure and her caregiving functions. It is the child's refusal and/or inability to identify with these functions which is, ultimately, associated with a susceptibility to psychosomatic illness.

Specifically, she argues that profound empathic failures in a significant early relationship may impede the child in his/her ability to identify with and thereby internalize the other and his/her caretaking functions. McDougall writes:

> Such mental structures appear to be organized in early childhood, when the mother-child relationship has failed to give rise to an internal representation with caretaking functions (with which the child needs to identify if he is to acquire the capacity for both physical and mental self-care) (McDougall, 1989, p. 38).

The unique role of the mother, to "interpret her baby's cries and gestures," lays the foundation for the infant's ability to symbolize.

> Lacking a language for his emotional states, he is incapable of dealing with them adequately. Thus it is within the unique mother-infant sphere that the child may hope to acquire a body which shall have symbolic meaning, and thus become conscious of its many messages and capable of elaborating symbolically, through verbal thought and imagination, the physical and emotional events that are truly his (McDougall, 1978/1992, p. 430-431).

When this process fails, one's conscious relationship to one's body and to others is stripped of emotional resonance. McDougall writes:

> The psychic reality of others or the significance of one's relation to them appears to be decathected. This deaf-and-dumb relation between psyche and soma is the hallmark of the "psychosomatic body" (McDougall, 1978/1992, p. 427).

Psychoanalysis, suggests McDougall, is "the antithesis of the psychosomatic process" for the process of somatization entails "a lack of symbolic structures to give meaning to the representations and their allied affects, so that sensations and experiences impinging from without and within are not readily integrated into an elaborated psychic system" (McDougall, 1978/1992, p. 368).

In other words, whereas Freud saw somatic symptoms as a manifestation of a repression of neurotic conflict, McDougall maintains that the defensive process of somatization takes place without the symbolic translation of conflict into a representational form. It is, she argues, specifically a result of these patients' inability to represent their psychic pain that their distress is encoded in the body.

Peter Fonagy has constructed an elegant integration of the work of Winnicott, Khan, Krystal and McDougall in his argument that chronic psychic trauma often leads to a "representational deficit" of what Fonagy has termed an individual's own "theory of mind" (1991).

> The representation of one's own ideas and desires must form the core of a coherent and mature identity (p. 652.)

Whereas McDougall emphasizes the consequences of the failure to symbolize affect, Fonagy points to the implications of an inability to represent ideas about oneself and others.

"The capacity," Fonagy writes, "to conceive of the contents of one's own, as well as the object's mind, is an important prerequisite for normal object relations ... and depends on the availability of adult models throughout development whose mature ego can provide the framework on the basis of which these mental processes may be formed" (Fonagy, 1991, pp. 649-50).

In cases of severe emotional trauma and/or deprivation, Fonagy argues, "traumatic events concerning one or other of the parents compel the child defensively to disregard perceptions related to the thoughts and feelings of the primary object (1991, p. 650). As a result, in an effort to "circumvent intolerable psychic pain" which comes with the inability to make meaning out of the chaotic and cruel behavior of important objects, "secondary representation of mental events may thus become permanently impaired" (p. 650). This deficit, Fonagy writes,

> ... is brought about by a defensive disavowal of the mental existence (in terms of psychic functioning) of the object ... [and] may be conceived of as the expunging from the mental world of the capacity to think about mental experience whether this concerns wishes, beliefs, desires or phantasies (p. 651).

There are three ideas here which relate directly to the empirical and clinical literature on somatization. First, like McDougall, Fonagy suggests that somatic symptoms may be conceived of as defenses against intolerable psychic pain. He carries this idea a step further, however, when he suggests that it is not only the mental contents of the self, but also of the object that are inhibited.

This leap suggests, and this is his second contribution, that the developmental lines of object representation and affect are intimately linked. The capacity to recognize one's own mental processes, and to realize that one inhabits an interpersonal universe in which such mental processes shape human experience, requires "repeated encounters with a mother capable of reflecting, containing and alleviating distress [which] will strengthen the child's capacity to tolerate negative affect and increase his confidence that his need for auxiliary support in regulating affect will not go unmet" (Fonagy, et al., 1983, p. 5). In this way, Fonagy continues, via her management of her child's affect, the mother helps to create a "representation of these emotional moments which is tolerable in place of their original experience which was not ... This reduces the need for splitting of frightening and incoherent mental representations of mental states, and new experiences of others' minds can more readily be integrated into the framework of past relationship representations" (Fonagy, et al., 1983, p. 9/10).

Finally, Fonagy points to a possible understanding of the relationship so often noted in somatizing patients between impaired functioning in the realms of affect tolerance and expression, on the one hand, and flat, unempathic object relational styles on the other. In connecting the inhibition of mental processes to early trauma in interpersonal relations, Fonagy extends the idea of dissociation from the self resulting from traumatic overstimulation to dissociation from one's entire interpersonal world. In making this bridge, he follows Khan's lead and links this defensive process of dissociation to the crucial operation of identification. In his discussion of a patient, Fonagy writes the following:

> Mr. S's objects lacked independent psychological existence because he projected his own incapacity to represent himself as a thinking, feeling person on to them... they lack mental capacity ... His attempt at protecting himself from the traumas of his early life must have included a profound identification with the thoughtless state of the original abusers (p. 645).

The absence of benevolent and reciprocal attunement with an "alert, adaptive and organizing" caretaker impeded this patient's ability to represent himself and others in effectively animated and vital ways. Instead, "his own and others, feelings and intentions can only be represented at a primary (the immediately accessible) level (of the body] and cannot be reflected upon or thought about" (Fonagy, 1991, p. 650). Fonagy writes:

> The capacity to represent the idea of an affect is crucial in the achievement of control over overwhelming affect. In the absence of this capacity, affect in others can be appreciated only through direct experiencing via emotional resonance (Fonagy, 1991, p. 642).

Fonagy correctly notes that alexithymic tendencies, what he calls "the absence of the capacity to represent affect mentally," have long been associated with psychosomatic disorders" (Fonagy, 1991, p. 642).

Herman is not alone, then, in implicating trauma, and in particular, early trauma, as a crucial determinant of somatic symptoms. In fact, a belief in the long-term psychological derivatives of cumulative psychological trauma lies at the heart of most contemporary psychoanalytic theories of psychosomatic illness and symptomatology. Unlike Herman, however, the psychoanalytic theorists discussed above emphasize the psychological derivatives of early traumatization rather than physiological consequences of traumatic overstimulation. An attempt to bridge these two approaches comes from Graeme Taylor.

Taylor builds on McDougall's work and psychoanalytic theory in general, but attempts as well a wide-ranging integration of the findings from animal studies (Hofer, 1978; Hofer, 1981; Reite, Seiler & Short, 1978) and the theoretical and clinical contributions of object relations, affect and attachment theory. Specifically, Taylor has outlined a psychoanalytically-oriented psychobiological theory of psychosomatic illness. Early relationships, he argues, are crucial psychobiological regulators of affect and physiological homeostasis. As such, these relationships constitute the foundation for the "biological mechanisms" underlying both health and somatic disease (Taylor, 1987). Taylor merges the psychobiological view with the perspectives outlined above regarding early developmental disturbance (McDougall; Krystal) when he suggests that the failure to adequately internalize a significant other as a "vital external psychobiological regulator" (and thereby develop this self-caring function for oneself) can directly affect the health of the body, and in particular, of the immune system, creating a high susceptibility to disease throughout one's lifetime (Taylor, 1987). In searching for the sources of psychobiological disregulation, Taylor, like those theorists presented above, points to empathic failures in the early mother-child relationship.

Implicit in the psychoanalytic theories of somatization outlined above are certain assumptions about the development of the capacities for affectivity and object relatedness and the extent to which early impairments in these areas may be implicated in the etiology of psychosomatic illness.

The underlying premise of this study is that an understanding of somatization can be enriched by a psychoanalytically-oriented developmental schema which takes into account the interconnectedness of the unfolding of the capacities for affectivity and

object relatedness. There are several theorists whose work is especially relevant to the construction of this sort of developmental model.

E. Epigenetic Theories of Development: The Role of Affect and Object Relatedness

Gedo (Gedo & Goldberg, 1973; Gedo, 1979; Gedo, 1988) developed what he referred to as an epigenetic, hierarchical model of development; epigenetic, because one must pass through one stage to reach the next; hierarchical, because there are five developmental modes which represent increasingly sophisticated aspects of functioning.

> Each mode is characterized by typical problems, an overarching aim/goal and reflects the successively greater differentiation of the self-organization and the environment (Keller, 1989, p. 64).

Informal clinical observations of somatizing individuals suggest that they generally operate with relatively low levels of affectivity and object relatedness as characterized in Gedo's schema.

Consistent with the work of Gedo, M. J. Horowitz describes qualitatively distinct periods of cognitive development. In each stage, we acquire a new mode of functioning which continues on into the next stage, and to which we can return periodically as needed. As infants, we operate in what he calls the "enactive" mode, which is defined by motoric, bodily responses. Next, we move to the level of "image representation," in which images can be represented symbolically and emotions condensed in representational form. Finally, we move to the stage of "lexical thought," where words are attached to "a thing-representation" (Horowitz, 1978).

It is one of the central ideas guiding this research that like infants, who experience the interpersonal and intrapsychic world through their bodies, individuals

who somatize are, during (and/or around) those periods of a somatic eruption, operating on a pre-symbolic level; the inner life of the mind is "acted out" on, or through, the body. They are unable to name feeling states, tolerate affect or fully express themselves metaphorically or lexically. To repeat McDougall's phrase, "Their bodies speak for them" (McDougall, 1989).

Daniel Stern (1985) beautifully describes the "dances of attunement" (cited in Keller, 1989) between an infant and his/her caretaker as the basis for the consolidation of the "core affective self" (Stern, 1985). Likewise, Stanley Greenspan (1979) emphasizes the "presymbolic, pre-imagistic and psychobiological nature of these affective phenomena" which he believes constitute the earliest forms of mentation in the infant. He thus labels these early stages as "somatic intelligence" (quoted in Keller, 1989, p. 56). Like McDougall, Krystal and Fonagy, Greenspan suggests that without the help of one's caretaker to manage overwhelming emotions, those affects "experienced as overwhelmingly painful at this preverbal period may not become subject to verbal representability..." (Keller, 1989, p. 57). Greenspan writes:

> We commonly assume human feelings are repressed secondarily. We do not assume the reverse--that early schemes and patterns related to these biological sensations may never become consolidated, or that the links within the representational, psychological, experiential systems may never be established. (Greenspan, 1979, p. 331, also cited in Keller, 1989, p. 57)

Like Greenspan and Gedo, Wilson (Wilson, Passik, Faude, Abrams & Gordon, 1989) and others suggest that "early, presymbolic core affective experiences mediate both affect and self-other differentiation and may persist throughout the life course" (Keller, 1989, p. 59).

An epigenetic perspective supports the theoretical contributions and clinical observations discussed above (Herman; McDougall; Winnicott; Khan; Fonagy). This perspective also lends support to the notion that somatization and other bodily-related symptoms such as self-mutilation and substance abuse may be best understood as expressions of early fragmentation and the squelching of subjectivity. Without a consolidated sense of self and effective affective regulatory mechanisms, affectivity and relatedness may come to feel like dangerous ventures which must be vigorously avoided in order to maintain psychic equilibrium. The split between psyche and soma described by Winnicott may represent a dissociation from subjective experience when conscious representation is impossibly threatening.

In a recent paper, Michael Robbins outlines what he considers to be the three essential differences between neurotics and those individuals with "primitive personalities" (Robbins, 1993b) in terms which strongly echo the writings of Winnicott, McDougall and Fonagy on the psychosomatic patients with whom they have worked. Primitive personalities, writes Robbins, suffer from inadequate "psychic integration." Contradictory elements, he continues, "are not integrated, with the result that the individual is incapable of experiencing intrapsychic conflict or emotional ambivalence" (Robbins, 1993b, p. 289). Along with this general structural feature, Robbins notes a relative lack of differentiation between self and other, and a "primitiveness of cognition and affect" which characterize the object relations of primitive personalities (Robbins, 1993b, p. 290).

Including in his morphology those individuals seen as belonging to borderline, narcissistic, paranoid and schizoid groups, Robbins acknowledges that these individuals

represent "a varied lot." What links them, he argues, is their inability to represent affect (Robbins, 1993a, p. 237).

> Knowledge of emotions and body feelings is the compass and beacon of mental life. Primitive personalities live in a chronic subtle state of disorientation (Robbins, 1993, p. 248).

Robbins, like McDougall and Fonagy, argues that while Freud saw "affect pathology [as] the result of conflict and defense" (Robbins, 1993a, p. 253), the type of affect impairment seen in primitive personalities is more appropriately construed as a developmental arrest. Robbins suggests, however, that such an arrest may involve either an adaptive response to a "particular kind of parenting" and/or a pre-symbolic "defense against a primal intrapsychic conflict over the continuing awareness of a state of dependency (that is, emotional ties to an object) that is intolerably painful for the infant" (Robbins, 1993a, p. 254) due, perhaps, to the malignancy of the environmental deprivations and/or abuse. In other words, Robbins also allows for the possibility that a pre-symbolic deficit in the capacity for affectivity and object relatedness may stem from early impingements in the caretaking relationship.

The psychoanalytically-oriented theorists presented above have made suggestive speculations about the complex links between affect development and the consolidation of identity through interpersonal experiences as they play out in the "theater of the body" (McDougall, 1989). In doing so, these clinicians implicate disturbances in affectivity and object representation and relatedness in the etiology of psychosomatic processes. To explore this line of thinking more fully, I will now move to a discussion of the empirical findings linking impaired capacity for affect regulation and object relatedness to somatization. Finally, I will examine relevant findings from attachment

theory and research linking somatization to maladaptive patterns of affect regulation and object relatedness as they develop within the infant-caretaker bond.

F. Affect and Somatization: Theory and Empirical Findings

Carroll Izard writes that "Emotional development at the neurophysiological level produces the inhibitory and self-regulatory capacities so essential to effective adaptation amid increasingly complex social and environmental demands" (Izard, 1984). In fact, much of the current research on somatization disorders and substance abuse points toward the impact of emotional over-stimulation, neglect and/or abuse on the development of self-soothing and self-regulatory capacities (See, for example, Herman, 1992b; Taylor, 1987; Hofer, 1978; Reite, et al., 1978).

The relatively limited capacity for affective vitality often strikes one immediately when treating patients with somatic symptoms in psychotherapy. In general, clinicians, researchers and theorists agree that patients presenting with psychosomatic symptoms have impaired capacity for affect tolerance and expression as well as for symbolization and the production of fantasy (McDougall, 1982-83; Wise, Mann, Hryvniak, Mitchell & Hill, 1990; Salisbury, 1990; Viederman, 1994). Together, these characteristics of impaired affectivity have been identified as "alexithymia" (Nemiah and Sifneos, 1970). Derived from Greek, alexithymia refers to the state of having-no-words-for-feelings (a-lex-thymia). Alexithymia has been the target of extensive research in studies of patients diagnosed with somatization disorders.

Employing a variety of measures designed to capture an individual's capacity for affect tolerance and expression, researchers have begun to establish reliable correlations between alexithymic characteristics and somatization.

In a controlled study comparing patients with somatization disorders to those without either serious physical illness or evidence of somatizing tendencies, Shipko, for instance, found that alexithymic characteristics were more prevalent among those in the somatization group than among healthy control subjects (Shipko, 1982). In a Rorschach study of four separate, homogenous groups of patients with one of three of the classical psychosomatic illnesses or lower back pain (LBP), Acklin et al. found that the psychosomatic and LBP patients distinguished themselves as a group from other medical patients as more alexithymic. In addition, the LBP patients, individuals known for their somatizing style, demonstrated the least capacity for affect tolerance and expression of the four target groups. (Acklin & Alexander, 1988)

Not all studies are conclusive, however. In a study of a normal sample, Cooper and Holmstrom found that the tendency toward somatization and alexithymic characteristics were correlated in females but not in males (Cooper & Holmstrom, 1984). In a study of the correlation between alexithymia and chronic pain patients, Mendelsohn did not find evidence supporting the view that alexithymia is significant in the "psychomaintainence" of chronic pain. He does suggest, however, that clinicians working with chronic pain sufferers be familiar with the concept of alexithymia and the obstacles to treatment this tendency can create (Mendelson, 1982).

Variations in measurement and difficulties in the operationalization of both alexithymia and somatization may account for some of the disagreement on the strength

of the relationship between alexithymia and somatization. In addition, competing and divergent philosophical and scientific views of the mind-body connection may also influence interpretations of data. Finally, Shedler's admonitions against the tendency to accept at face value self-reports on standardized measures of psychological functioning rather than to rely on the more subtle albeit subjective judgement of trained, psychoanalytically-oriented clinicians may apply to the search for alexithymia among somatization patients as well (Shedler et al., 1993).

In all of the studies noted above, subjects were screened for confounding incidence of neurotic or psychotic co-morbidity in order to isolate the dynamics of somatization per se. And yet, as Robbins, Fonagy and others suggest, these syndromes may have significant overlap in disturbances in the realms of affect regulation and object relatedness stemming from a common etiology of chronic early trauma.

Individuals with severe personality disorders, and in particular, Borderline Personality Disorders (BPD) often alternate between acting out behaviorally, which can include self-mutilating acts, drug or alcohol abuse, and other, more "purely" somatic symptomatology, such as developing infections. As with individuals who have unexplained somatic symptoms but are not diagnosed with a personality disorder, it is theorized that both the acting out and the somatization occur in individuals with personality disorders because they are "unable to utilize verbalization and fantasy to work through unacceptable affects and impulses" (Hull, Okie, Gibbons & Carpenter, 1992).

In order to explore the relationship between somatic and non-somatic symptoms in patients with severe personality disturbances, James Hull and his colleagues at The

New York Hospital-Cornell Medical Center, Westchester Division closely followed the symptom course in a young woman diagnosed with a Borderline Personality Disorder (BPD). In this recent case study (1992), Hull et al. found that as inpatient treatment progressed, and the woman became increasingly able to verbalize her aggressive impulses, symptomatic "acting up" and somatization became both more synchronized and eventually, went into remission. In other words, as affect became tolerable, and as the patient learned to express aggressive and negative affect verbally, the rechanneling of those impulses into somatic expression diminished.

Unable to integrate overwhelmingly painful feelings, the patient in the study presented above expressed her affect initially through bodily channels, or, in Horowitz's terms, in an "enactive" mode (Horowitz, 1978). Once her capacity to tolerate and represent a modulated range of affects increased, or, in developmental terms, matured, she was able to function more often in the symbolic and lexical modes outlined by Gedo, Wilson and Horowitz.

This study lends substantial support to Freud's original theory that somatic symptoms express "strangulated affect" and to one of the central premises of this study, i.e., that somatization represents, in part, an impairment in the capacity to symbolically or verbally represent affect.[9]

Implicit here, as well, is the idea that as affect became more tolerable, so too was this patient able to relate in a more direct and integrated fashion to herself and

[9] Robbins notes that it is precisely this impaired capacity for affectivity which characterizes individuals with primitive personalities (Robbins, 1993b).

others; that is, her object representations may have shifted to a slightly higher, more stable and integrated level such that her capacity for relatedness also increased.

In a study of changes in separation-individuation and intersubjectivity in patients hospitalized with Borderline Personality Disorders, Diamond et al. found that toward the end of long-term treatment, patients showed a "clearer sense of boundaries and separateness, as well as a greater degree of empathic relatedness" in their object representations (Diamond, Kaslow, Coonerty & Blatt, 1990, p. 363).

The capacity to integrate polarized affects and object representations is critical to what Mahler and others have referred to as the attainment of "object constancy" (Mahler, Pine & Bergman, 1975). Object Constancy is viewed by many as the principle cognitive achievement of the first two years of life (see Mahler, 1975; Diamond, 1990; and Blatt, Brenneis & Schimek, 1976; Blatt & Lerner, 1983). It is an additional premise of this study that requisite to the capacity for object constancy is the ability to symbolically represent self and other, as each comes to be known through mutually regulated affective expression and intersubjective exchange (Stern, 1985).

As implied above, however, affect representation is "not simply another description" of object constancy (Robbins, 1993a), Most theorists agree that the developmental lines of affect and object relations are separate, but integrally related. Robbins, for instance, notes that "the capacity to represent affect must be an essential component of that more complex cognitive achievement" of differentiation of self from object, and that disturbances in object relations may have disastrous consequences for the development of affect representation (Robbins, 1993a). Stern and Greenspan also recognize that affect develops in the context of interpersonal experiences. By

definition, they argue, disturbances in affect must reflect disturbances in one's object relations. It is to this realm of functioning that I now turn, more explicitly, to examine how it is that disruptions in object relations may also be implicated in the etiology of somatization.

G. Object Relations and Somatization: Theory and Empirical Findings

The essential premise of object relations theory is that "relations with others constitute the fundamental building blocks of mental life" (Greenberg & Mitchell, 1983, p. 3). What is meant by this is that each of us creates, in our minds, images of ourselves and of others, that are born out of our early social and effectively charged interactions with other people. In their comprehensive review of object relations theory, Greenberg and Mitchell write of these images in this way:

> What is generally agreed upon about these internal images is that they constitute a residue within the mind of relationships with important people in the individual's life. In some way crucial exchanges with others leave their mark; they are "internalized" and so come to shape subsequent attitudes, reactions, perceptions, and so on. (Greenberg & Mitchell, 1983, p. 11).

Mahler, Pine and Bergman (1975) outlined a theory of development characterized by increasingly complex interpersonal negotiations between infant, then toddler and caretaker. "A major aspect of separation-individuation as articulated by Mahler is the differentiation, integration and internalization of self- and object representations" (Diamond, et al., 1990). An epigenetic framework of development such as that developed by Gedo and elaborated by Wilson et al. (Wilson, et al., 1988) suggests that object relational difficulties can be best understood in the context of developmental disturbances in affect regulation since "affective difficulties perforce

originate within a disturbed self-other differentiation sequence" (Keller, 1989, p. 61. See also Kernberg, 1984; Stern, 1985).

The psychoanalytic literature on somatization is replete, as noted above, with speculations about the relationship between early disturbances in the mother-child bond (or important caretaking relationships) and the emergence of a somatic symptoms (Fonagy, 1991; Krystal, 1979). McDougall writes of the failure to internalize a capacity for self-care (McDougall, 1989). In his writings on the importance of the "holding stage of maternal care," Winnicott writes that experiences "which seem to be purely physiological but which belong to infant psychology" are precisely those experiences which determine later object relationships (Winnicott, 1960, p. 44). Attainment of what Winnicott refers to as "unit-status," that is, the nascent sense of oneself as "an individual in his own right," is tantamount, Winnicott continues, to "the psyche indwelling in the soma" (Winnicott, 1960, p. 44-45).

Clinical observations of somatizing patients suggest that these individuals have particular difficulties forming meaningful, empathic relationships with others, and that their representations of self and others are relatively impoverished (See, for example, McDougall, 1978/1992; M'Uzan, 1974; McDougall, 1989; Nemiah, 1970; Taylor, 1987; Fonagy, 1991).

More precisely, McDougall, Taylor and others suggest that the object relatedness of individuals who somatize is characterized by disturbances in self-other boundaries, fragmentation of self and an inability to achieve mature object constancy. A failure to complete what Mahler (Mahler, 1971) originally termed the separation-individuation process due to emotional unavailability and/or symbiotic needs of the

primary care-taker has been implicated as one of the critical factors contributing to both low levels of object relatedness in somatizing patients (Taylor, 1987; McDougall, 1978/1992) and to the inability to develop a coherent sense of one's own bodily limits and boundaries (Winnicott, 1964/1992; Orbach, 1994).

Empirical research has provided some evidence to support the theoretical speculations that somatizing individuals may share some of the same difficulties in object relational functioning as those observed in individuals with borderline and other personality disorders.

Salisbury found, for example, that chronic pain patients demonstrated an impaired capacity for human-relatedness on the Rorschach (Salisbury, 1990). Jessner et al. observed that asthmatic children tended to have conflictual relationships with their mothers, with both members of the dyad oscillating between closeness and distance (cited in Taylor, 1987, p. 237).

Masterson noted that a central interpersonal struggle for anorexic patients revolves around fears of "loss of self or loss of object" and suggests that the development of these individuals was arrested at the symbiotic phase of the separation-individuation process (cited in Taylor, 1987, p. 239).

Finally, Karush et al. found that the level of object relational functioning in a group of ulcerative colitis patients was both a "critical predisposing factor" to illness as well as an important determinant of psychotherapy outcome (cited in Taylor, 1987, p. 243).

Stern (Stern, 1985) argues that infants have an innate capacity for social interaction and intersubjective experience. As indicated above, Stern believes that it is

through the social and affective exchanges between infant and caretaker that the "core sense of self" emerges. Stern's theory of intersubjectivity convincingly lays the groundwork for the notion that traumatic disturbances in the infant-caretaker dyad can have disastrous consequences for the consolidation of the infant's core self and "body ego organization" (Khan, 1991).

Much of the literature reviewed above suggests, in fact, that early disturbances in the infant-caretaker dyad are implicated in the development of a somatizing defensive style. For this reason, I now turn to a brief discussion of the empirical findings linking disturbances in affect regulation and object relatedness to disruptions in the bonds to early attachment figures.

H. Affect Regulation, Object Relatedness and Somatization: Findings from Attachment Theory and Research

To date, there is no research on the attachment histories of somatizing individuals per se. There is suggestive evidence, however, linking disturbed early attachment experiences with physiological and emotional dysregulation. I begin this discussion with a brief summary of research which has examined the impact of maternal separation and object loss on psychological and physiological development.

In the 1940's, Rene Spitz (Spitz, 1945) described the effects of isolation and hospitalization of infants abandoned during the Second World War as hospitalism. Separated from their mothers and unable to form a stable attachment bond, these infants developed increased susceptibility to disease and had higher risks of mortality.

In addition to Spitz's early infant studies and the work on hospitalism, there are a number of studies which link object loss to increased risk of illness and mortality

(Laudenslager & Reite, 1984). The principle body of work in this more specific area has been conducted on primates (see, for example, Hofer, 1978; Reite, Short, Seiler & Pauley, 1981). These research efforts focus on the effects of maternal separation on immune systems and physiological functioning. Results indicate that the disruption in physiological functioning can be quite significant, and cannot be adequately explained by the "psychological" loss of the mother: Her presence as an external regulator of crucial psychophysiological processes, argues Hofer, is at the core of the disruption in normal functioning (Hofer, 1978).

Although, as noted, there has been no research directly implicating particular attachment styles with a predisposition toward somatization, there is evidence that various styles of attachment behavior might be related to the affective style, level of object relatedness, and disturbances in the regulation of bodily processes characteristic of persons with psychosomatic symptoms. There are a number of relevant findings.

Roger Kobak has described attachment styles as "styles of emotional regulation" (Kobak, 1987). If this is the case, then a study of one's attachment behaviors ought to reveal a great deal about the way one manages affect, both positive and negative. Studies show that if one's parent is receptive and responsive toward a child's expression of negative affect, the child will develop the "ability to display, acknowledge and eventually achieve positive mastery of negative emotional states" (Kobak, 1987). When negative affects are rejected, however, a child will find for him or herself "alternative control strategies for regulating negative emotions and associated attachment behavior" (Kobak, 1987). In fact, children identified as having avoidant attachment styles are generally unable to use negative affect effectively in their interpersonal

communications. Consequently, these children develop a variety of symptoms or other inappropriate ways to express their negative affect (Kobak, 1987).

Fonagy draws on these findings from attachment theory and research when he notes that the psychological processes involved with "reflective self-function" represent "an intrapsychic and interpersonal developmental achievement which emerges fully only in the context of a secure attachment relationship" (Fonagy, et al., 1983, p. 6). Findings from a recent study of diabetic patients suggest that an inability to manage negative affect may be linked to somatic expressions of experience (Fonagy & Moran, 1994).

These findings indicate that a secure attachment is directly related to the development of a capacity for affect expression and flexible emotional regulatory styles. Many attachment theorists also argue that there is a direct connection between the quality of one's emotional regulatory style, as it has evolved in the context of early attachment relationships, and one's capacity for object relatedness. The capacity to "access our own feelings consistently gives us a sense of familiarity about who we are despite many changes over time" (Zeanah, Anders, Seifer & Stern, 1989). Functioning in the "affective domain" relates directly, Zeanah maintains, to the continuity of an individual's sense of self (Zeanah, et al., 1989). In other words, an essential condition for the successful passage toward object constancy as it relates, specifically, to the coherence of mind and body, may be the quality of a child's attachment to important caretakers.

Attachment has been described, in fact, as a "representation of the history of the caregiving relationship" (Main, et al., 1985). As such, one's attachment history is

suggestive of the quality of one's early interpersonal experiences as well as the quality of one's internalized objects. In a recent article, Beebe and Lachmann argue that the earliest interpersonal experiences of mutual and self-regulation between caretaker and baby constitute the basis for "the pre-symbolic origins of internalization" (Beebe & Lachmann, 1994, p. 154).

There is evidence, in fact, that various attachment styles are related to differing styles in verbal and affective flexibility and expression. In research on the attachment patterns of children and adults, Main found that subjects with "different early attachment organizations had predictably different language organization" (Main, et al., 1985).

Seen in the context of these findings from attachment theory and research, the capacity for self-care described by McDougall as well as the development of a "theory of mind" as explicated by Fonagy, appear to be potentially critical outcome measures of an individual's early attachment history. As such, the impact of early attachment experiences on one's ability to consolidate, in Winnicott's words, the "personalization" of one's body self seems undeniable.

In fact, research on early mother-infant interaction shows that patterns of physiological arousal are closely tied to affective interaction patterns between within the infant-caretaker dyad (Beebe & Lachmann, 1994). Above, I have discussed the implications of these findings for the development of one's capacity to tolerate and regulate negative affect states, and for the quality of one's internalized representations of self and other. Now, I want to link these findings from attachment theory more directly to disturbances in the regulation of bodily processes.

Beebe and Lachmann (1994) link early bodily experiences with the ways in which one's earliest interactions organize the inner experiences which will form the basis of later internalizations. The authors describe three "principles of salience" which, they suggest, characterize these early interactions. With regards to their first principle, that of "ongoing regulations," the authors note that "bodily states organize experience insofar as they are repeated and expected" (Beebe & Lachmann, 1994, p. 153). That is, the interaction between the infant's capacity for self-regulation and the caretaker's capacity to respond sensitively to the bodily needs and desires of the infant is one of the most basic building blocks of early inner experience. In their effort to link the evolution of these mutual and self-regulatory processes with an infant's experience of bodily states, the authors write:

> What will be organized is the expectation that compelling bodily needs will or will not be adequately regulated, with particular affect and arousal patterns (Beebe & Lachmann, 1994, p. 153).

Citing Schafer, the authors note that "the regulatory interaction has been interiorized" (Beebe & Lachmann, 1994, p. 155).

Expanding on their discussion of "the principle of disruption and repair," Beebe and Lachmann argue that "bodily experiences of disruption can be defined as those instances where mutual regulation is inadequate to sustain self-regulation. Bodily experiences such as hunger, cold, or fatigue then impinge and overwhelm the self-regulatory process" (Beebe & Lachmann, 1994, p. 153).

Here, one can see the important parallels between the discussion of self-regulation as it has emerged in the psychoanalytic literature on psychosomatic illness and in the field of infant research. Where McDougall (McDougall, 1978/1992) points

to the dangers of the "satiating" versus "restrictive" mothers, current mother-infant research emphasizes the curvilinear relationship between the intensity of a mother's affective attunement and engagement with her infant: Infants of mothers who are intrusive in their efforts to connect to their infants, as well as infants whose mothers are emotionally unavailable and detached, later demonstrate insecure patterns of attachment and an inability to adequately regulate bodily states (Beebe Lachmann, 1994).

Finally, Beebe and Lachmann point to affect peaks as organizing moments, and note, further, that "heightened affects are simultaneously heightened arousal states (Beebe & Lachmann, 1994, p. 153). Again, this finding from the field of infant research supports the more inferential and speculative arguments of Krystal, McDougall, Fonagy and others who, working from a psychoanalytic perspective, with adult patients, have implicated early experiences of overwhelming affect in disturbances of self-regulatory processes of the body.

I. Summary

Psychoanalytically-oriented epigenetic theories of development suggest that in order for each of us to experience the vitality and richness of our emotional lives, to become empathically aware of ourselves, of our inner experiences, and of the inner experiences of others, we must pass through several stages of cognitive and emotional development. Necessary conditions for this passage include early experiences with caretakers who are consistently able to provide safety, nurturance and containment in face of the inevitable affect storms of infancy and early childhood.

Theory and research from the fields of affect, object relations and attachment theory suggest that disturbances in the earliest infant-caretaker dyad can have profoundly deleterious consequences for the development of the capacities for internal affect regulation, representation and object relatedness.

Empirical studies and clinical observations of patients diagnosed with chronic somatic distress suggest that these areas of psychological dysfunction and impairment are also implicated in these regulatory disturbances of the body and of the self (Salisbury, 1990; Taylor, 1994; McDougall, 1982-83; Fonagy and Moran, 1994; Winnicott, 1964/1992).

More specifically, however, it is the underlying premise of this study that it is the capacity for "reflective self-function" (Fonagy, 1992) born out of an evolving experience of intersubjective attunement with caretakers (Stern, 1985) which ultimately enables an infant, and later, a young child, to symbolize his/her own inner and interpersonal experiences, and thereby regulate physical and emotional stimulation.

Out of our earliest interactions grow our first representations of self and others. These experiences create, in Stern's words, "an organizing subjective perspective that can be called a sense of a core self" (Stern, 1985, p. 99). Stern's idea of the "core self" is, I believe, very close to Winnicott's notion of the "body-ego organization" (Khan, 1991). This is critical to an understanding of somatization because it is by way of the "core self," and through the "body ego organization," that one is able, eventually, to represent effectively and symbolically that which was first experienced somatically (Winnicott; Khan; Greenspan; Orbach; Fonagy; Wilson).

It is, in other words, the organization of a subjective and cohesive self as it unfolds in the context of a child's earliest relationships which facilitates the development of representational abilities, affectivity, and the capacity for self-care (McDougall, 1978/1992).

By linking the underlying psychodynamics of the processes of somatization to early disturbances in the infant-caretaker dyad which impede the development of the capacities for subjectivity, symbolization, and affect regulation, we may deepen our understanding of somatization. In this way, we may open the door to more sensitive and effective therapeutic approaches to working with individuals whose lives both affirm and defy the unspeakable relationships between mind, body and experience.

CHAPTER THREE

METHODOLOGY

> A river can be represented in a photograph, which fixes its flow and makes it possible for it to be viewed and grasped. Yet the movement of the river, in its larger course, cannot be grasped in a moment. Rivers and selves, like music and narratives, take time to happen in.
>
> -Stephen Mitchell, 1993.

A. Rationale for the Design of the Study

As suggested in the quote above from Stephen Mitchell, life is an experience of continuity and discontinuities. An exploration of the vicissitudes of affectivity and object relatedness in the context of somatic symptomatology therefore requires an intensive, longitudinal model of investigation. This study followed the single-case paradigm of research (Barlow & Hersen, 1984); this method has been increasingly employed in psychotherapy process and outcome studies (see, for example, Jones, 1993; Jones, Ghannam, Nigg & Dyer, 1993; Moras, Telfer & Barlow, 1993). In doing so, I was able to follow the fluctuations in somatic symptoms as they related to shifts in affectivity and relatedness over time. This process closely approximated the experiences of psychotherapists and medical practitioners working with somatizing patients over extended periods of time.

The rationale for this type of design derives from the use of time-series analyses in recent single- and multiple-case studies employed in psychotherapy research (Jones, 1993; Jones, et al., 1993; Moras, et al., 1993) and medical outcome studies (Fonagy & Moran, 1990; Hays, Marshall, Wang & D., 1994; Hull, Okie, Gibbons & Carpenter, 1992). Findings from this new body of research suggest that single-case studies may

help us test theoretical models and refine clinical theory (Kazdin, 1992; Jones, 1993) because the data are closer to subjects' subjective daily experiences.

These studies also illustrate the "limitations of controlled clinical trials for informing us about how patients change through psychotherapy" (Jones, 1993, p. 371). It is evident from clinical observations of somatizing patients, for example, that the course of somatic symptoms varies considerably both from person to person and within the experience of a given individual as life circumstances shift (McDougall, 1978/1992; Fonagy and Moran, 1994). In line with these observations, Jones notes in a recent review of the utility of single-case designs that aggregate data derived from group studies often has little relevance to the nuances of clinical material which patients bring to their psychotherapy sessions. Jones suggests, instead, that "single-case research... is the only means for testing clinically important hypotheses about within-subject change and variation" (Jones, 1993, p. 371). It is for these reasons that a single-case design was selected as the most theoretically appropriate, and clinically relevant, experimental design for this project.

It is in keeping with the paradigm of intensive, clinical research to have as principle vehicles for clinical assessment instruments which are sensitive not only to the stability of personality traits but to changes in mood as well. It is for this reason that this study relied principally on the structural and thematic vicissitudes of narrative samples as reflections of subjects' shifting inner states.

B. Subjects

The subjects in this study were three women between the ages of 20 and 55. All three women were college graduates, and were currently employed. Initial eligibility was based on 1) evidence that each subject experienced medically unexplained somatic distress based on their personal accounts of their symptoms and help-seeking behaviors, and 2) an indication based on SCL-90-R scores that subjects had elevated levels of somatization symptoms compared to normative non-patient samples. Scores collected in the Initial Screening Interview indicated that each subject scored above the mean non-patient normative sample score (.36) on the SOMATIZATION subscale of the SCL-90-R by at least .47, with raw scores ranging from .83 to 1.17. Mean scores for the subjects over the course of the Twenty Week Protocol, though lower, were also above the normative sample score of .36, with mean scores ranging from .48 to .77.

C. Selection Criteria for Participation in the Study

Since this is a within-subjects design, I did not try to select a homogenous group of subjects. The study explored, instead, the clinical implications of the relationship between each individual subject's shifts in relevant psychological factors and fluctuations in somatic symptomatology.

Inclusion Criteria

1. Women, between the ages of 20 and 55.
2. A history of chronic somatic distress without adequate medical explanation.
3. A score on the SOMATIZATION subscale of the SCL-9-a-R above the normative sample mean score of .36.

4. Reported interference of somatic symptoms with functioning in social and/or occupational spheres of activity.
5. Repeated help-seeking behaviors related to the principle complaints.
6. Capacity to produce a narrative in reasonably fluent English.

Exclusion Criteria

1. Current evidence of psychosis.
2. Current evidence of substance abuse.
3. Current evidence of confounding medication regimens.

D. Procedure

I. Recruitment

Interested subjects responded to advertisements posted in their neighborhoods. Following a brief telephone screening interview (Appendix K), possible subjects were invited to participate in an Initial Screening Protocol interview.

The three subjects giving written consent were screened in an Initial Screening Protocol, and selected as participants in the study on the basis of the inclusion and exclusion factors outlined above.

II. Confidentiality and the Protection of Subject's Rights

Subjects were asked to sign a consent form (Appendix C) which explained study procedures and provisions for protecting subjects' rights and confidentiality. Subjects signed one form prior to commencing the Initial Screening Protocol.

III. Initial Screening Protocol

Overview:

I met with each subject giving written consent for a two-hour interview in order to assess relevant personality and psychiatric factors. Instruments included in the Initial Screening Protocol are outlined in the Instruments section of this chapter.

Subjects were paid $10 for each hour of their time, and tokens were provided to subsidize transportation costs to and from the interview site when appropriate.[10]

Three individuals participated in the Initial Screening Protocol. Following completion of the screening interview, these individuals, each of whom met selection criteria as outlined above, were invited to participate in the twenty-week protocol.

Following the completion of the twenty-week series of interviews, subjects were invited to participate in a follow-up debriefing telephone interview (Appendix D). This was designed to assess any changes in the symptomatology, and also, to give each subject an additional chance to reflect on, and react to, her experience of participating in the study. All subjects accepted the offer, and interviews were scheduled to be held approximately eight weeks later.

Initial Screening Protocol

Description of Procedures:

The Initial Screening Protocol had three sections. All interview material was tape-recorded and transcribed for later analysis.

[10] In some cases, interviews were conducted in subject's home.

I. The first portion of the Initial Screening Protocol was a clinical assessment of the subject's history of chronic somatic distress using the SCL-90-R and a medical history questionnaire. No effort was made to match subjects for symptom type.

II. The second portion of the Initial Screening Protocol consisted of a semi-structured clinical interview (Illness Narratives Interview - I, Blaustein, 1994) designed to assess each subject's experiences with, and perceptions of, her own physical symptoms and related family illnesses.

III. The third portion of the Initial Screening Protocol included the administration of five instruments designed to assess general personality functioning, psychopathology and relevant biographical information. These data were collected in order to most meaningfully and qualitatively assess the impact of these factors on symptom course for each individual participating in the study. In addition, data derived from this portion of the interview was used to identify for exclusion from the study any subjects not meeting the selection criteria outlined above.

The five instruments administered during this portion of the interview include four paper-and-pencil measures (Demographic Information Form; SCL-90-R; TAS-20; Trauma History Questionnaire) and one verbal measure, the Gottschalk Five-Minute Speech Sample (see Instruments section for a description of each measure).

IV. Twenty-Week Protocol

The three subjects who met the eligibility criteria participated in weekly interviews administered over the course of twenty weeks. Each weekly interview lasted

approximately one hour. Subjects were paid $10 for each interview, and subway tokens were provided to subsidize transportation costs to and from the interview site when appropriate (see above).

The three instruments administered during the weekly interviews included the Illness Narratives Interview-II (INI-II), the Recent Experience Memory Test (REM), and the SCL-90-R. Each of these instruments is described in the instruments section below. All oral material was tape-recorded and transcribed for later analysis.

E. Instruments

INITIAL SCREENING PROTOCOL: INSTRUMENTS (8)	INITIAL SCREENING PROTOCOL: SCORING METHODS	TWENTY-WEEK PROTOCOL: INSTRUMENTS (3)	TWENTY-WEEK PROTOCOL: SCORING METHODS
Illness Narratives Interview-I (INI-I)	N/A	Illness Narratives Interview-II (INI-II)	N/A
Five-Minute Speech Sample (Gottschalk, 1968)	The Differentiation-Relatedness Scale of Self and Object Representations (Diamond, 1993)	Recent Experience Memory Test (REM)	Epigenetic Assessment Rating Scale (EARS)
SCL-90-R	N/A	SCL-90-R	N/A
Medical History Questionnaire	N/A	*******	*******
Toronto Alexithymia Scale	N/A	*******	*******
Trauma History Questionnaire	N/A	*******	*******
Bell Object Relations and Reality Testing Inventory*	N/A	*******	*******
Biographical Information Form	N/A	*******	*******

*The Bell Object Relations and Reality Testing Inventory was administered twice, in the first and last interviews.

I. Instruments included in the Initial Screening Protocol:

Section One of the Initial Screening Protocol:

Clinical assessment of unexplained chronic somatic distress based on subject's description of her medical history and experiences with reported symptoms and help-seeking behaviors. This included as well the administration of the Medical History Questionnaire (Cornell Internal Medicine Associates, 1994, Appendix H).

Section Two of the Initial Screening Protocol:

Illness Narratives Interview - I, (Blaustein, 1994, Appendix F).

This questionnaire was designed to elicit qualitative and subjective accounts of subjects' experiences and memories of illness, relationships to the medical community and to significant others in the context of illness experiences. The INI-I was administered during the Initial Screening Protocol in order to facilitate the building of an alliance with subjects. The INI-I takes about 20-30 minutes to complete.

A shorter version of this measure was also given on a weekly basis to assess changes in medical symptoms and subjective perceptions relating to most recent experiences of health and illness.

Section Three of the Initial Screening Protocol:

1. Bell Object Relations and Reality Testing Inventory (BORRTI) (Bell, 1991, Appendix A). The BORRTI is a self-report questionnaire consisting of ninety items. The scale was designed to assess the ego functions of object relatedness and reality testing.

The BORRTI was administered during the Initial Screening Protocol and in the last of the twenty weekly interviews in order to assess possible changes in object relatedness over the course of the twenty weeks. The BORRTI takes about 20 minutes to complete.

The BORRTI subscales were derived through factor analysis and ten years of studies have shown the object relations factors to be valid and reliable (Bell, 1991). Test-Retest reliability, which is particularly relevant for this study since the test was used once at the beginning and once at the end of the study, indicated that the scale is sensitive to changes in state. A review of the BORRTI in Test Critiques found it a reliable and valid assessment tool for object relations and reality testing (Bell, 1991; Alpher, 1990).

For this study, only one of the object relations subscales was considered ("Alienation"). High scores (T>60) on this subscale have been found to correlate with personality disorders, basic mistrust in relationships and is rarely found in high functioning normals. Bell suggests that alone, this scale may signal an avoidance of "the painfulness of relatedness by keeping others at a distance" (Bell, 1991, p. 12).

2. Biographical Information Form (Blaustein, 1994, Appendix B).

This is a basic form adapted from standard demographic measures designed to elicit information regarding SES, age, etc.

3. Five-Minute Speech Sample (Gottschalk, 1968)

In this version of the Five-Minute Speech Sample (Appendix E), subjects were asked to describe each of their parents in two five minute monologues. This modification derives from the development by Blatt (1979) and Diamond (1990) of a projective measure which employs the technique of eliciting narrative speech samples from subjects.

This measure is included in the present study for two reasons. First, the measure was used in order to assess potential subjects' capacity for narrative production. Second, these narratives were analyzed for clinical features of each subject's object relational world.

4. Symptom Checklist-90-Revised
(Derogatis, 1975; Derogatis, 1977, Appendix J).

The SCL-90-R is a multi-dimensional self-report symptom inventory used to assess symptomatic psychological distress and the physical symptoms most commonly associated with various forms of psychopathology. The questionnaire takes approximately 15 minutes to complete.

"The SCL-90-R reflects psychopathology in terms of 9 primary symptom dimensions and 3 global indices of distress. The nine symptom dimensions include Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation and Psychoticism." Of most importance, for this study, are the indices of Somatization, Depression, Anxiety, and Psychoticism (an exclusion criterion).

Of the three indices of global severity assessed on the SCL-90-R, only the "Global Severity Index" (GSI) was included in statistical analyses. The GSI combines information on numbers of symptoms and intensity of distress, and it has been found to be a highly reliable measure of distress. The GSI has been used widely in various studies in psychiatric, medical and non-medical settings (See, for example, (Acklin, Bibb, Boyer & Jain, 1991; Beck, et al., 1988b; Buckelew, et al., 1988).

Validation of the instrument has been approached using a wide array of populations. The SCL-90-R has shown high levels of both internal consistency and test-retest reliability. Yet, importantly for this study, the measure has also proven itself to be very sensitive to change in a broad variety of clinical and medical contexts. Of particular interest is the instrument's sensitivity to stress-related changes. The SCL-90-R has also been used extensively in a number of medical contexts, both as a screening tool and as an outcome measure.

Of particular relevance is research supporting the validity of the SCL-90-R as a sensitive psychological distress measure with pain patients (Derogatis, 1975). Also of interest for this study is the recent finding by Acklin and his colleagues that psychopathology (and somatization in particular), as measured on the SCL-90-R, correlated highly with the quality of relationships as expressed in subjects' early memories (Acklin, et al., 1991).

In addition to its application in the Weekly Protocol as a measure of Somatization, the SCL-90-R was administered in the Initial Screening Protocol of this study in order to identify for exclusion those subjects showing evidence of psychoticism.

5. Toronto Alexithymia Scale-20
(Bagby, Taylor & Parker, 1992a; Bagby, Taylor & Parker, 1992b, Appendix L).

The TAS-20 is a self-report index of Alexithymia, defined as "a cognitive-affective disturbance that affects the way individuals experience and express their emotions" (Taylor, 1984). The TAS-20 was administered once during the Initial Screening Protocol, and scores were included in qualitative analysis of the data. This scale takes about 10 minutes to complete.

The TAS-20 represents a revised version of the original TAS which had 26 items, and was found to have some problems with the compositional structure (Bagby, et al., 1992a). "The Tas-20 showed good internal reliability and test-retest reliability, and a 3-factor structure theoretically congruent with three major facets of the alexithymia construct -- difficulty identifying feelings, difficulty describing feelings, and externally-oriented thinking" (Bagby, et al., 1992a).

Alexithymia has been strongly correlated in clinical observations and some empirical studies with the presence of Somatization Disorder and chronic pain syndromes (McDougall, 1974; McDougall, 1978/1992; McDougall, 1982-83; McDougall, 1989; Mendelson, 1982; Nemiah, 1975; Nemiah & Sifneos, 1970; Taylor, 1987; Wise, et al., 1990). This instrument has been relatively well-validated with other measures (The Psychological Mindedness Scale, Need for Cognition Scale, NEO-Personality Inventory).

6. Trauma History Questionnaire (THQ)
(Green, in development, Appendix M).

The THQ is an experimental self-report inventory designed at Georgetown University Medical Center to collect data about past traumatic events. It was designed for use with an outpatient population, and it is based on the "high magnitude" stressor questionnaire used in the DSM-IV field trials (Green, personal communication). The THQ takes about 15 minutes to complete.

The instrument consists of 24 items addressing a range of traumatic events (including injury, disaster, abuse) and asks subjects to indicate whether these events have occurred, and if so, at what age and who was involved. The authors write that this was designed to be a "relatively complete inventory of events that are consensually considered to be potentially traumatic without being overly detailed or intrusive for use with general/community populations" (Green).

Since the THQ is an experimental instrument, reliability and validity data is limited. A pilot study (n=25) suggested, however, that test-retest reliability was relatively high (Green).

II. Instruments included in the Weekly Protocol

1. Illness Narratives Interview - II (Blaustein, 1994, Appendix G).

As indicated above, the Illness Narratives Interview - II (INI-II) was designed to assess each subject's most current perceptions and severity ratings of her physical symptoms. In addition, the INI-II was designed to elicit subjects' representations of their most recent experiences of dealing with other people around the subjects' own somatic problems.

2. Recent Experience Memory Test (REM), (Blaustein, 1994, Appendix I). Subjects were asked to describe the single Best and Worst experiences they had had in the past week which involved at least one other person. This modification of the well-known Early Memories Test, used widely in projective testing studies (Adelman, 1993; Mayman, 1968), was designed to capture both the projective and representational quality of the standard Early Memory Test.

Various sources of projective material have been studied in recent years as invaluable windows into the texture of personality functioning and object representation. Mayman's (1968) investigations of early memories, Krohn and Mayman's studies of dreams (Krohn & Mayman, 1974), along with research into recent memories of interpersonal experiences (Barends, Westen, Leigh, Silbert & Byers, 1990), open-ended descriptions of others (Blatt, Wein, Chevron & Quinlan, 1979; Diamond, Kaslow, Coonerty & Blatt, 1990), and, finally, on-going explorations of the object representational themes of Rorschach responses (Tuber, 1989; Urist, 1977) represent just a few of the studies which have as their premise the idea that internal object representations are intimately linked with psychological adjustment and adaptation. The combined findings of these studies suggest that "the level of object representation appears to be a salient, consistent, researchable personality dimension..." (Krohn and Mayman, 1974, cited in Acklin et al. 1991, p. 178). It has been suggested that early memories, in particular, reflect "the quality and range of the individual's internalized repertoire of interpersonal relationship paradigms" (cited in Acklin, 1991, p. 179).

The instructions for the Recent Experience Memory Test (REM) (Blaustein, 1994) resemble those given for the TAT. The investigator instructed subjects to describe the single Best and Worst experiences which occurred during the previous week, which involved at least one other person. The "other person" was included in the protocol in order to elicit an interpersonal, object relational paradigm (See, for example, Barends, et al., 1990). In addition, subjects were instructed to describe what each person was doing, thinking and feeling, what led up to the event, and what followed. The aim, in other words, was to elicit episodic memories which include both relational and affective dimensions.

In their development of the Epigenetic Assessment Rating Scale, Wilson and his colleagues had clinicians rate TAT cards for their levels of arousal. Cards 1 and 13MF were found to reliably represent low and high levels of arousal respectively. While I make no claim, here, that the Best and Worst REM narratives replicate the TAT stimuli in terms of arousal, it is clinically relevant to note how subjects are able to represent self, other and the affective links between people in experiences which they themselves classify as more or less stressful.

Barends et al. (1990) found, for example, that affect tone of TAT narratives and the affect tone of narratives representing pleasant and unpleasant experiences with others over the last two years were highly correlated. By requesting the Best and Worst memories, I hoped to capture more of an individual's range of functioning than a single memory might reveal.

The REM was incorporated into a small pilot study to see what kind of material it would yield. Results were promising. Pilot study data suggested that such accounts

of recent experiences can produce projective material similar to that produced in TAT responses, open-ended descriptions of others, and early memories, all of which have been successfully analyzed for object relational themes and affective style with the Epigenetic Assessment Rating Scale (Wilson, et al., 1988; Passik, 1990; Adelman, 1993).

3. SCL-90-R (Derogatis, 1975; Derogatis, 1977, Appendix J).
(See above for a full description of the measure).

Although all subscales were scored, the subscale of central interest for the weekly protocol is the Somatization scale. The Somatization subscale was scored in order to assess fluctuations in somatic symptoms in the context of fluctuations in affectivity and relatedness as represented and measured on the Recent Experience Memory Test. The Depression, Anxiety and other subscales were scored in order to keep a record of fluctuations in these symptoms and to correlate these fluctuations with somatic symptoms.

F. Scoring Methods

1. The Differentiation-Relatedness Scale of Self and Object Representations, (Diamond, et al., 1993).

Building on the work of Blatt and others, this scale was designed to assess, along more thematic rather than structural lines, an individual's developmental level of object relatedness and capacity for intersubjectivity. It is a 10-point scale which ranges, as the authors put it, "from self/other boundary confusion at the more primitive levels, through various levels of separation-individuation corresponding to early

differentiation... to higher levels of object constancy, identity, intersubjectivity and construction of meaning" (Diamond, et al., 1990, p. 370).

In a recent study, Diamond et al. found that patients' representations of self and others grew increasingly differentiated toward the end of treatment: "Patients show a clearer sense of boundaries and separateness, as well as a greater degree of empathic relatedness" (Diamond, et al., 1990).

Preliminary interrater reliability findings were strong (.83) when the ratings of 90 descriptions assigned by five independent judges were compared (Diamond et al., 1993).

This scale was included in the present study in order to assess, along with the EARS object relations dimensions, the degree to which subject's internal experience was thematically and defensively dominated by a need to guard against fluid and unpredictable boundaries between self and other or, conversely, by a capacity for intersubjective experience characterized by empathic relatedness and mutuality.

This scale was used to assess the thematic qualities of object relatedness in the two five-minute monologues generated by each subject during the Initial Screening Protocol.

2. Epigenetic Assessment Rating Scale (EARS) (Wilson, et al., 1988, Appendix N).

The EARS is "an instrument designed for psychoanalytically informed research on clinical processes and personality organization" (Wilson, et al., 1988). Designed originally for use with the TAT (Murray), the EARS has been used to score a variety of narrative sources, including early memories (Adelman, 1993), speech samples, (Passik,

1990), and psychotherapy process material from therapeutic sessions (Wilson, in progress).

One advantage of the EARS, when used with the TAT (Wilson, et al., 1989) and with traumatic and non-traumatic memories (Adelman, 1993), is that it allows raters to score responses under conditions of low and high arousal, thereby enabling researchers to track fluctuations in functioning across a variety of stimuli and situations.

The EARS is organized along a developmental continuum with five modes, such that each narrative production is scored for the modal level of developmental functioning for each of the EARS' ten dimensions. The four dimensions of interest for this study include Affect Tolerance, Affect Expression, Empathic Knowledge of Others, and Use of the object.

The hierarchical organization of the EARS is based on the schema outlined by Gedo (1973; 1979). Modes I, II and III of the EARS represent the earliest phases of developmental experience, and together constitute the pre-subjective period of psychological functioning.

Mode I represents the mode of functioning most characteristic of the earliest developmental period, where experience is global and responses are generally in an enactive, sensori-motor mode. Primary dangers include overstimulation and annihilation. Defenses are organized around escape in the form of explosive outbursts, sleep or death.

Mode II operations are slightly more advanced, allowing for discrimination between pleasurable and painful experiences. This mode represents a transition between the enactive and imagistic levels of Modes I and III (Passik, 1990). Primary

dangers of Mode II include separation from, and intrusive merger with, powerful others. Defenses such as splitting and denial generally enable the individual to block out painful and contradictory affects.

Mode III allows for the primitive integration of contradictory experiences and the positioning of oneself in the world of objects. Primary dangers include threats to one's self-esteem. Defensive strategies may include grandiosity, idealization and contempt, along with a rather rigid adherence to stereotypy.

Modes IV and V represent more sophisticated levels of functioning, and are considered more fluid and flexible than the first three modes. Mode IV is characterized by oedipal conflicts. Contradictory experiences are acknowledged and tolerated, but without satisfactory resolution. The primary dangers include competition, rivalry and moral anxieties. Defenses are more complex than at the lower modes, and include such maneuvers as intellectualization, reaction formation and rationalization.

Mode V is characterized by flexible and benevolent tolerance and resolution of conflicts. Aggression, negative and positive affects are all available, but contained. Primary dangers stem from the poignant realities and emotional demands of human experience when lived most fully.

The authors of the EARS assume that any individual may have access to all five modes during one's lifetime. While the assumption guiding this study is that functioning in individuals during a somatic eruption may be characterized by relatively low EARS scores by virtue of the affective and relational difficulties implicated in the etiology of the disorder, the scoring system is adopted here because it is also sensitive to fluctuations in functioning.

The EARS was chosen to score the narrative samples in this study in order to assess in as sensitive a manner as possible each subject's capacities to function in the general areas of affectivity and object relatedness. Specifically, I chose the dimensions of Affect Tolerance and Affect Expression in order to assess shifts in each subject's ability to manage affect, and Empathic Knowledge of Others and Use of an Object in order to assess subjects' shifting capacities for object relatedness. These four dimensions were used to score each subject's representations of her recent memories of the best and worst interpersonal episodes (Recent Experience Memory Test) she described each week. Presented in more detail in Appendix N each dimension is described here briefly:

Descriptions of EARS Dimensions Employed in this Study:

Affect Tolerance refers to the way individuals "manage their affective arousal" (Wilson, 1988). Mode I represents an extreme intolerance for affect demonstrated through explosive bursts of activity and direct action whereas Mode V indicates a capacity to tolerate conflictual and complex affect states (Wilson, 1988).

Affect Expression refers to how subjects are able to express and communicate affects to others. Mode I represents the expression of "global and undifferentiated affects" whereas Mode V responses included a full range of affects (including love, grief and anger) which are accepted as "ego-syntonic" (Wilson, 1988).

Empathic Knowledge of Others deals with the capacity to tune into and understand the inner emotional experiences of self and other; that is, to see and represent self and others as having "separate psychologies and perspectives" (Wilson,

1988). Mode I responses represent empathy as a "contagion of affect." People are not separate or differentiated psychologically. Mode V responses recognize that people have "independent and integrated psychological existences."

Use of an Object refers to the ways in which interpersonal relationships are organized and the psychological aims they serve for each person. Mode I responses indicate a "physical use of an object" designed to manage and respond to someone's most basic dependency needs. By contrast, Mode V responses reflect the capacity for intimate relatedness, where the "object is used unselfishly for the enhancement of others as well as the self" (Wilson, 1988).

Reliability

Inter-rater reliability was found by the authors of the EARS to be the most appropriate type of reliability for the scale (Wilson, 1988). Consequently, reliable scoring for the EARS is achieved through an extensive training and reliability trial period for each individual planning to score data with the scale. "Raters must be sensitive to subtle distinctions between dimensions, and be careful to score them independently rather than allow one score to bias another for a particular subject" (Wilson, 1988, p. 28).

Wilson et al. set the criteria for qualification as an expert rater at the following level: 90%. of the judgments must be between +1 and -1 scale point with a minimum of 50% exact matches, all compared with those of an already qualified expert rater" (Wilson, 1988, p. 27).

Five raters, including the investigator for this study, worked together for 18 months, beginning 12/93, in order to achieve reliability on the EARS. Raters met weekly or biweekly, with regular consultations with the primary author of the scale (Wilson), in order to become familiar with the underlying theoretical principles, and to develop reliable scoring skills on a range of narrative samples, including TAT cards, memories and psychotherapy transcripts.

All five raters qualified as expert raters in the spring of 1995. Raters were reliable with previous expert raters, and all members of the coding group achieved inter-rater reliability with each other, on three distinct styles of narrative material: TAT cards; memories; psychotherapy transcript data. The inter-rater reliability criterion was set at .80.

For this study, raters again scored recent memories in June, 1995, in order to sharpen coding skills and to ensure that reliability on this type of data had been maintained. Inter-rater reliability figures ranged from .90 to 1.0.

The 120 narrative samples collected for this study were then divided randomly among four raters (not including the investigator for this study). Mid-point in each rater's batch of memories, the rater and the investigator scored five of the same memories in order to guard against coder drift. Reliability figures ranged from .90 to 1.0.

Validity

Validity for the affect and object relations dimensions of the EARS has been provisionally achieved through a series of studies. Of particular note is a study of the

relationship between parental affectivity and their schizophrenic children's premorbid adjustment. Results indicated that parental "emotional over-involvement was correlated with difficulties in affect tolerance and expression." In addition, the EARS "appeared to be sensitive to aspects of enmeshed and dependent object relations in parents of schizophrenics that are associated with their children's symptoms and course" (Passik, 1990).

Keller found that the EARS successfully discriminated between normal subjects and cocaine and opiate abusers on the dimensions of affect tolerance and self-other differentiation. On the dimension of affect expression, opiate and cocaine abusers were significantly different from each other and from normals (Keller, 1989).

Finally, Adelman (1993) found significant correlations using the EARS and the Krohn Scale for Object Relations between capacities for affectivity and for relatedness in women who survived the Holocaust and their adult daughters.

CHAPTER FOUR

HYPOTHESES

I live in company with a body, a silent companion, exacting and eternal.

-Eugene Delacroix, 1824.

This is an exploratory study. As such, this research was designed, first, to experimentally operationalize current theoretical and etiological notions about somatization. Second, this study has tried to link these ideas to a method of clinical inquiry which is sensitive to the vicissitudes of human experience and the therapeutic enterprise. For these reasons, some of the following hypotheses have been framed as exploratory research questions rather than as predictions. When a prediction is made regarding the direction of the relationship being tested, a rationale for that prediction is provided.

Hypotheses

Hypothesis One: The first hypothesis explores the construct validity of the Illness Narratives Interview-II (INI-II), a semi-structured interview also designed to elicit the specific nature, number, and intensity of each somatic complaint reported by the subject each week. Specifically, I wanted to explore the relationship between the widely used and standardized measure of somatization, the SOMATIZATION subscale of the SCL-90-R, and the INI-IT.

Rationale: The INI-II was included in the study in order to assess those experiences of somatic distress which may not be included in the rather general somatic

symptom list provided in the SCL-90-R inventory. Representations of chronic somatic distress, particularly as experienced by individuals with a chronic pain (or other quite specific) condition may be easier to elicit with a more open-ended questionnaire than with a standardized checklist.

Moreover, people describe their symptoms in treatment - both medical and psychological - in open and often random ways. The INI-II was therefore designed to mirror the presentation of symptoms as it might generally occur in a therapeutic setting.

Hypothesis Two: Which of the eight EARS scores assigned to REM narratives each week will best predict weekly levels of somatic distress? The speculative prediction is that the affect dimensions of the EARS will be more strongly correlated with somatic distress than will the object relational dimensions. In addition, it is predicted that these correlations will be negative: When affectivity increases, reported levels of somatic distress will decline.

Rationale: There are four dimensions of the EARS included in this study. Two of these dimensions relate explicitly to affectivity: Affect Tolerance; Affect Expression. The other two dimensions deal with aspects of object relatedness: Empathic Knowledge of Others; Use of an Object. Each Recent Experience Memory (REM) will be scored along these four EARS dimensions.

Each EARS dimension (described in the Methods chapter above) represents a different aspect of psychological functioning which, theoretically, is related to early emotional experiences with others. In the lower modes, experience revolves around the

satisfaction and regulation of basic needs such as those managed in mother-infant relationships. In the higher modes, the capacity for abstract representation and perspective-taking make a range of emotional and interpersonal responses possible.

Although somatization processes have also been speculatively linked to disturbances in early relationships (McDougall, 1978; 1989), affect regulation rather than object relatedness has been the focus of most clinical discussion and empirical observation of somatizing patients. The link between affect and somatic processes is also more strongly established theoretically. For these reasons, the correlations between affect and somatic distress have been predicted to be the strongest. Nevertheless, it will be useful to examine how fluctuations in all four of these dimensions of psychic life are related to fluctuations in somatic distress.

Hypothesis Three (a): What is the relationship between the combined weekly mean scores assigned for the two affect dimensions of the EARS and the combined weekly mean scores for the two object relational dimensions of the EARS under each arousal condition (Best and Worst)?

Hypothesis Three (b): Will the combined weekly mean scores for affect or object relatedness be more strongly associated with weekly reports of somatic symptoms? The hypothesis is that the combined affect dimensions will be more strongly associated with somatic distress.

Rationale: Clinical observations have long linked problems with affect regulation to somatization. More recent studies (see Hull, 1992) have also suggested

that psychosomatic symptomatology is related to deficits in object relatedness. This hypothesis explores the temporal relationship of shifts in each of these two general domains of functioning to eruptions and remissions in somatic distress and symptomatology.

Hypothesis Four (a): What is the relationship between REM-Best narratives and REM-Worst narratives?

Hypothesis Four (b): Will there be any significant relationships between the average weekly scores assigned to the Recent Experience Memories (REM-Best and REM-Worst) and weekly levels of somatic distress (as measured on the SCL-90-R and on the INI-II)? The speculative hypothesis is that weekly EARS scores for REM-Worst will be negatively and more strongly correlated with reported levels of somatic distress. Cross-lagged analyses will be performed in order to determine the temporal relationship among factors.

Rationale: It is has been found that the evocation of positive as opposed to negative experiences or fantasies can evoke different states of emotional arousal in the subject (Barends, 1990; Wilson, 1988). It is speculated that as subjects in the present study recall pleasant as opposed to distressing recent interpersonal events they may access and thereby expose different aspects of their inner experience. In other words, they may reveal the range of functioning with which they manage their lives under more and less stressful conditions. Finally, it is a central premise of this study that subjects'

somatic distress may reflect shifts in their ability to effectively regulate and manage their affective and interpersonal experiences.

For these reasons, I wanted to examine the relationship between somatic distress and how individuals function when they feel they are at their best as well as when they must confront more painful experiences.

Qualitative Data

In addition to the hypotheses outlined above, four additional aspects of each subject's inner life and phenomenological experience will be examined. Data collected only once (during the Initial Screening Protocol) are not appropriate for statistical analysis. Therefore, these data will be treated descriptively.

I. Trauma: Herman (1992b) has suggested that chronic traumatic experiences may lie at the root of somatization processes. What role has the experience of overt trauma played in the lives of the subjects in this study? Can subjects' experience of somatic distress be linked to their having lived through one (or more) traumatic experience(s)? These questions will be addressed by examining subjects' responses to the Trauma History Questionnaire (Green).

Rationale: A central debate in the field of psychosomatic medicine revolves around the extent to which traumatic experiences must be acute in order to precipitate somatization processes. Herman, for instance, has emphasized the experience of overt, visible trauma. By contrast, Krystal (1988), Khan (1991), and Taylor (1987) have emphasized the importance of invisible, cumulative trauma as a necessary, though not sufficient, condition for psychosomatic tendencies to emerge. This exploration is

intended simply to highlight the possible role that overt trauma may have played in the etiology of the somatic processes demonstrated by the women in this study.

II. Alexithymia: Alexithymia is a term coined by the french psychosomaticists (M'Uzan, 1974; Nemiah, 1970). Somatizing patients have been repeatedly described as alexithymic by clinicians and researchers (McDougall, 1978; 1989; Taylor, 1987).

I want to explore the extent to which the subjects in this study can be classified as truly "alexithymic". That is, does their management of affect correspond to that typically seen in somatizing patients. Further, I want to explore what relationships might exist between subjects' levels of alexithymia, as measured on a standardized scale, and their experiences of somatic distress. Finally, I want to explore the extent to which levels of alexithymia correspond to subjects' affectivity as assessed on the affect dimensions of the EARS. Alexithymia will be assessed by administering the Toronto Alexithymia Scale-20 (Bagby et al, 1992b).

Rationale: These questions are based on earlier findings linking alexithymia and problems with affect regulation in general to psychosomatic processes (McDougall, 1982; Nemiah, 1970; Taylor, 1984). The assumption here is that TAS-20 scores will reflect each subject's capacity for abstract, affectively-laden cognitions. Therefore, these scores should have a strong relationship to each subject's ability to manage affect in verbal rather than non-verbal (and possibly somatic) modes.

III. Parental Representations: Blatt (1979), Diamond (1990; 1993), and others have suggested that early experiences "organize and guide subsequent interpersonal

experience" (Diamond, 1993). What clues, then, can a subject's adult representation of her early caregivers give us about her current relational paradigms? To what extent does the quality of these representations correspond to the object relatedness as measured on the EARS? Is there any relationship between the quality of these representations and each subject's experience of somatic distress?

These questions will be explored by scoring each subject's narrative descriptions of her parents. These descriptions were collected during the Initial Screening Protocol by administering the Five Minute Speech Sample (Gottschalk, 1968). These narratives were then scored with the Differentiation-Relatedness Scale of Self and Object Representations (Diamond et al., 1993).

Rationale: These questions are based on the idea that the capacity to represent self and others as separate, unique and empathically related individuals represents a high achievement in the realm of object relatedness. It is assumed, further, that early experiences (and/or a mutative psychotherapeutic experience) enabled such an achievement. Scores in this area should, therefore, be negatively correlated with chronic somatization if, indeed, somatic processes are linked to early disruptions in the area of self-other differentiation.

IV. Alienation: What relationship exists between the extent of malevolence subjects experience in the interpersonal world and each subject's management of somatic processes? Is there a meaningful relationship between each subject's experience of the interpersonal world as risky and her overall scores for each of the two object relational dimensions of the EARS (Empathic Knowledge of Others; Use of an Object)? Finally,

will there be any change over time in subjects' representation of interpersonal encounters?

These questions will be explored by examining subjects' scores on the Alienation dimension of the Bell Object Relations and Reality Testing Inventory (BORRTI) as administered in the first and final meetings with each subject.

Rationale: The Alienation dimension of the BORRTI has been found to have strong associations with basic mistrust in relationships (Bell, 1991). It is speculated, therefore, that disruptions in bodily regulation may be linked to evidence of a sense of personal and psychological isolation and inability to achieve satisfactory mutual intimacy in important relationships.

CHAPTER FIVE

RESULTS

Prologue

Generally, the interpretation of results is geared toward the goal of drawing generalizable conclusions across subjects. As indicated above, however, this is an exploratory study designed to open inquiry and operationalize accepted clinical theory about somatic processes. Although general findings will, of course, be noted, of equal interest for this study are those findings which are idiosyncratic to each subject. In order to examine the very personal and variable nature of each individual's somatic processes, results will be presented separately for each subject, with patterns and themes across subjects woven into the discussion of each hypothesis.

A. Descriptive Statistics. In this section, descriptive profiles of each subject will be presented. There are three sources for data relevant to the primary hypotheses, including the Symptom Check List-90-Revised, the Illness Narrative Interviews-II (the weekly measures of somatic distress give to each subject), and the Recent Experience Memory Test as scored on the four dimensions of the EARS.

1. Symptom Check List-90-Revised (SCL-90-R)

This self-report measure is scored on a 5-point scale, from 0-4, where 0 indicates "no distress" and 4 indicates "extreme distress." Raw scores collected weekly for each subscale were analyzed descriptively. Subscales include:

SOMATIZATION.....(SOM)
OBSESSIVE-COMPULSIVE..... (O-C)
INTERPERSONAL SENSITIVITY..... (I-S)
DEPRESSION.....(DEP)
ANXIETY.....(ANX)
HOSTILITY..... (HOS)
PHOBIC ANXIETY.....(PHOB)
PARANOID IDEATION..... (PAR)
PSYCHOTICISM.....(PSY)
GLOBAL SEVERITY INDEX.....(GSI)
POSITIVE SYMPTOMS DISTRESS INVENTORY.....(PSDI)

Table 1 shows the mean and standard deviations scores for the three subjects on the SCL-90-R subscales of interest. The SOMATIZATION Subscale is the key scale for this study. Because somatization has been so often linked with symptoms of DEPRESSION and ANXIETY, these subscales are also of particular interest.[11] In addition, post-hoc correlational analyses revealed that the OBSESSIVE-COMPULSIVE and PSYCHOTICISM subscales were associated with somatic distress. Therefore, these two scales are presented as well. Finally, Table 1 includes scores from the weekly computed ratings of the GLOBAL SEVERITY INDEX, a single score designed to capture the overall intensity of an individual's somatic and psychological distress as

[11] Somatic symptoms including pain (Beck, Scott, Teague, Perez & Brown, 1988b), lung disease (Buckelew, Burk, Brownlee-Duffeck, Frank & DeGood, 1988), and neurovegetative symptoms (Davidson, Krishnan, France & Pelton, 1985) have been associated with depression (see also, Acklin & Bernat, 1987; Blumer & Heilbronn, 1982; Hudson, Hudson, Pliner, Goldenberg & Pope, 1985). Approximately 50% of all patients presenting with undiagnosed medical symptoms will respond favorably to antidepressant medications (Biederman, 1994).

As with depression, anxiety and somatization are often linked. Somatic symptoms are typically associated with Generalized Anxiety Disorder (DSM-IV, 1994). It is well-known, for example, that Panic Disorders often appear first, phenomenologically, as somatic symptoms. Patients with medical problems often have elevated levels of both anxiety and depression (Beck, et al., 1988b). No literature exists, however, on the relationship between anxiety and the course of physical symptoms in somatizing patients.

If affectivity and object relatedness are markedly different with depressed (as opposed to anxious individuals), different therapeutic approaches to their somatization problems may be called for.

measured from the subject's responses to all of the 9 subscales on the checklist. Non-patient normative sample means have also been included for comparison.

As expected, all subjects show mean Somatization scores above the non-patient sample norm (.36). Subjects 1 and 3 also show mean scores well above the non-patient sample norms on the indices of Obsessive-Compulsive, Depression, Anxiety, Psychoticism, and for the Global Severity Index. Only Subject 2 (Ruth) shows mean scores comparable to (or lower than) the non-patient sample norms for the non-somatic indices of psychopathology.

Table 1
Mean and Standard Deviation Scores from Relevant SCL-90-R Subscales for each Subject and Non-patient Normals[12]

	Subject 1: Cindy	Subject 2: Ruth	Subject 3: Lisa	Non-patient Sample
	Mean SD	Mean SD	Mean SD	Mean SD
SCL-SOMATIZATION	.56 .45	.46 .40	.77 .36	.36 .42
SCL-OBSESS-COMPULSION	.80 .40	.31 .37	1.13 .39	.39 .45
SCL-DEPRESSION	1.00 .49	.24 .25	1.18 .41	.36 .44
SCL-ANXIETY	.62 .42	.12 .22	1.09 .53	.30 .37
SCL-PSYCHOTICISM	.41 .22	.08 .14	.74 .34	.14 .25
SCL-GSI	.72 .29	.21 .21	.95 .31	.31 .31

Of particular note is the fact that Ruth not only has lower mean scores for each index; she also has a much tighter range around her mean scores. That is, together, Ruth's mean and standard deviation scores for the non-somatic indices suggest that,

[12] See Derogatis, (1977).

overall, Ruth has significantly fewer symptoms of psychological distress than does either Cindy or Lisa.

2. Illness Narrative Interviews-II (INI-II)

This self-report measure of somatic distress is scored on a 10-point scale, from 1-10, where 1 indicates "least distress" and 10 indicates "most distress." The INI-II scores are divided into two basic categories:

1) Intensity of somatic distress, which includes weekly ratings of OVERALL Somatic Distress, HIGHEST discomfort rating assigned to any single complaint, LOWEST discomfort rating assigned to any single complaint, and a computed AVERAGE score of all ratings assigned to all complaints.

2) Frequency of somatic complaints, which includes weekly reports of the NUMBER (#) of symptoms reported. Reported somatic distress levels for the INI-II are presented in Tables 2a-c.

Subjects differed most on the NUMBER of symptoms reported weekly, with means ranging from 2.5 to 4.8. Whereas Subject 1 reported between two and five symptoms each week, and Subject 3 reported between one and four symptoms, Subject 2 reported between one and nine symptoms weekly.

Of additional interest is the fact that the intensity of Subject 2's somatic distress was less on all intensity indices of the INI-II. For example, her mean LOWEST rating was 1.72, whereas Subjects 1 and 3 had LOWEST means of 3.10 and 4.53 respectively. Likewise, Subject 2 had a mean OVERALL rating of 3.9, whereas Subjects 1 and 3 had mean OVERALL ratings of 4.55 and 4.80 respectively. These data suggest that the

somatic distress for Subject 2 was less intense, more diffuse and less centered on a small number of bodily systems than it was for Subjects 1 and 3. Again, as with the non-somatic distress measures from the SCL-90-R, Subject 2 (Ruth) seems to have a different phenomenological experience of her inner life and bodily symptoms than the other two subjects.

Table 2a

Frequencies for Responses to the INI-II
Subject 1: Cindy

	MIN	MAX	MEAN	SD	MEDIAN
INI-OVERALL	3.0	5.0	4.55	1.33	4.25
INI-HIGHEST	2.0	10.0	6.55	2.38	7.50
INI-LOWEST	1.0	7.0	3.10	1.71	2.75
INI-AVERAGE	1.5	7.7	4.62	1.83	4.78
INI-# SYMP	2.0	5.0	3.30	1.03	3.00

Table 2b

Frequencies for Responses to the INI-II
Subject 2: Ruth

	MIN	MAX	MEAN	SD	MEDIAN
INI-OVERALL	2.00	7.5	3.90	1.78	3.0
INI-HIGHEST	2.50	9.0	6.20	2.16	6.75
INI-LOWEST	.50	3.5	1.72	1.05	1.50
INI-AVERAGE	2.25	7.0	3.96	1.14	3.96
INI-# SYMP	1.00	9.0	4.8	2.29	4.0

Table 2c

Frequencies for Responses to the INI-II
Subject 3: Lisa

	MIN	MAX	MEAN	SD	MEDIAN
INI-OVERALL	3.0	8.0	4.80	1.74	4.50
INI-HIGHEST	4.0	10.0	7.68	1.33	8.00
INI-LOWEST	2.0	7.0	4.53	1.65	4.75
INI-AVERAGE	3.5	10.0	6.22	1.48	6.08
INI-# SYMP	1.0	4.0	2.50	.95	2.50

3. Recent Experience Memory Test (REM)

This measure was scored on a 5-point scale known as the Epigenetic Assessment Rating Scale (EARS). Mode I represents the "least adaptive" mode of functioning, and Mode V represents the "most adaptive" mode of functioning.

Each memory sample was scored along four separate dimensions: Affect Tolerance (AFF-TOL), Affect Expression (AFF-EXP), Empathic Knowledge of Others (EMP-KNO), and Use of an Object (USE-OBJ).

Each week, subjects were asked to describe the Best (REM-B) and Worst (REM-W) experiences they had had during the previous week which involved at least one other person. Thus, there are two sets of REM scores for each week, (REM-B & REM-W), with each set containing four separate scores, (one for each dimension), making a total of eight REM scores each week. Tables 3a-c show the lowest, highest, mean and standard deviation scores assigned to each subject's narrative accounts of her Best and Worst recent memories.[13]

[13] Note for Tables 3a-3c: Tables 3a-3c include data from the 20 weeks of memory narratives as scored along each of the four EARS dimensions, under the two conditions of BEST memory and WORST memory. Each of the EARS dimensions was assigned a label. These labels are listed here:

AFF-TOL-BEST: Affect Tolerance, under the Best condition.
AFF-EXP-BEST: Affect Expression, under the Best condition.
EMP-KNO-BEST: Empathic Knowledge of Others, under the Best condition.
USE-OBJ-BEST: Use of an Object, under the Best condition.
AFF-TOL-WORST: Affect Tolerance, under the Worst condition.
AFF-EXP-WORST: Affect Expression, under the Worst condition.
EMP-KNO-WORST: Empathic Knowledge of Others, under the Worst condition.
USE-OBJ-WORST: Use of an Object, under the Worst condition.

Table 3a
Frequencies for the Best and Worst EARS Scores on the REM

Subject 1: Cindy

EARS VARIABLES	MIN	MAX	MEAN	SD	MEDIAN
AFF-TOL-BEST	2	5	3.4	.75	3.0
AFF-EXP-BEST	2	5	3.4	.75	3.0
EMP-KNO-BEST	2	4	3.25	.64	3.0
USE-OBJ-BEST	2	5	3.5	.89	3.0
AFF-TOL-WORST	1	4	2.7	.98	3.0
AFF-EXP-WORST	2	5	2.85	.93	3.0
EMP-KNO-WORST	2	4	3.15	.67	3.0
USE-OBJ-WORST	1	5	2.8	.83	3.0

Table 3b
Frequencies for the Best and Worst EARS Scores on the REM

Subject 2: Ruth

.EARS VARIABLES	MIN	MAX	MEAN	SD	MEDIAN
AFF-TOL-BEST	1	5	3.15	.99	3.0
AFF-EXP-BEST	2	5	3.50	.83	3.5
EMP-KNO-BEST	2	5	3.55	.83	3.0
USE-OBJ-BEST	2	5	3.85	.88	4.0
AFF-TOL-WORST	2	5	3.55	.19	4.0
AFF-EXP-WORST	2	5	3.75	.97	4.0
EMP-KNO-WORST	2	5	3.8	.89	4.0
USE-OBJ-WORST	2	5	3.8	.95	4.0

Table 3c
Frequencies for the Best and Worst EARS Scores on the REM

Subject 3: Lisa

EARS VARIABLES	MIN	MAX	MEAN	SD	MEDIAN
AFF-TOL-BEST	2	5	3.50	1.00	3.0
AFF-EXP-BEST	2	5	3.55	.95	3.0
EMP-KNO-BEST	3	5	3.55	.76	3.0
USE-OBJ-BEST	2	5	3.65	.81	4.0
AFF-TOL-WORST	2	4	2.95	.76	3.0
AFF-EXP-WORST	2	4	2.85	.75	3.0
EMP-KNO-WORST	2	5	3.00	.80	3.0
USE-OBJ-WORST	1	5	2.90	.97	3.0

The range in EARS scores on the REM narratives for each subject, from 1-5, suggests that all three subjects showed evidence of pre-subjective as well as subjective functioning. Mean scores for Subjects 1 and 3 ranged from 2.7 to 3.5 and 2.8 to 3.65 respectively. Standard deviation scores for the two subjects were comparable, with Best and Worst narratives. This suggests that although their range included both higher and lower modes of functioning, each subject generally operated in the transitional mode (Mode III) between pre-subjective and subjective functioning. The authors of the EARS scale describe the principal tasks of Mode III in this way:

> Self-enhancement and the maintaining of self-esteem is a key concern. A powerful need is the protection of these wishful illusions about one's capabilities and capacities that support and bolster one's self-esteem (Wilson et al, 1988).

More specifically, for the dimension Affect Tolerance, Mode III responses indicate that subjects had some capacity to integrate positive and negative affects without regularly demonstrating a fully developed capacity to tolerate contradictory and conflictual affect states. For the dimension of Affect Expression, Mode III responses reveal that typical affects revolved around anger over others' noncompliance and failed grandiose aims. In the object relational dimension of Empathic Knowledge of Others, Mode III responses suggest an inability to recognize others as fully separate. Subjects were able to acknowledge the internal states of others, but showed some stereotypy and selective empathy when describing the internal states of other people. Finally, Mode III responses on the EARS dimension of Use of an Object indicate that subjects generally used other people in the service of "self-esteem maintenance and regulation" (Wilson, 1988).

By contrast, Subject 2 had a higher range of mean scores (3.15 to 3.85). Thus, although she had the same overall range of scores (1-5), these scores suggest that she more often had access to the more flexible and adaptive modes of affectivity and relatedness.

Of interest, for example, is the fact that whereas Subjects 1 and 3 had REM-Worst means consistently below their REM-Best means, Subject 2 had REM-Worst means comparable to (or higher than) her REM-Best mean scores. Subject 2 also had REM-Worst scores consistently above the REM-Worst scores for Subjects 1 and 2. Of particular note is the very small standard deviation (.19) on the Affect-Tolerance-Worst scores recorded for Subject 2. This makes her mean score of 3.55 for this dimension even more significant, and positions her capacity to tolerate affect solidly into the transitional and higher modes of the EARS. These findings suggest that Subject 2's defenses enabled her to function more flexibly and maturely than the other subjects under stressful conditions of emotional arousal.

B. Statistical Data

Hypothesis One: The Relationship Between the SCL-90-R and the Illness Narratives Interview-II. The first hypothesis explored the construct validity of a new measure designed specifically for this study, the INI-II. Data from the INI-II, a semi-structured interview, included each subject's rating of her OVERALL level of discomfort, the average NUMBER of symptoms reported, the HIGHEST and LOWEST single discomfort ratings given to any one symptom, and finally, the AVERAGE rating computed from ratings given to all symptoms mentioned in each weekly interview. The

hope in designing this measure was that by allowing subjects to report their own idiosyncratic symptoms and rate the intensity of those symptoms each week, the measure might capture more of the nuances of a given individual's somatic experiences than the standardized SCL-90-R is able to do.

It is important, nonetheless, to verify to what extent there is overlap between the INI-II and the well-known and standardized SCL-90-R SOMATIZATION scale. Construct validity was assessed by correlating each of the INI-II indices with the SCL subscale. Results are presented in Tables 4a-c.

Table 4a

Correlations Between SCL-90-R SOMATIZATION SUBSCALE and Somatic Distress Indices from the Illness Narratives Interview-II

Subject 1: Cindy

INI-II INDICES	OVERALL		#SYMPTOMS		HIGHEST		LOWEST		AVERAGE	
	r	p	r	p	r	p	r	p	r	p
SCL-SOM	.582	.007	.395	.085	.462	.04	.377	.102	.53	.016

Table 4b

Correlations Between SCL-90-R SOMATIZATION SUBSCALE and Somatic Distress Indices from the Illness Narratives Interview-II

Subject 2: Ruth

INI-II INDICES	OVERALL		#SYMPTOMS		HIGHEST		LOWEST		AVERAGE	
	r	p	r	p	r	p	r	p	r	p
SCL-SOM	.488	.029	.440	.052	.642	.002	.104	.680	.771	.00

Table 4c

Correlations Between SCL-90-R SOMATIZATION SUBSCALE and Somatic Distress Indices from the Illness Narratives Interview-II

Subject 3: Lisa

INI-II INDICES	OVERALL		#SYMPTOMS		HIGHEST		LOWEST		AVERAGE	
	r	p	r	p	r	p	r	p	r	p
SCL-SOM	.448	.048	.539	.014	.192	.417	.026	.918	.055	.82

Results varied across the three subjects. The INI-II index which correlated most strongly with the SOMATIZATION subscale of the SCL-90-R was the INI-OVERALL rating of somatic distress ($p = \leq .05$). This was true for all three subjects. Also strongly associated with the SCL-SOM subscale was INI-#SYMPTOMS index, although for Subject 1 this correlation was less significant than for the other two subjects (Subject 1: $p = .085$). Interestingly, although the INI-AVERAGE computed for all distress ratings given each week was strongly associated for Subjects 1 and 2 ($r = .529$; $p = .016$; $r = .771$, $p = .000$), the INI-AVERAGE index showed a very weak association for Subject 3 ($r = .055$, $p = .818$).

These results suggest that for different people, the SCL-SOMATIZATION subscale may not capture the full nature of their somatic experience. The INI-LOWEST rating, in particular, was not strongly correlated with the SCL subscale. In addition, results from Subject 3 suggest that her INI-HIGHEST ratings, as well as her INI-

AVERAGE ratings were not correlated with the SCL-SOM subscale, probably because the principal symptoms which she was rating are not listed on the SCL scale.[14]

Because of the variability of these findings, the SOMATIZATION subscale of the SCL-90-R and all of the indices from the INI-II (with the exception of the INI-LOWEST rating) were included in each of the subsequent correlations and multiple regression analyses conducted.[15] Together, these somatic distress indices will be referred to as Somatic Distress Measures (SDM). It was felt that by including each of these indices throughout the statistical analyses which follow, one might see more clearly how it is that different aspects of one's experience of somatic distress may be more and less related to psychological functioning at different times. More specifically, it was thought that the different dimensions of bodily experience tapped by the dimensions of the INI-II may be more (or less) related to shifts in psychological functioning in the areas of affectivity and relatedness than the SCL-SOM scale.

Hypothesis Two: The Relationship Between the EARS Measures of Affectivity and Object Relatedness and Somatization. The second hypothesis raised the question of which of the four dimensions of the EARS, (Affect Tolerance; Affect Expression; Empathic Knowledge of Others; Use of an Object), scored under the two conditions of Best memories and Worst memories, would be most strongly associated with somatic

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[14] Subject 3 (Lisa) had as her principal complaint a chronic pain condition affecting the genital area. This condition will be discussed in more detail below, in the Clinical Data chapter. Here, it is simply important to note that rather unusual complaints such as this are not included in the SCL-90-R. This checklist tends to focus on more common somatic complaints such as headaches, dizziness, etc.

[15] In only a very few cases were the INI-LOWEST ratings found to be significantly correlated with EARS scores. Although the analyses were done, data is not shown in most tables.

symptomatology. It was speculated that the two Affect dimensions of the EARS would be most strongly correlated with the Somatic Distress Measures (SDM).

Multiple regression analyses were conducted to see which dimensions, and which combinations of dimensions (if any), might be most strongly predictive of somatic distress (Tables 5a-c). Each of the EARS dimensions was entered as an independent variable for each SDM measure, which stood as the dependent variables.

In the case of Subject 1 (Table 5a),[16] stepwise analyses of the five dependent variables constituting the various Somatic Distress Measures found that four of the eight predictor variables met the entry criterion (set at .20). The object relational variable from the EARS (Empathic Knowledge of Others-Worst) was the most powerful predictor in three out of four cases. That is, shifts in somatic symptoms were generally most strongly associated with shifts in object relatedness for Subject 1.

In the case of Subject 2 (Table 5b), stepwise analyses of the five dependent variables constituting the various Somatic Distress Measures found that four of the eight predictor variables met the entry criterion. Again, it is significant that the two object relational variables from the EARS (Empathic Knowledge of Others-Worst; Use of an Object-Worst) were the most powerful predictors in three out of four cases. As with

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[16] Notes for Tables 5a-c:

1) The predictor variables used in these regression analyses are the four EARS variables as measured under Best and Worst conditions (AFFECT TOLERANCE-BEST; AFFECT EXPRESSION-BEST; EMPATHIC KNOWLEDGE-BEST; USE OF AN OBJECT-BEST, AND AFFECT TOLERANCE-WORST; AFFECT EXPRESSION-WORST; EMPATHIC KNOWLEDGE-WORST; USE OF AN OBJECT-WORST).

2) R^2 = proportion of variability in dependent variable explained by whole regression at indicated step.

3) "t at entry" provides test for the significance of the predictor at the step at which it was entered.

4) Beta = standardized regression coefficient in final equation.

5) "N/E" indicates that the independent variable was "Not Entered" into the equation because it did not achieve the required level of statistical significance (PIN =.20).

Subject 1, these results suggest that for Subject 2, shifts in somatic symptoms were usually most strongly associated with shifts in object relatedness.

In the case of Subject 3 (Table 5c), stepwise analyses of the five dependent variables constituting the various Somatic Distress Measures found that four of the eight predictor variables met the entry criterion. Again, it is important to note that an object relational variable from the EARS (Use of an Object-Worst) was the most powerful predictor in two out of three cases. As with Subjects 1 and 2, these results demonstrate that for Subject 3, shifts in somatic symptoms were strongly associated most often with shifts in object relatedness.

Looking across the data from all three subjects, Tables 5a-c indicate that the hypothesis that the Affect dimensions would be most strongly associated with somatic distress was not proven. Instead, these analyses reveal that the Object Relational dimensions of the EARS (Empathic Knowledge of Others; Use of an Object) were the strongest predictors of somatic distress- In all but two cases where strong associations were found, the object relational dimensions were the most powerful predictors. Interestingly, however, in five out of the nine instances where an object relational dimension was the strongest predictor of somatic distress, the association became stronger when an affect dimension was added into the regression equation. This suggests that the combination of shifts in affective and object relational functioning may correlate most strongly with measures of somatic distress.

Table 5a
Multiple Regression Analyses:
EARS Scores for the Recent Experience Memory Test (REM-Best & REM-Worst)
and Somatic Distress Measures (SDM)
Subject 1: Cindy

EARS SCORES FOR RECENT EXPERIENCE MEMORY TEST

SDM		AFF-TOL BEST[1]	AFF-EXP BEST	EMP-KNO BEST	USE-OBJ BEST	AFF-TOL WORST	AFF-EXP WORST	EMP-KNO WORST	USE-OBJ WORST
SCL-SOM	STEP ENTERED	N/E[5]	N/E	N/E	N/E	N/E	N/E	N/E	N/E
	R^2 AT ENTRY[2]	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E
	t AT ENTRY[3]	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E
	BETA[4]	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E
INI-II OVERALL	STEP ENTERED	N/E	N/E	N/E	N/E	N/E	N/E	1	N/E
	R^2 AT ENTRY	N/E	N/E	N/E	N/E	N/E	N/E	R^2 = .13 p = .12	N/E
	t AT ENTRY	N/E	N/E	N/E	N/E	N/E	N/E	t = -1.66 p = .12	N/E
	BETA	N/E	N/E	N/E	N/E	N/E	N/E	B = -.36	N/E
INI-II # SYMP	STEP ENTERED	N/E	N/E	N/E	N/E	N/E	N/E	1	N/E
	R^2 AT ENTRY	N/E	N/E	N/E	N/E	N/E	N/E	R^2 = .20 p = .05	N/E
	t AT ENTRY	N/E	N/E	N/E	N/E	N/E	N/E	t = 2.13 p = .05	N/E
	BETA	N/E	N/E	N/E	N/E	N/E	N/E	B = -.45	N/E

Table 5a (continued)

SDM		AFF-TOL BEST[1]	AFF-EXP BEST	EMP-KNO BEST	USE-OBJ BEST	AFF-TOL WORST	AFF-EXP WORST	EMP-KNO WORST	USE-OBJ WORST
INI-II HIGHEST	STEP ENTERED	2	N/E	N/E	N/E	N/E	N/E	1	N/E
	R^2 AT ENTRY	R^2 = .24 p = .09	N/E	N/E	N/E	N/E	N/E	R^2 = .16 p = .08	N/E
	t AT ENTRY	t = 1.37 p = .19	N/E	N/E	N/E	N/E	N/E	t = -1.86 p = .08	N/E
	BETA	B = .28	N/E	N/E	N/E	N/E	N/E	B = -.39	N/E
INI-II AVERAGE	STEP ENTERED	N/E	N/E	3	2	N/E	N/E	1	N/E
	R^2 AT ENTRY	N/E	N/E	R^2 = .47 p = .01	R^2 = .40 p = .01	N/E	N/E	R^2 = .25 p = .02	N/E
	t AT ENTRY	N/E	N/E	t = -1.46 p = .16	t = -2.02 p = .06	N/E	N/E	t = -2.48 p = .02	N/E
	BETA	N/E	N/E	B = .44	B = .73	N/E	N/E	B = -.48	N/E

Table 5b
Multiple Regression Analyses:
EARS Scores for the Recent Experience Memory Test (REM-Best & REM-Worst)
and Somatic Distress Measures (SDM)
Subject 2: Ruth

EARS SCORES FOR RECENT EXPERIENCE MEMORY TEST

SDM		AFF-TOL BEST[1]	AFF-EXP BEST	EMP-KNO BEST	USE-OBJ BEST	AFF-TOL WORST	AFF-EXP WORST	EMP-KNO WORST	USE-OBJ WORST
SCL-SOM	STEP ENTERED	N/E[5]	N/E	N/E	N/E	2	N/E		N/E
	R^2 AT ENTRY[2]	N/E	N/E	N/E	N/E	R^2 = .24 p = .09	N/E	R^2 = .15 p = .09	N/E
	t AT ENTRY[3]	N/E	N/E	N/E	N/E	t = -1.40 p = .17	N/E	t = 1.82 p = .08	N/E
	BETA[4]	N/E	N/E	N/E	N/E	B = -.39	N/E	B = .65	N/E
INI-II OVERALL	STEP ENTERED	1	N/E	N/E	N/E	N/E	N/E	N/E	N/E
	R^2 AT ENTRY	R^2 = .14 p = .10	N/E	N/E	N/E	N/E	N/E	N/E	N/E
	t AT ENTRY	t = -1.74 p = .10	N/E	N/E	N/E	N/E	N/E	N/E	N/E
	BETA	B = -.38	N/E	N/E	N/E	N/E	N/E	N/E	N/E
INI-II # SYMP	STEP ENTERED	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E
	R^2 AT ENTRY	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E
	t AT ENTRY	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E
	BETA	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E

Table 5b (continued)

SDM		AFF-TOL BEST[1]	AFF-EXP BEST	EMP-KNO BEST	USE-OBJ BEST	AFF-TOL WORST	AFF-EXP WORST	EMP-KNO WORST	USE-OBJ WORST
INI-II HIGHEST	STEP ENTERED	N/E	N/E	N/E	N/E	2	N/E	N/E	1
	R^2 AT ENTRY	N/E	N/E	N/E	N/E	R^2 = .34 p = .03	N/E	N/E	R^2 = .20 p = .04
	t AT ENTRY	N/E	N/E	N/E	N/E	t = -1.84 p = .08	N/E	N/E	t = -2.18 p = .04
	BETA	N/E	N/E	N/E	N/E	B = -.49	N/E	N/E	B = .80
INI-II AVERAGE	STEP ENTERED	N/E	N/E	N/E	N/E	N/E	N/E	1	N/E
	R^2 AT ENTRY	N/E	N/E	N/E	N/E	N/E	N/E	R^2 = .16 p = .08	N/E
	t AT ENTRY	N/E	N/E	N/E	N/E	N/E	N/E	t = 1.86 p = .08	N/E
	BETA	N/E	N/E	N/E	N/E	N/E	N/E	B = .40	N/E

Table 5c
Multiple Regression Analyses:
EARS Scores for the Recent Experience Memory Test (REM-Best & REM-Worst)
and Somatic Distress Measures (SDM)
Subject 3: Lisa

EARS SCORES FOR RECENT EXPERIENCE MEMORY TEST

SDM		AFF-TOL BEST[1]	AFF-EXP BEST	EMP-KNO BEST	USE-OBJ BEST	AFF-TOL WORST	AFF-EXP WORST	EMP-KNO WORST	USE-OBJ WORST
SCL-SOM	STEP ENTERED	N/E[5]	N/E	N/E	N/E	N/E	2	N/E	1
	R^2 AT ENTRY[2]	N/E	N/E	N/E	N/E	N/E	R^2 = .32 p = .04	N/E	R^2 = .20 p = .05
	t AT ENTRY[3]	N/E	N/E	N/E	N/E	N/E	t = -1.76 p = .10	N/E	t = 2.13 p = .05
	BETA[4]	N/E	N/E	N/E	N/E	N/E	B = -.42	N/E	B = .69
INI-II OVERALL	STEP ENTERED	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E
	R^2 AT ENTRY	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E
	t AT ENTRY	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E
	BETA	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E
INI-II # SYMP	STEP ENTERED	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E
	R^2 AT ENTRY	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E
	t AT ENTRY	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E
	BETA	N/E	N/E	N/E	N/E	N/E	N/E	N/E	N/E

Table 5c (continued)

SDM		AFF-TOL BEST[1]	AFF-EXP BEST	EMP-KNO BEST	USE-OBJ BEST	AFF-TOL WORST	AFF-EXP WORST	EMP-KNO WORST	USE-OBJ WORST
INI-II HIGHEST	STEP ENTERED	3	2	N/E	N/E	N/E	N/E	N/E	1
	R^2 AT ENTRY	R^2 = .33 p = .08	R^2 = .26 p = .08	N/E	N/E	N/E	N/E	N/E	R^2 = .16 p = .09
	t AT ENTRY	t = -1.37 p = .19	t = 1.52 p = .15	N/E	N/E	N/E	N/E	N/E	t = -1.82 p = .09
	BETA	B = -.58	B = .88	N/E	N/E	N/E	N/E	N/E	B = -.63
INI-II AVERAGE	STEP ENTERED	N/E	N/E	N/E	N/E	N/E	N/E	N/E	1
	R^2 AT ENTRY	N/E	N/E	N/E	N/E	N/E	N/E	N/E	R^2 = .25 p = .02
	t AT ENTRY	N/E	N/E	N/E	N/E	N/E	N/E	N/E	t = -2.46 p = .02
	BETA	N/E	N/E	N/E	N/E	N/E	N/E	N/E	B = -.50

Regression analyses say nothing, however, about the direction of the association. That is, are symptoms rising or falling when functioning becomes, for example, more adaptive? To explore this question, Pearson correlations between the eight EARS scores assigned to each Recent Experience Memory (REM), (four dimensions, Best and Worst for each), and the five Somatic Distress Measures (SDM) were calculated. These results are presented in Tables 6a-c.

As with the multiple regression analyses presented above, these correlational analyses found that the object relational dimensions of the EARS were more strongly associated with somatic distress than were the affect dimensions. In fact, whereas only one affect dimension was found to be significantly correlated at the .10 level, five significant correlations were found between the object relational dimensions and the SDM at the .05 level of significance.

These findings again indicate that when comparing functioning in the four areas of Affect Tolerance, Affect Expression, Empathic Knowledge of Others and Use of an Object with reported somatic distress in the same week, the two Object Relational dimensions were more strongly associated with somatic distress.

A particularly curious finding, however, is that some of the correlations between the EARS variables were positive while others were negative. Theory suggests that a drop in psychological functioning would be associated with a rise in somatic symptomatology. This held true strongly for Subject 1 in the REM-Worst dimensions of the EARS, but not on the REM-Best correlations, which included Affect Tolerance-Best and Use of an Object-Best. This was largely the case for Subject 3 as well,

although her Use of an Object-Worst scores showed a positive and significant correlation (.448, p = .048).

By contrast, Subject 2 showed all positive correlations for her REM-Worst scores, and a negative correlation for her Affect Tolerance-Best score. That is, as her level of functioning dropped on the REM-Worst scores, so did her somatic distress. The alternate pattern held true for her in the realm of Affect Tolerance-Best.

These mixed results raise several questions. First, the finding of positive and negative correlations operating differently for different people suggests that somatic symptoms may not simply reflect maladaptive modes of psychological functioning, but may, instead, actually support more adaptive psychological functioning in certain realms, for certain people.

Second, the fact that individual subjects show different patterns of relationships between somatic distress suggests that some people may be able to maintain a high level of functioning, for example, in the REM-Best categories of affectivity, even though more pathological processes may be activated at the same time, as in the case of Subject 2.

Table 6a[17]

Correlations Between EARS Scores for the Recent Experience Memory Test (REM-Best & REM-Worst) and Somatic Distress Measures (SDM)

Subject 1: Cindy

EARS SCORES FOR RECENT EXPERIENCE MEMORY TEST

SOMATIC DISTRESS MEASURES	AFF-TOL BEST	AFF-EXP BEST	EMP-KNO BEST	USE-OBJ BEST	AFF-TOL WORST	AFF-EXP WORST	EMP-KNO WORST	USE-OBJ WORST
SCL-90-R SOM	N/S	N/S	N/S	N/S	N/S	N/S	r = -.262 p = .265	r = -.162 p = .494
INI-II OVERALL	N/S	N/S	N/S	N/S	N/S	N/S	r = -.364 p = .115	N/S
INI-II # SYMP'S	N/S	N/S	N/S	N/S	N/S	N/S	r = -.449 p = .047	N/S
INI-II HIGHEST	r = .297 p = .204	N/S	N/S	N/S	N/S	N/S	r = -.401 p = .080	N/S
INI-II AVERAGE	N/S	N/S	N/S	r = .402 p = .079	r = -.328 p = .158	r = -.282 p = .228	r = -.505 p = .023	N/S

[17] Due to small sample size for each subject (n =20 weeks), it is apparent that there may not be enough power to yield statistically significant findings in some cases. Therefore, some insignificant correlations have been presented in order to note potentially meaningful associations even though the findings are not statistically significant with this data set.

Table 6b

Correlations Between EARS Scores for the Recent Experience Memory Test (REM-Best & REM-Worst) and Somatic Distress Measures (SDM)

Subject 2: Ruth

EARS SCORES FOR RECENT EXPERIENCE MEMORY TEST

SOMATIC DISTRESS MEASURES	AFF-TOL BEST	AFF-EXP BEST	EMP-KNO BEST	USE-OBJ BEST	AFF-TOL WORST	AFF-EXP WORST	EMP-KNO WORST	USE-OBJ WORST
SCL-90-R SOM	N/S	N/S	N/S	r = .321 p = .168	N/S	N/S	r = .394 p = .086	r = .310 p = .184
INI-II OVERALL	r = -.380 p = .099	N/S	N/S	N/S	N/S	N/S	N/S	N/S
INI-II # SYMP'S	N/S	N/S	N/S	N/S	N/S	N/S	N/S	r = .295 p = .206
INI-II HIGHEST	N/S	N/S	N/S	N/S	N/S	N/S	r = .377 p = .101	r = .457 p = .043
INI-II AVERAGE	N/S	N/S	N/S	N/S	N/S	N/S	r = .401 p = .080	r = .388 p = .091

Table 6c

Correlations Between EARS Scores for the Recent Experience Memory Test (REM-Best & REM-Worst) and Somatic Distress Measures (SDM)

Subject 3: Lisa

EARS SCORES FOR RECENT EXPERIENCE MEMORY TEST

SOMATIC DISTRESS MEASURES	AFF-TOL BEST	AFF-EXP BEST	EMP-KNO BEST	USE-OBJ BEST	AFF-TOL WORST	AFF-EXP WORST	EMP-KNO WORST	USE-OBJ WORST
SCL-90-R SOM	N/S	N/S	N/S	N/S	N/S	N/S	N/S	r = .448 p = .048
INI-II OVERALL	N/S	N/S	N/S	N/S	N/S	N/S	N/S	N/S
INI-II # SYMP'S	N/S	N/S	N/S	N/S	N/S	N/S	N/S	N/S
INI-II HIGHEST	N/S	N/S	N/S	N/S	N/S	N/S	N/S	r = -.394 p = .085
INI-II AVERAGE	N/S	N/S	N/S	N/S	r = -.325 p = .161	N/S	r = -.413 p = .071	r = -.501 p = .024

Hypothesis Three: Relationships Between the Combined Affect and the Combined Object Relational Dimensions of the RARE and the Somatic Distress Measures. In the third hypothesis, it was speculated that, together, the two EARS dimensions which tap different aspects of affectivity (Affect Tolerance; Affect Expression) might yield stronger associations with somatic distress than would the combined object relational dimensions of the EARS (Empathic Knowledge of Others; Use of an Object).

To explore the differences between these two sets of variables, intercorrelations between the corresponding pairs of scores were first calculated. The two related dimensions (AT+AE) and (EMP+USE) were combined, and then each pair was subjected to intercorrelational analyses. The division between Best and Worst REM scores was maintained for these calculations. The results of these correlations are presented in Tables 7a-c.

In the case of Subject 1 (Table 7a), significant correlations were detected between AFF-BEST and OBJ-REL-BEST, and between AFF-WORST and OBJ-REL-WORST. Very weak correlations were found between AFF-BEST and AFF-WORST, and between OBJ-REL-BEST and OBJ-REL-WORST. This same pattern of significant correlations was detected for Subject 2 (Table 7b).

These findings suggest that affectivity and object relatedness rose and fell together for Subjects 1 and 2 under like conditions of arousal.

In the case of Subject 3 (Table 7c), the same significant correlations were found. In addition, however, significant correlations were detected between OBJ-REL-WORST on the one hand, and both AFF-BEST and OBJ-REL-BEST. These results

indicate that unlike for Subjects 1 and 2, object relational functioning was closely tied to affectivity for Subject 3 regardless of the arousal conditions. Further, the results suggest that object relatedness was less affected by arousal conditions for Subject 3 than it was for either Subject 1 or 2.

Table 7a

Intercorrelations Among Combined Affect and Combined Object Relational Scores for Best and Worst Recent Experience Memory Narratives

Subject 1: Cindy

Mean Scores for Combined REM Dimensions (Best & Worst)	AFFECTIVITY (WORST)		OBJ-RELATIONAL (BEST)		OBJ-RELATIONAL (WORST)	
	r	p	r	p	r	p
AFFECTIVITY (BEST)	.24	.31	.81	.00	.08	.73
AFFECTIVITY (WORST)			.20	.39	.81	.00
OBJ-RELATIONAL (BEST)					.16	.49

Table 7b

Intercorrelations Among Combined Affect and Combined Object Relational Scores for Best and Worst Recent Experience Memory Narratives

Subject 2: Ruth

Mean Scores for Combined REM Dimensions (Best & Worst)	AFFECTIVITY (WORST)		OBJ-RELATIONAL (BEST)		OBJ-RELATIONAL (WORST)	
	r	p	r	p	r	p
AFFECTIVITY (BEST)	-.11	.64	.71	.00	.20	.40
AFFECTIVITY (WORST)			-.17	.46	.76	.00
OBJ-RELATIONAL (BEST)					.23	.34

Table 7c

Intercorrelations Among Combined Affect and Combined Object Relational Scores for Best and Worst Recent Experience Memory Narratives

Subject 3: Lisa

Mean Scores for Combined REM Dimensions (Best & Worst)	AFFECTIVITY (WORST)		OBJ-RELATIONAL (BEST)		OBJ-RELATIONAL (WORST)	
	r	p	r	p	r	p
AFFECTIVITY (BEST)	.19	.42	.63	.003	.45	.045
AFFECTIVITY (WORST)			.34	.15	.78	.000
OBJ-RELATIONAL (BEST)					.47	.04

Correlational analyses between these combined EARS variables and measures of somatic distress were then conducted in order to explore which variable might predict somatic distress most powerfully. When correlations between Best Affect, Worst Affect, Best Object Relational and Worst Object Relational scores and SDM were performed, only one significant correlation was found, for Subject 3, between her AVERAGE weekly symptom distress rating and her Worst Object Relational weekly scores ($r = -.502$, $p = .024$).

To further explore the different relationships that affectivity and object relatedness might have to somatic distress, multiple regression analyses were performed. These analyses also used the four pairs of EARS dimensions described above (AT+AE, Best and Worst) and (EMP+USE, Best and Worst) as independent

variables, and the five Somatic Distress Measures (SDM) as dependent variables. Results for each subject are presented in Tables 8a-c.[18]

[18] Notes for Tables 8a-c:

1) The predictor variables used in these regression analyses represent the combined affect variables of the EARS under Best and Worst conditions (AFFECT-BEST; AFFECT WORST) and the combined object relational variables of the EARS (OBJECT-RELATIONAL-BEST; OBJECT-RELATIONAL-WORST).

2) R^2 = proportion of variability in dependent variable explained by whole regression at indicated step.

3) "t at entry" provides test for the significance of the predictor at the step at which it was entered.

4) Beta = standardized regression coefficient in final equation.

5) "N/E" indicates that the independent variable was "Not Entered" into the equation because it did not achieve the required level of statistical significance (PIN =.20).

Table 8a

Multiple Regression Analyses of Combined Affect and Object Relational EARS Dimensions (Best and Worst) and Somatic Distress Measures

Subject 1: Cindy

SDM		AFFECT-BEST[1]	AFFECT-WORST	OBJ-REL BEST	OBJ-REL WORST
SCL-COM	STEP ENTERED	N/E[5]	N/E	N/E	N/E
	R^2 AT ENTRY[2]	N/E	N/E	N/E	N/E
	t AT ENTRY[3]	N/E	N/E	N/E	N/E
	BETA[4]	N/E	N/E	N/E	N/E
INI-II OVERALL	STEP ENTERED	N/E	N/E	N/E	N/E
	R^2 AT ENTRY	N/E	N/E	N/E	N/E
	t AT ENTRY	N/E	N/E	N/E	N/E
	BETA	N/E	N/E	N/E	N/E
INI-II # SYMP	STEP ENTERED	N/E	N/E	N/E	1
	R^2 AT ENTRY	N/E	N/E	N/E	R^2 = .09 p = .19
	t AT ENTRY	N/E	N/E	N/E	t = -1.37 p = .19
	BETA	N/E	N/E	N/E	B = -.31

Table 8a (continued)

SDM		AFFECT-BEST	AFFECT-WORST	OBJ-REL BEST	OBJ-REL WORST
INI-II HIGHEST	STEP ENTERED	N/E	N/E	N/E	1
	R^2 AT ENTRY	N/E	N/E	N/E	R^2 = .13 p = .13
	t AT ENTRY	N/E	N/E	N/E	t = -1.61 p = .13
	BETA	N/E	N/E	N/E	B = -.35
INI-II AVERAGE	STEP ENTERED	N/E	1	2	N/E
	R^2 AT ENTRY	N/E	R^2 = .11 p = .15	R^2 = .25 p = .09	N/E
	t AT ENTRY	N/E	t = -1.49 p = .15	t = 1.79 p = .09	N/E
	BETA	N/E	B = -.41	B = .38	N/E

Table 8b

Multiple Regression Analyses of Combined Affect and Object Relational EARS Dimensions (Best and Worst) and Somatic Distress Measures

Subject 2: Ruth

SDM		AFFECT-BEST[1]	AFFECT-WORST	OBJ-REL BEST	OBJ-REL WORST
SCL-COM	STEP ENTERED	N/E[5]	2	N/E	1
	R^2 AT ENTRY[2]	N/E	R^2 = .31 p = .05	N/E	R^2 = .15 p = .10
	t AT ENTRY[3]	N/E	t = -1.98 p = .06	N/E	t = 1.75 p = .10
	BETA[4]	N/E	B = -.61	N/E	B = .84
INI-II OVERALL	STEP ENTERED	1	N/E	N/E	N/E
	R^2 AT ENTRY	R^2 = .10 p = .18	N/E	N/E	N/E
	t AT ENTRY	t = -1.39 p = .18	N/E	N/E	N/E
	BETA	B = -.31	N/E	N/E	N/E
INI-II # SYMP	STEP ENTERED	N/E	N/E	N/E	N/E
	R^2 AT ENTRY	N/E	N/E	N/E	N/E
	t AT ENTRY	N/E	N/E	N/E	N/E
	BETA	N/E	N/E	N/E	N/E

Table 8b (continued)

SDM		AFFECT-BEST	AFFECT-WORST	OBJ-REL BEST	OBJ-REL WORST
INI-II HIGHEST	STEP ENTERED	N/E	2	N/E	1
	R^2 AT ENTRY	N/E	R^2 = .35 p = .03	N/E	R^2 = .21 p = .04
	t AT ENTRY	N/E	t = -1.96 p = .07	N/E	t = 2.17 p = .04
	BETA	N/E	B = -.58	N/E	B = .90
INI-II AVERAGE	STEP ENTERED	N/E	2	N/E	1
	R^2 AT ENTRY	N/E	R^2 = .31 p = .04	N/E	R^2 = .18 p = .08
	t AT ENTRY	N/E	t = -1.73 p = .10	N/E	t = -1.86 p = .059
	BETA	N/E	B = -.54	N/E	B = .83

Table 8c

Multiple Regression Analyses of Combined Affect and Object Relational
EARS Dimensions (Best and Worst)
and Somatic Distress Measures

Subject 3: Lisa

SDM		AFFECT-BEST[1]	AFFECT-WORST	OBJ-REL BEST	OBJ-REL WORST
SCL-COM	STEP ENTERED	N/E[5]	2	N/E	1
	R^2 AT ENTRY[2]	N/E	R^2 = .19 p = .06	N/E	R^2 = .10 p = .17
	t AT ENTRY[3]	N/E	t = -2.00 p = .06	N/E	t = 1.43 p = .17
	BETA[4]	N/E	B = -.66	N/E	B = .83
INI-II OVERALL	STEP ENTERED	N/E	N/E	N/E	N/E
	R^2 AT ENTRY	N/E	N/E	N/E	N/E
	t AT ENTRY	N/E	N/E	N/E	N/E
	BETA	N/E	N/E	N/E	N/E
INI-II # SYMP	STEP ENTERED	N/E	N/E	N/E	N/E
	R^2 AT ENTRY	N/E	N/E	N/E	N/E
	t AT ENTRY	N/E	N/E	N/E	N/E
	BETA	N/E	N/E	N/E	N/E

Table 8c (continued)

SDM		AFFECT-BEST	AFFECT-WORST	OBJ-REL BEST	OBJ-REL WORST
INI-II HIGHEST	STEP ENTERED	N/E	N/E	N/E	1
	R^2 AT ENTRY	N/E	N/E	N/E	R^2 = .12 p = .14
	t AT ENTRY	N/E	N/E	N/E	t = -1.56 p = .14
	BETA	N/E	N/E	N/E	B = -.35
INI-II AVERAGE	STEP ENTERED	N/E	N/E	N/E	1
	R^2 AT ENTRY	N/E	N/E	N/E	R^2 = .25 p = .02
	t AT ENTRY	N/E	N/E	N/E	t = -2.46 p = .02
	BETA	N/E	N/E	N/E	B = -.50

In the case of Subject 1 (Table 8a), stepwise analyses of the five dependent variables constituting the various Somatic Distress Measures found that three of the four predictor variables met the entry criterion (set at .20). It is significant that the variable which represented the combined object relational dimensions from the EARS (Object Relational-Worst) was the most powerful predictor in two out of three cases. As indicated earlier, when dimensions were treated separately (Tables 5a-c), these results demonstrate that for Subject 1 shifts in somatic symptoms were most strongly associated with shifts in object relatedness. In particular, somatic distress seemed to be most strongly linked to her experiences of relatedness as represented in her REM-worst memory narratives.

In the case of Subject 2 (Table 8b), stepwise analyses of the five dependent variables constituting the various Somatic Distress Measures found that three of the four predictor variables met the entry criterion (set at .20). It is significant that the variable which represented the combined object relational dimensions from the EARS (Object Relational-Worst) was again the most powerful predictor in three out of four cases. Again, these findings suggest that for Subject 2, shifts in somatic symptoms were most strongly associated with shifts in object relatedness, and in particular, to relatedness as represented in her REM-Worst narratives.

In the case of Subject 3 (Table 8c), stepwise analyses of the five dependent variables constituting the various Somatic Distress Measures found that two of the four predictor variables met the entry criterion (set at .20). It is significant that the variable which represented the combined object relational dimensions from the EARS (Object Relational-Worst) was the most powerful predictor in three out of three cases. As with

Subjects 1 and 2, these results demonstrate that for Subject 3 shifts in somatic symptoms were most strongly associated with shifts in object relatedness under conditions of stress.

In general, then, results from the multiple regression analyses show that for all three subjects, the combined object relational dimensions, and particularly, those in the WORST memory sample, were most powerfully associated with somatic distress. These findings are important, for they suggest that object relatedness may be more closely linked with somatic processes than has generally been thought to be the case. Further, these findings suggest that shifts in object relatedness, more than shifts in affectivity, may be linked to somatic distress. Finally, evidence that the REM-Worst narratives were those most strongly associated with somatic distress points to the importance of assessing functioning under different conditions of stress and arousal.

Hypothesis Four: Difference Between "Best" and "Worst" Recent Experience Memory Narratives in Predicting Somatic Distress. In the fourth hypothesis, it was suggested that a subject's representation of the Best experience she has had during the week may differ in meaningful ways from her representation of her Worst Recent Experience Memory. In order to test this, t-tests were first run to determine if REM-Best and REM-Worst scores differ significantly from each other, for each subject (Table 9a-c).

Table 9a

Results of t-tests Between REM-Best Scores and REM-Worst Scores

Subject 1: Cindy

	MEAN	t-VALUE	2-TAIL PROB
REM-BEST	3.388	2.59	.018
REM-WORST	2.875	—	—

Table 9b

Results of t-tests Between REM-Best Scores and REM-Worst Scores

Subject 2: Ruth

	MEAN	t-VALUE	2-TAIL PROB
REM-BEST	3.513	-.89	.383
REM-WORST	3.725	—	—

Table 9c

Results of t-tests Between REM-Best Scores and REM-Worst Scores

Subject 3: Lisa

	MEAN	t-VALUE	2-TAIL PROB
REM-BEST	3.563	3.66	.002
REM-WORST	2.925	—	—

Tables 9a-c indicate that for Subjects 1 and 3, there was a significant difference overall between their Best and Worst scores. In both cases, scores for REM-Worst narratives were significantly below scores for REM-Best narratives. This was not the case for Subject 2, whose REM-Worst scores were actually above her REM-Best scores. The differences between these scores was not significant. These findings suggest that Subject 2 (Ruth) was able to maintain a higher level of functioning under stress (relative to her own capacities under less stressful situations) than were Cindy and Lisa.

It was further speculated that, as a group, scores from the REM-Worst narratives might better predict somatic distress than scores from the REM-Best narratives. To test this hypothesis, Pearson correlations were calculated between each subject's combined weekly averages for the four REM-Best scores and the four REM-Worst scores and the ratings from the Somatic Distress Measures (SDM) collected weekly for each subject (Tables 10a-c).

Table 10a

Correlations Between REM-Best and REM-Worst Scores and Somatic Distress Measures

Subject 1: Cindy

SOMATIC DISTRESS MEASURES	REM-BEST	REM-WORST
SCL-90-R SOM	N/S	N/S
INI-II OVERALL	N/S	N/S
INI-II # SYMP'S	N/S	N/S
INI-II HIGHEST	N/S	r = -.306 p = .189
INI-II AVERAGE	N/S	r = -.346 p = .135

Table 10b

Correlations Between REM-Best and REM-Worst Scores and Somatic Distress Measures

Subject 2: Ruth

SOMATIC DISTRESS MEASURES	REM-BEST	REM-WORST
SCL-90-R SOM	N/S	N/S
INI-II OVERALL	N/S	N/S
INI-II # SYMP'S	N/S	N/S
INI-II HIGHEST	N/S	r = .295 p = .208
INI-II AVERAGE	N/S	r = -.346 p = .135

Table 10c

Correlations Between REM-Best and REM-Worst Scores and Somatic Distress Measures

Subject 3: Lisa

SOMATIC DISTRESS MEASURES	REM-BEST	REM-WORST
SCL-90-R SOM	N/S	N/S
INI-II OVERALL	N/S	N/S
INI-II # SYMP'S	N/S	N/S
INI-II HIGHEST	N/S	r = -.308 p = .185
INI-II AVERAGE	N/S	r = -.443 p = .050

Tables 10a-c indicate that the strongest associations for all three subjects between Somatic Distress Measures and the EARS variables were found, as predicted, between the SDM and the EARS scores for the REM-Worst narratives. These associations were not significant, except in one instance (Subject 3, INI-AVERAGE), but they showed strong trends nonetheless.

These results suggest that in most cases, as REM-Worst scores dropped, somatic distress rose. That is, under more stressful situations, psychological functioning became more primitive, and somatic symptoms tended to increase.

The one exception to this was in the case of Subject 2, where, as noted also in Table 5b, her somatic distress rose as her affectivity and relatedness scores also rose to higher modes of functioning on the EARS.

In order to explore these relationships further, the weekly averages of REM-Best and REM-Worst scores were lagged one and two weeks, as were the SDM indices. Pearson correlations were then calculated, in each direction, in order to explore possible temporal relationships between shifts in psychological functioning and somatic eruptions.

Results varied across the three subjects. For Subject 1, no significant results were noted when examining the lagged correlations between REM-Best scores and SDM. However, three significant positive correlations were found between SDM indices lagged for one week and her REM-W scores. (OVERALL-LAG1: $r = .56$, $P = .01$; AVERAGE-LAG1: $r = .53$, $p = .02$; SCL-SOM-LAG1: $r = .44$, $p = .05$). That is, evidence of high somatic distress in week A predicted adaptive functioning (high REM-

W scores) in week B. Conversely, low levels of somatic symptomatology in week A predicted poor functioning (low scores) on the REM-Worst narratives in week B.

Intriguingly, though, a strong negative correlation was found when the REM-W scores were lagged one week with AVERAGE ($r = -.42$, $p = .05$). This suggests that poor functioning on the memory narratives in one week predicted high somatic distress in the following week.

A similar pattern was detected for Subject 3. When REM-Worst scores were lagged by one week, two strong positive correlations were found with #SYMPTOMS ($r = .47$, $p = .04$) and SCL-SOM scores, ($r = .38$, $P = .11$). When SDM indices were lagged by one week, two strong negative correlations were found with HIGHEST scores ($r = -.54$, $p = .02$) and AVERAGE scores ($r = -.52$, $p = .02$).

No significant results were found when REM-Best scores were lagged for Subject 3. When #SYMPTOMS was lagged one week, a positive correlation with REM-B scores was noted ($r = .442$, $p = .058$).

Again, this pattern suggests that more primitive functioning (low REM-W scores) predicted low levels of somatic distress in the following week. Conversely, though, low somatic distress predicted high functioning on the Worst memory narratives (High REM scores) in the next week. Further, the data suggest that more adaptive functioning as measured by the EARS on the Worst narratives (High REM-W scores) predicted high levels of somatic distress in the following week. These high levels of somatic distress were then followed by a drop in functioning on the narratives (low REM-W scores). A schematic of the pattern suggested by these results for Subjects 1 and 3 is presented in Chart 1.

Chart 1

Schematic of Lagged Correlations Between REM-W Scores and Somatic Distress Measures

Subjects 1 and 3: Cindy and Lisa

HIGH		***	***			***	***
LOW	***			***	***		
	REM-W	SDM	REM-W	SDM	REM-W	SDM	REM-W
	WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5	WEEK 6	WEEK 7

Subject 2 showed a different pattern. When lagged correlations were calculated for Subject 2 between the REM-Worst scores and somatic distress, results were mixed. In several cases, the correlations appeared to become stronger when either the REM-W scores or the SDM scores were lagged by one week. No discernible pattern was evident however.

Lagged analyses of Subject 2's REM-Best scores proved to be more revealing. Whereas Subjects 1 and 3 showed virtually no significant associations between SDM and lagged REM-Best scores, Subject 2 showed stronger and negative associations between REM-B and each SDM index when REM-B was lagged by one week. Correlations ranged from ($r = -.16$, $p = .52$) to ($r = -.33$, $p = .18$). That is, adaptive functioning on the Best memory narratives (high REM-B scores) predicted low somatic distress for Subject 2 in the following week. Conversely, poor functioning on the Best memory narratives (low REM-B scores) predicted high somatic distress for Subject 2 in the following week.

When the Somatic Distress Measures (SDM) were lagged with REM-Best scores, stronger negative correlations were found with four of the SDM indices than were found in the same week correlations of these same variables.

Correlations ranged from ($r = -.30$, $p = .21$) to ($r = -.45$, $p = .056$). These negative correlations suggest a more rapidly oscillating pattern, where high functioning (high REM-B scores) predicted low somatic distress in the following week, and vice-versa. A schematic of this pattern for Subject 2 is presented in Chart 2.

Chart 2

Schematic of Lagged Correlations Between REM-B Scores and Somatic Distress Measures

Subjects 2: Ruth

HIGH		***		***		***	
LOW	***		***		***		***
	REM-B	SDM	REM-B	SDM	REM-B	SDM	REM-B
	WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5	WEEK 6	WEEK 7

In sum, there was evidence for Subjects 1 and 3 that the eruption and remission of somatic symptoms were predictably linked to shifting levels of functioning as measured on their REM narratives under the Worst condition. This pattern was described above and schematized in Chart 1. By contrast, data show that for Subject 2, the experience of somatic distress was more powerfully linked to her Best memory narratives than to her Worst memory narratives. Finally, her weekly pattern of symptomatology (Chart 2) was more rapidly oscillating than that found for Subjects 1 and 3.

C. Qualitative Data

In this section, results from the analyses of the qualitative data will be presented.

I. Trauma

The Trauma History Questionnaire was administered during the Initial Screening Protocol in order to assess the level of acute trauma to which each subject had been exposed over the course of her lifetime. There did not appear to be meaningful differences in their experiences. Subjects 1, 2 and 3 reported a total of 9, 10 and 7 different types of traumatic events respectively. Each reported the experience of having been robbed, each reported having had a serious or life-threatening illness, and each reported some incidence of physical and/or sexual assault.

"Chronic abuse," writes Herman," causes serious psychological harm" (Herman, 1992b, p. 116). In fact, it is impossible to assess from a screening instrument such as the THQ the emotional impact of the traumatic events reported. Therefore, it is difficult to determine whether there is a linear relationship between these subjects' experiences of overt traumatic events and their current capacities for either affectivity or relatedness. However, none of the events appeared to be chronic, or to have occurred in early childhood. Thus, it seems unlikely that these events, in and of themselves, have had a profound impact on the development of personality and defensive styles exhibited by these three women.

II. Alexithymia

The authors of the Toronto Alexithymia Scale-20 (TAS-20)indicate that scores greater than or equal to 61 indicate the presence of strong alexithymic tendencies (Bagby et al., 1992b). Scores for the TAS-20 are presented in Table 11.

These scores again highlight the differences between Subjects 1 and 3 on the one hand, and Subject 2. Whereas Subjects 1 and 3 hovered around the alexithymia cut-off (≥-61), Subject 2 scored considerably lower. This score corresponds, in particular, to Subject 2's capacity to manage affect effectively under stressful situations.

Table 11

Scores on the Toronto Alexithymia Scale-20 for Subjects 1-3

Subject 1	Subject 2	Subject 3
TAS-20 = 65	TAS-20 = 45	TAS-20 = 59

No clear patterns were detected in the results when TAS-20 scores were compared to somatic distress as measured on either the SCL-90-R or the INI-II. There were some suggestive findings, however. The one subject who had a TAS-20 score above 61 (Subject 1, 65) had the highest SCL-90-R somatization score (.56). Subject 2 had the lowest TAS-20 score (45) and had the lowest average of all of the INI-II scores (4.16).

Tables 12a-c show that with these three subjects, TAS-20 scores were also suggestively related to scores on the combined affect dimensions of the EARS. Subject 1 had the highest TAS-20 score (65), and the lowest EARS affect average (3.09). Subject 3 had the second highest TAS-20 score (59) and the second lowest EARS affect average (3.21). Subject 2 had the lowest TAS-20 score (45) and the highest EARS

affect score (3.49). In sum, each subject's capacity for affectivity as measured on the EARS corresponded, relative to the other subjects, to her level of affectivity as measured on the TAS-20.

Table 12a

Scores from the Toronto Alexithymia Scale-20 and the Combined Best and Worst Affect Scores of the EARS.

Subject 1: Cindy

TAS	AFFECT (B + W)
65	3.09

Table 12b

Scores from the Toronto Alexithymia Scale-20 and the Combined Best and Worst Affect Scores of the EARS.

Subject 2: Ruth

TAS	AFFECT (B + W)
45	3.49

Table 12c

Scores from the Toronto Alexithymia Scale-20 and the Combined Best and Worst Affect Scores of the EARS.

Subject 3: Lisa

TAS	AFFECT (B + W)
59	3.21

III. Parental Descriptions

Scored representations of parents indicate that each subject's narratives were, generally, in the middle range of development toward psychological maturity and empathic relatedness. These scores are presented in Table 13.

Table 13

Scored Parental Descriptions using the Differentiation Relatedness Scale of Self and Object Representations (Diamond, 1990)

Subject 1 (Cindy)	Subject 2 (Ruth)	Subject 3 (Lisa)
Mother: 5 Father: 6	Mother: 2 Father: 5	Mother: 6 Father: 7

Five out of the six scores assigned were in the range from levels 5-7. These mid-range scores are highly consistent with the EARS object relational scores on the Recent Experience Memory narratives, where mean scores for each subject were in the transitional Mode III, between pre-subjective (Modes I and II) and subjective functioning (Modes IV and V).

It is noteworthy, too, that the mean score for maternal descriptions (4.33) across all three subjects was markedly lower than the mean score for paternal descriptions (6.00). In fact, all three maternal descriptions were less developmentally advanced than were subjects' descriptions of their fathers. That is, as a group, these subjects had more difficulty maintaining self- and other boundaries when describing their mothers than their fathers.

Subjects 1 and 2 received level 5 scores for their descriptions of mother and father, respectively. The authors of the Differentiation-Relatedness Scale describe

Level 5 as "semi-differentiated." Representations at this level are characterized by "primitive splitting of experience of self or other into polarized extremes." Others are described in absolute terms, without "contextual influences or temporal perspectives." Instead, concrete, physical features may be used in descriptions (Diamond et al., 1993).

By contrast, Level 6 scores, (such as those assigned to Subject 1 for her description of her father, and Subject 3 for her description of her mother) suggest an "emergent, ambivalent constancy." This is described as a transitional level, where representations become slightly more integrated and stable. Relatedness at this level "includes an emergent .and equivocal sense of tolerance for and ability to bring together divergent aspects of interpersonal experience" (Diamond et al., 1993).

A score of 7 was assigned to Subject 3 for her description of her father. Level 7 represents continued growth in this direction. "Descriptions at this level reflect consolidated, stable self and other representations...[and] an increasing tolerance of and integration of disparate aspects of experiences of self and other" (Diamond et al., 1993).

The most dramatic digression from these mid-range scores was noted on the description that Subject 2 gave of her mother. A long, rambling description, this narrative was given a score of 2 due to its vague and confused features. Boundaries between self and others were blurred, and, as the authors of the scale suggest, the subject provided a "flood of details which fail to portray a distinguishable person to whom one is related interpersonally" (Diamond et al., 1993).

This score is particularly striking, since, in general, Subject 2 demonstrated the highest scores on the object relational dimensions of the EARS. It may be that the task of describing her own very difficult and complex mother strained her capacities for self

definition and empathic relatedness. This challenge, in fact, may have triggered an extreme version of her characteristic narrative style of camouflaging her true feelings in an overwhelming barrage of detail (to be discussed in the Clinical Data chapter below).

These findings also suggest a strong association between object representations of early caregivers and subjects' experience of somatic distress. It is noteworthy, for example, that Subject 2, with the lowest scored description of her mother (2), was also the subject with the greatest range and number of somatic symptoms.

Theoretically, one would expect to see very high scores on these representations associated with very low somatization. In the case of these three subjects, their mostly mid-range scores suggest moderate, but not utterly paralyzing difficulties with object relatedness. This corresponds to their moderate, though not debilitating experience of somatic distress. Further and more systematic exploration of these relationships is required, however, before more conclusive interpretations may be made regarding the relationship between these early caregiver representations and somatic processes.

IV. Alienation

A score above 60 on the Alienation subscale of the BORRTI, according to its author, indicates severe object relational pathology (Bell, 1991). None of the subjects in this study scored above the 60-point cut-off. There are, however, some noteworthy findings. The scores for each subject's responses to the BORRTI subscale Alienation are presented in Table 14.

Table 14

Scores on the Alienation Dimension of the Bell Object Relations and Reality Testing Inventory (BORRTI)

Subject 1	Subject 2	Subject 3
Time 1: 12 Time 2: 23	Time 1: 6 Time 2: 5	Time 1: 26 Time 2: 24

The differences between BORRTI mean scores for Subjects 1 and 3 were minimal (17.5 versus 25). These scores on the Alienation subscale were in a middle range of scores. The data reveal a moderate degree of social isolation and a sense of not being able to meaningfully connect to others. These scores correspond to the EARS scores for Subjects 1 and 3, where the differences in their mean EARS scores on the object relational dimensions were also minimal (3.18 versus 3.28). This correspondence between scales is meaningful in that Mode III on the EARS also indicates only a moderate degree of empathic connection to others.

By contrast, Subject 2, with the lowest mean BORRTI score of 5.5 had the highest mean EARS score for object relatedness (3.75). The Alienation scores indicate that her feelings of social isolation were relatively limited. Her EARS scores correspond to this, indicating some capacity for sustained empathic relatedness. In addition, however, the EARS scores pointed to struggles around full capacities for separation-individuation and mutality.

Scores on the Alienation subscale also suggest a relationship between the mean BORRTI scores (averaged over the two administrations) and reported intensity levels of somatic distress. Subject 2 had the lowest mean BORRTI score (5.5) and the lowest mean SCL-SOM score (4.57). Subject 2 also had the lowest OVERALL INI-II score

(3.90), but the highest number of symptoms reported (4.8). The BORRTI mean for Subject 1 was the second highest (17.5) and she had the second highest SCL-SOM score (.561) and OVERALL INI-II score (4.55). Finally, Subject 3 had the highest mean BORRTI score (25), and the highest mean scores on the SCL-SOM and OVERALL INI-II scales (.773 and 4.80) respectively. In sum, scores on the BORRTI suggest that the extent of each subject's tendency to experience the interpersonal world as malevolent may be related to her level of somatic distress.

Finally, with regards to the possible changes in the BORRTI scores between the first and last interviews, only Subject 1 (Cindy) showed a marked change in her scores. Her elevated score at Time 2 reflected more isolation and disappointment in her personal relationships. Statements such as "It is hard for me to get close to anyone" and "I've been hurt a lot in life," which had received negative (false) responses at Time 1, were given positive (true) responses at Time 2. This shift may reflect, paradoxically, an increase in Cindy's ability to acknowledge the painful nature of her most important relationships (husband; mother) and a decrease in her need to disavow her own disappointments.

CHAPTER SIX

CLINICAL DATA

The human body is the best picture of the human soul.

-Ludwig Wittgenstein.[19]

A. Clinical Vignettes

My aims in this chapter are twofold: First, to describe through the presentation of three clinical vignettes how each woman in the study grappled, in her own unique way, with the emotional, relational and physical challenges of her life. Second, I will explore conceptually the common struggles in which they engaged as well as the personal solutions which each woman found for herself.

The following vignettes were compiled from the initial interview and the twenty weekly interviews conducted with each woman over the course of this study. The interview excerpts are presented verbatim in order to convey content as well as the particularities of each woman's narrative style. Occasionally difficult to read, I have left them in their original form so that each woman may speak for herself.

1. Secret Pleasures, Secret Rage: Cindy[20]

Cindy is a married woman in her mid-twenties. Born and raised in the south, she is living in New York temporarily because of her husband's current professional training needs. For the last four years, since around the time Cindy got married, Cindy

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[19] Cited in Morris (1991).

[20] Actual names and key identifying data have been changed to protect the confidentiality of each subject.

has been trying to cope with a changeable, often vague set of symptoms including rashes, dizziness, urinary tract infections, muscle aches, stomach problems, fatigue, anxiety and depression. After moving to New York, the symptoms intensified, and Cindy was forced to leave her job as a nurse when the symptoms became too intense for her to continue to function effectively. She has since found a part-time job in another field.

Cindy was greatly relieved when, several months ago, she was diagnosed with Candidiasis, a condition of excess yeast production in the body, and a mild case of Chronic Fatigue Syndrome (CFS). Two bona fide diagnoses made her feel less "crazy" and more hopeful that a clear course of action might lead her toward feeling healthy, strong and productive again.

Candidiasis is an invasive disease generally caused by a bacterial infection in patients with suppressed immune systems (Berkow and Fletcher, 1992). In fact, however, the precise causes of the condition are unknown, and symptoms have been linked to a wide array of possible triggers, including food allergies and psychological factors. Cindy linked her own condition to a reaction to excessive use of antibiotics prescribed for various yeast and urinary tract infections.

Chronic Fatigue Syndrome (CFS) is "a common and disabling problem in primary care practice" (Matthews et al., 1991). CFS has been linked to a variety of causes, both physiological and psychological. CFS "can be considered as a continuum ranging from cases with chronic [viral illness] on the one hand to instances of frank psychiatric illness on the other" (Byrne, 1991). Numerous studies report the complex and difficult nature of making a differential diagnosis between CFS as a distinct organic

entity and one profoundly influenced by psychiatric factors such as depression, panic disorder and somatization disorder (Matthews et al, 1991; Manu et al., 1993; Manu et al., 1992; Taerk and Gnam, 1994). "In fact, no specific etiologic role for infections or immune dysfunction" has been confirmed (Manu et al., 1992).

In one study, Somatization Disorder was diagnosed in 10% of patients with CFS, and patients in the CFS group were 23% more likely than age- and gender-matched control subjects to show signs of Somatization Disorder (Manu et al., 1993). In a separate study, psychodynamic treatment of patients with CFS found "an intimate relationship over time of fatigue symptoms to disturbances in object relationships, particularly within the transference" and "the importance of the patient-therapist bond as a facilitating medium for clinical improvement" (Taerk and Gnam, 1994).

These etiological pictures of each of these diagnoses, then, are somewhat ambiguous. My interest was not in the exact origins of her symptoms, however, but in the ways in which they changed over time. And, in fact, Cindy's levels of somatic distress did fluctuate in intensity. Furthermore, her symptoms changed. In all, Cindy reported nine different somatic symptoms over the course of the study, with an average of 3.7 symptoms reported at each weekly interview.

The impact of her somatic distress on Cindy's sense of herself has been profound. When asked what the worst thing about having these problems has been, Cindy replied, "I'm not the same person I used to be. I'm not happy anymore, I just wanna be back to normal. . . pretty much it's really screwed up my life."

Cindy had to relinquish the burden of supporting her husband through school when she left her nursing job. She felt guilty that in addition to her no longer keeping

her promise to support the couple, her medical problems had become financially burdensome. Disappointed in herself, she believed that others were disappointed in her as well. In our last interview, she said,

> I just feel like I've kind of lost my identity in that I feel like, you know, pretty much a loser right now because I'm not doing anything and I don't know what I want to do, and especially for [husband] - he has to kind of - explain to, you know, the people at (work) what does your wife do and, you know, I feel bad that he has to say "oh, well, she was an RN but you know," I mean, it's true I still am an RN but it's hard to explain what kind of position I'm in, I guess. . . I just feel like I'm floundering, you know, I don't know what I'm supposed to be doing and so - I don't know. . . I really feel kind of lost.

Many times during the course of our conversations, Cindy described her struggles around food and medication regimens. Cindy acknowledged, first, that she had always had a difficult time managing food and weight. For many years, she had cycled up and down with her weight, with a range of about fifty pounds.

> I've always used food as a comfort. It's the first thing I go to when I feel bad. . . I use it to feed my emotions, but then I always feel worse.

Cindy resented the fact that she had special dietary and medical needs. She wanted "to be like everyone else." Food, Cindy said, "is like a reward. . . It feels like a punishment not to eat what I want. . . I'm a nurse, I should know, but I still can't do it."

Later in the course of our meetings, Cindy revealed that she also had trouble taking her medications regularly. Frequently she would forget them. Sometimes she would take them all at once, or without food, when the prescriptions explicitly instructed that the pills be taken at meal time. She once said that having all these medicines made her feel like an old man, and that she hated feeling that way.

Gradually, as Cindy described in more detail her struggles with food and medication, it became clear that these difficulties with self-regulation were intimately

connected to her representations of herself and of others. She hated having the identity of a sick person, and she did not want to be a burden. She described herself as a "complainer," however, and regularly told her husband how she was feeling, physically and emotionally, hoping, in exchange, for understanding and support. She feared that he "no longer pays any attention," and that he was getting sick of her. After a bout of violent and disturbing dreams, Cindy approached her husband to talk about what was on her mind. She described her feelings about the encounter:

> I don't know. I guess I just . . . I can't expect him to read my mind or know exactly how I feel but . . . guess I wish that he would understand more . . or at least, talk to me in a more in depth way 'cause like last night, you know, he goes to school and listens to all this serious talk all day and talks to people who . . . so, when he gets home, he was just, you know, kind of in a silly, joking, everything was a joke and . . . he didn't really want to talk about anything. So, that was making me mad.

Likewise, Cindy was repeatedly disappointed by her mother's apparent refusal to talk to Cindy about how she (Cindy) felt. In speaking of her typical exchanges with her mother, Cindy said the following:

> When she calls, you know, it's basically, you know, what did. . . what'd you do today or what'd [husband] do today, or, you know, what my brothers are doing and what my dad's doing and what she's doing and so it gets to me that we don't really ever talk about anything. It's just kind of a daily, weekly update on the news, you know. And, I don't really know what I want to talk about but I feel somehow cheated that we're, you know, unfulfilled. I don't get any big conversation or any feedback from my family or whatever.
>
> . . . and I don't want to say anything. I don't want to, like, make it look like, oh, you know, I've been sick why don't you ever ask about . . . you know, I don't want to seem like a baby. That's not what I want, I just want to talk about things. . . I don't know.

Later in the study, Cindy again described her disappointment with her mother:

> . . . I don't know - I just guessed that I feel like she (mother) should be more interested or - I don't know - at least ask me how I'm feeling but she doesn't really do that. And even when I was sick it was obvious she didn't really - you

> know - offer much help. I don't know, it was kind of weird. . . I guess I want more of a reaction and it kind of makes me feel bad when she doesn't ask or say anything either.

Rarely did Cindy feel truly connected to another person. She tried to connect by talking about the way she felt physically. But her ambivalence around being a patient, being the one who was cared for, instead of acting as the caretaker, the nurse, led to a powerful "disavowal" (the first narrative style referred to above) of her own needs to be nurtured. It was hard for her to find the right balance. Following a trip to visit her family when Cindy felt utterly overwhelmed by others' demands on her, she ended up in bed for two days with the flu. Her mother drove her back to her apartment, and Cindy made these comments about the weekend:

> "Well, I hope you feel better," (mother said dropping her off), and then they left. So I kind of felt abandoned, but really they couldn't have really done anything if they would have stayed. But then when [husband] came home, you know, that makes me feel good and so I felt better so, I don't know, it was just kind of strange. . . I don't know, just, that it, there are so many things going on. You know, [husband]'s parents and then my parents and then I've got three brothers and I try to, you know, I'm only there for a couple of days so I kind of like catch up with them so I had, and then the (visiting) student, so it's almost like I have four siblings and then we had this wedding and you know, just feel like I'm being spread out trying to do all that and when I come here and it's just the opposite, you know, I'm by myself and I have nothing to do and I kind of like, I mean I like it today, I feel so much better and I have energy to get things done, but I wish I had a happy medium.

The most joyful moments Cindy described during our conversations were either those in which she experienced herself actually sharing feelings with another person, or in which she fantasized about the possibility of finding emotional connection through becoming a mother and relating to a baby. In both cases, these longings were secret and problematic. The structure of the narratives reflects this tension.

In the first example, Cindy and a friend, who happened to be a new mother, discovered a shared love of softball, and spontaneously went out to buy gloves and play catch in the park. She described the event this way:

> . . . going yesterday, I called my friend that has the baby, I love her little baby, he's so cute. Anyway, I said, you know we should go for a walk in the park and I thought just we would take a walk (for 10 blocks) and walk back or something. But we ended up walking all the way down (30 blocks) in the park and then we started talking about, we both played softball in high school and that we would like to do that. So we went and bought - it was almost like on a whim - we went and bought gloves and a softball and played in the park. That was so much fun. Felt guilty for spending the money but it was fun and I, I liked to hold the baby and everything, you know. So, it ended up we spent like four hours and I thought it was only going to be a quick walk and she, she really thought it was a good idea, you know, had fun and she doesn't really get out that much with the baby. So she was excited too. . . but then, you know. . . I felt, well, (husband) was kind of upset that I spent almost $50 for a baseball glove. I didn't ever remember them being that expensive. So he was kind of upset about that, so then that kind of ruined my night, you know. Oh well.

In this example, Cindy was unable to fully own or hold onto her pleasure in sharing the playfulness of the afternoon. Her account of this event as her example of the best thing that had happened to her that week was spoiled by an intrusion of guilt and hidden anger at her husband.

One month later, Cindy was wondering if she herself might be pregnant. She reported that she "always loses track" of her menstrual cycle, and that she often had to ask her husband if he remembered when she last had her period. In this case, she felt that her period was some weeks late, and began to fantasize about actually being pregnant and having a child:

> I thought oh, god, how am I going to tell my mom and I mean, I was kind of . . . I mean, I don't know. . . I didn't . . . I was kind of hoping, not hoping but . . . I don't know. I've been thinking lately that that would be . . . that I want to have a baby and so when that came up, it was . . . I didn't know how to feel I guess. Because even if I was happy, [husband] wouldn't be happy and his parents wouldn't be happy and I don't know how my mom would feel (chuckle) you

> know, so I guess for some reason it didn't really matter if I was going to be happy. It wasn't really the right thing, you know . . . Just . . . I don't know. . . just the . . . (husband) doesn't really want to you know, he doesn't . . . he does . . . well he's very uptight anyway, so, if that would be it would just mess up his whole . . . you know, plan, and I don't want to cause . . . I mean, I don't want to do it on purpose or anything else like that, you know. That would be . . .

Reading this narrative, one has the feeling that Cindy had many yearnings about becoming a mother that she was unable to fully share with her husband. Her excitement and pleasure in her friend's baby, and her longing to be closely to connected to someone, in the painful absence of that kind of intimacy with either her husband or mother, were hinted at but never expressed openly or directly.

Cindy's representations of anger and disappointment, in fact, were rarely full-blown. Instead, anger seemed to express itself in violent dreams, and in her fragmented presentation of her experiences. She repeatedly broke off her sentences, regularly punctuating her narratives with "I don't know." Her narrative style, which I will refer to as "disavowal," allowed her to get very close to expressing herself, and then to pull back, leaving the room thick with her secret, but silent rage and her unsatisfied longings for empathic merger.

Feeling used by a friend who hadn't called for months until she needed to stay at Cindy's apartment before an early morning flight, Cindy made the following confession about how she would handle her feelings:

> I don't know and I don't know how . . . when my friend gets here tonight, I don't know how that'll be (chuckle). I guess we'll just pretend. I don't know, it just makes me upset. It's not like I'm gonna you know, have a disagreement about it, like an argument or anything. But it kind of upset me (chuckle).

There seemed to be a striking correspondence between Cindy's inability to acknowledge her own needs and her pattern of somatic symptomatology. In fact, it

appeared to be precisely at the times that Cindy felt most overwhelmed with negative affect (often when feeling abandoned by important people in her life), that Cindy would report more intense somatic distress. In sum, Cindy's body seemed to express for her that which she was only partially able to put into words.

For example, following the week that Cindy learned that her parents were coming to visit her in New York, she reported feeling excited about their visit. She regretted, however, that one of her brothers would be unable to make the trip. During that same interview, she reported six different somatic symptoms and a HIGH somatic distress rating of 9 out of 10 to describe the intensity of her worst symptom (managing her diet). During that same week, Cindy drank too much alcohol at a dance and blacked out for several hours. Terrified that she might have done something uncouth or unkind, she was mortified by the entire event.

After the family visit, Cindy reported three different somatic symptoms and a HIGH somatic distress rating of 8 out of 10 to describe the intensity of her worst symptoms (exhaustion; dizziness). Cindy's narrative description of the visit began positively. She ended, however, by describing how much work it had been, how exhausted she had felt, and how much nicer it would have been if her husband had helped her out in hosting her relatives.

Several weeks later, when she was wondering if she might be pregnant, Cindy reported four different somatic symptoms for the week, and a HIGH somatic distress rating of 10 out of 10 to describe the intensity of her worst symptom during that week (her rash). During that same week, her friend with the new baby had left town, leaving Cindy alone, without someone with whom she could connect emotionally.

Interestingly, after Cindy's husband moved back home for the summer for a temporary job, Cindy reported only two symptoms for the week, with a HIGH somatic distress rating of 2. About his departure, she simply reported flatly that he had been "gone since Sunday."

Eager to please and say the right sorts of things, Cindy was often on the verge of communicating something, but more often than not, catching herself before letting out the truth with full force. Her home, where most of our interviews were conducted, was artfully and carefully decorated, with many cute and homey little nick-knacks, photos and crafts. Each item seemed to have a message of "We're happy," "This is a home," "We are a family." Clearly, however, the feelings between Cindy and her husband were more complicated than these emblems would suggest.

My own experience of being with Cindy was profoundly affected by her oscillating capacities to tolerate and express affect. I often left the interviews filled with feelings of sadness for her, struck by the unrequited and unacknowledged nature of her desires for intimacy and understanding. As our relationship progressed, I felt that she turned to me more and more for an experience of identification, mirroring and merger. She began to share her crafts with me. She commented that it was so nice to talk to someone who did not judge her at all. I even wondered if her fantasies about becoming pregnant were related to her unconscious awareness of changes in me brought on by my own new pregnancy. At the time of our last interview, conducted by telephone because she had left town for the summer, Cindy expressed sadness over the end of our

interviews. It became clear that these interviews had become, for Cindy, a time and a place where the language of her body might find expression and understanding.

2. Odd Man Out: Ruth

Ruth is in her fifties. Divorced, with grown children, Ruth has always lived on the east coast. Trained in the social services, Ruth is currently pursuing her second master's degree in a related field. Single, she lives with a roommate and her roommate's teenage daughter.

Ruth reported that she has had chronic somatic distress since childhood. Her principle complaints included what she described as "dysfunctional eating," bowel and digestive troubles, bronchitis, debilitating fatigue and various intermittent sites of pain, including her legs, feet, and lower back. In all, Ruth reported thirty-two different somatic symptoms over the course of the study, affecting virtually every system in her body. She reported an average of 4.8 symptoms each week. Her interest in participating in the study stemmed from her desire to understand why her body has so many things wrong with it. "I don't like to be sick," she said in our fifth interview. "I do what I do, but I'm somatizing, and I'm not getting to what's going on."

Although Ruth was accustomed to medical problems, having had numerous surgical procedures performed over the years, she reported that living with chronic somatic distress took its toll emotionally. She often felt "too tired to enjoy anything." Poignantly, Ruth remarked that the worst thing about living with chronic albeit shifting physical problems was that "You can't count on yourself."

Like Cindy, Ruth struggled with an inability to consistently regulate her diet. Rather overweight, Ruth reported that her problems with eating began when she was a child. Ruth told the story this way:

> Well, eating was a big issue. She (mother) made a -- whatever she made and I'm eating and I'm a very slow eater and she would -- and I really was intending to eat, I remember thinking -- I remember eating. And she thinks I'm not gonna eat or she gets impatient and she hollers and I lose my appetite, like a tenuous appetite. I liked cheese and vegetables. I didn't like meat, I didn't like certain vegetables. I was like a -- I had strange tastes. Anyway, so she screamed a lot, she did this a lot. And I think -- I remember feeling like buying candy with my own money and eating stuff, eating so it would be like a calm atmosphere. I think I was only like six and seven, the only thing you buy is junk. I remember that being nice, relaxed, quiet, you know. [laugh] And so her personality and where she wasn't like -- because she was having a difficult time in life, and then what she cooked, it -- I mean I was like a crazy eater. Somehow there had to be -- nutrition was in that craziness. But she was doing like whatever you do for the whole family, so I didn't know how to take care of me within those boundaries.

Over the course of our meetings, Ruth regularly reported her struggles with food. Mustering the energy to think about what to cook, to shop for it and actually make it, even to chew her food, seemed, at times, too burdensome. In the second interview, however, Ruth began to make some stunning connections between her early experiences with her mother around food and her life-long struggles with self-regulation and self-care.

> And I have been eating better this week than I have ever been because when I say that, I mean more variety, not that it's more dietetic or anything, just more variety. And I've had the patience, it's really the patience to cook more, to get up in the morning and make not only breakfast, but lunch, too, and think about dinner too. . .
>
> After we talked last week, what was interesting to me was that I felt like I didn't know how to take care of myself, 'cause my mother didn't take care of me well, like in eating or things like that. I didn't eat well. She did what she should do but it wasn't tailored to me and it didn't work. So I did not know how to do it well. That hit me that night and the next morning. 'Cause I feel like I'm learning how to do it now. Isn't that something?

As with food, Ruth struggled to find for herself a healthy dose of activity. Saddled with a demanding job, Ruth nevertheless repeatedly found herself taking on extra responsibilities, at work and in her personal life. Thus, along with feeding herself, the dilemma over how to budget her emotional and physical resources literally consumed Ruth, and was the focus of many of our meetings.

Ruth frequently described the many things going on in her life, and revealed how burdened she felt by all of her commitments. Over the course of the study, Ruth reported numerous absences from work. Unable to muster the energy to go, she had to spend one, sometimes two days resting in order to rejuvenate herself and gather enough energy for the next plunge. "I didn't feel I had any time for myself," she reported in our third interview. Ten weeks later, she made the following comments about the experience of feeling trapped in her busy life:

> At this stage in my life, I have to go away to relax. Once I wanted to just go to a hotel in town, but I kept forgetting to do this. I liked the idea, I just never got around to it. Part of the syndrome of feeling overwhelmed is that even getting away is too much trouble.

In our nineteenth meeting, Ruth said that she felt as though her choking and stomach symptoms that week were a result of doing too much. "It's not a normal pace," she said. "I didn't even have time to go to the bathroom." Elsewhere, Ruth described her conflict over extending herself, and implied that her body is unwilling to accept the emotional and physical demands she takes on. After spending the week responding to the personal crises of two close friends, she said:

> Anyway, they were glad to have me around and I was glad to be there. The other part of me wanted to be in Hong Kong but then. . . no, I would say that's wrong, another part of me wanted to be someplace else. It felt like need, it felt like need. I wanted to be where I was, but the system doesn't work like that, you know, it doesn't work, um, so many days in a row. Selflessness is not for human

> beings - (pause) - to that degree. (pause) (yawning). Well, so that's it. Another simple [laughter] week [laughter]. I want to take a vacation!

Ruth came upon the following insight regarding this incessant push toward activity in our ninth meeting:

> My mother was very negative. In fact, I used to kid her that she brought me up with a paradoxical method of child rearing. . . Whatever she said, I analyzed and did the opposite (laughter). I thought I was very helpful, because I had to like prove to myself that she was wrong all the time, and she was negative. She was um, like if you said something, oh, what about this? She said, yeah, but look at this, look at this, look at that, all negative aspects. And so, you'd have to prove like a hundred percent the other way in order to make the move or whatever, or prove her wrong. You're gonna get sick if you don't wear boots. You'd have to be . . . go without boots and not get sick, you know, and that. Anyway, so I went to um. . . . and she . . . actually I . . . her judgment wasn't that good, she was wrong like most of the time.
>
> Q: So, you've spent even your childhood going full force in the positive direction?
>
> A: Yeah, yeah, yeah, it was like an uphill fight. . . a struggle.

Ruth's conflict over regulating her activity level was also powerfully influenced by her desire for emotional contact with others. Ruth repeatedly referred to "nice" feelings of "camaraderie" when asked about the best experience she had had during each week. "Meeting of the minds" is a phrase that she used often, and she repeatedly reported her pleasure at being included in various social and family events.

In the course of her narratives, it became clear, in fact, that Ruth's greatest pain in life stems from the experience of feeling like "the odd man out." The rare experiences of being truly seen, understood and valued were extraordinary for her; so extraordinary, in fact, that she barely let herself know she wanted them. When they did occur, her accounts of them were "camouflaged," the second narrative style I'd like to highlight. That is, the intimate and precious experience of being seen by and attuned to

another was buried amidst so much voluminous detail that even Ruth might have missed what was at the core of her story.

Two powerful examples illustrate this tendency. The first is an elegant and playful description of an experience of acceptance and attunement:

> My roommate's daughter sings and I sing with her and I sing off tune. When I go off tune she's there on tune. She sings alto when I sing on tune and if I go off tune she sings on tune. She makes me the alto and she's on tune. So, my son's girlfriend wants her to sing "Ave Maria" at the wedding. So she says she could fit me in (laughing). She was very pleased and very thrilled about that and she says, 'Oh wow, they want me to do that.' She said, you know, 'I could fit you into a piece" and that just made me laugh out loud. . . it's just this big dream of me going off tune in a church and her blending in (laughter). . it's ok for the kitchen, but I don't know if I was ready to take that on the road but, she would just, when we would do it . . . when we'd sing together it just tickles her, she's really good at it and it is . . . it's an interesting phenomenon, it's like a challenge to her and it really works 'cause it makes me sound like I'm singing so I like it, anyway, so she just made me laugh out loud with a vision of us doing this in a formal setting.

To truly (and literally) find herself in harmony with another person was a rare and precious experience for Ruth. The next example offers another poignant illustration. As part of her continuing education, Ruth designed a project that involved the possible participation of many of her colleagues. In this example, she described what happened when she started to pass the proposal around. I include this long excerpt in order to illustrate not only the content, but Ruth's tendency to "camouflage" her feelings as well.

> I feel really relieved because what we did yesterday was untangle everything. So that it's very busy but it makes sense. It was like how to coordinate all these people - 10 people - and still have to get packets to them but and I'm going to, there is one other person I have to talk to because I got mixed up, I see some teachers certain times and other people other times. The people I don't see I have to fax the stuff to. But mainly we got the whole thing organized so that we attend this meeting on Tuesday and on Wednesday was our last class and a bunch of people will join us there and then on Thursday the main people who wind up writing it will meet, and then the larger group will go, too, on Thursday.

> The main people are going to ask the main questions and I figure if someone else can step up, it's just an addition that comes with us. . .
>
> And it continues to be extremely positive. I'm, it's such an unusual position for me to be in, it's overwhelming. I spoke to, we never had, I mean I never had time to like get a community family member or something like that from (school), you know a parent and I spoke to a parent, to (organization) president Mr. P. and he said he's leaving, but the person who is going to be there gave me her number and then like the next day there was someone else, like I heard him say T., I was looking at the name and it was her, and she loved it. . .
>
> And I learned to make a ring out of a dollar bill, you know like an origami thing. Now I had a lot of trouble with origami because I have right/left confusion, but I keep trying to buy easier and easier books, I mean if I sat there for like hours I could do it, do anything but I don't devote that much time, so anyway between this ring I mastered, and everybody liked that ring including kids, the doorman, grown ups, teachers.
>
> So I have these two things, like one that is kind of silly and then one that's important that is like overwhelmingly accepted by every type of person. That's like a strange, I hit a mother lode or something 'cause gosh, usually I'm odd man out, people nod their head because they like me or something and they don't know why I'm saying what I'm saying or why it makes sense but somehow I picked the right time or something.
>
> Q: What was that like for you?
>
> A: It just makes you have like a giggle inside, like totally it's really funny! The ring was a very funny thing, very funny. I mean you would have like ghetto kids responding to it and teachers liking it so I just give them away or people give me dollars and I make it on the spot. Now I'm so good (laughs) I can make it different sizes, I can adjust it. And the doorman wanted me to make one out of a $100 bill, which is a total adjustment because it's built differently so like it has to show the $1 here but the $100 had to show the $100 there and it was in different place. So I said this is just very funny, it's totally tickled me when I think of it.

What made Ruth happiest, it seemed, were the fortuitous moments in life when friends or family or colleagues serendipitously found themselves sharing something. It was not simply that she enjoyed the company of others; what was special about these moments of connection was that they happened effortlessly. She didn't have to work for

them. They were, to use her words, "happy accidents." Ruth described one encounter in this way:

> Well, I met a friend on Friday night. She works for the (same company) and ah, we've been friends for 10 years. We hung out, talked and laughed, you have to be with someone from the (company) and they have to have that kind of sense of humor! I know we both appreciated each other a lot, that we could laugh about this stuff. That felt good, it was fun, because I was someplace, I was going to call her and then I started food shopping and I was carrying too much. I was carrying too much of it to go out for a drink or dinner or something. But when I got home, put everything down, she had called. . . and we had had no pre-arranged thing, so that was fun. Great minds think alike.

Ruth's perception of herself as the "odd man out" and her difficulties in acknowledging her desire for support impeded her ability to ask for help. She described herself as someone who readily acknowledges feeling physically ill, but her narratives revealed that she was much less likely to admit emotional exhaustion or overload. Generally, she was prepared to handle things alone, until, as often happened, she collapsed physically. Occasionally, however, in the course of our meetings, she described encounters in which she found herself being the nurtured one. In one case, she said that a friend who picked her up remarked that Ruth had not eaten, and took her out to eat. "She pampered me," Ruth remarked. "I could have lived without it, but I liked it," she continued almost sheepishly. Weeks later, Ruth described her evolving relationship to this kind of caretaking in the following way:

> I've been independent since I was a little girl. So when someone treats me like I was a child, kindly, when I get it, it's just feels unusual because I'm not used to it. Because I don't need it, because I've done it in isolation, so it's like I don't need that, but it feels nice, too. It's really from like when you are uncomfortable with something and you are a little awkward with it, because it's not something I, I was used to or I grew up with. When I was a kid I stayed out all the time, I had lots of illnesses, but my mother wasn't that type. She wasn't indifferent. She was being more pragmatic. . . Actually it feels good, so I don't want it to stop, but I'm not used to it.

Interestingly, Ruth's experience of somatic symptoms corresponded to her narrative style in striking ways. As with her representations, Ruth's experience of symptoms was one of excess and camouflage. As noted above, she reported 32 different symptoms over the course of our meetings. She often seemed to be buried under an overwhelming array of physical ailments. Her sense of self seemed submerged beneath the discomforts.

Or, paradoxically, it may be that her somatic symptoms represented a way of recovering her sense of self. At times, in fact, somatic symptoms seemed to stand out as concrete islands in an otherwise virtually endless sea of thoughts and feelings. It is possible that, for Ruth, her lifelong struggle with her body has been a response to her early experiences of not being seen, and of being lost in what she describes as the hysterical neediness of her mother's personality.

Clearly, her body reacted to the excessive demands and pace she set for herself. Ruth reported the lowest number of symptoms (1, 2 or 3, compared to her weekly average of 4.8) following weeks when she experienced considerably greater leisure time and/or emotional closure on stressful matters. Her physical and emotional burdens temporarily lifted, it may be that Ruth no longer needed her symptoms to retain (or recover) a sense of self.

My experience of being with Ruth was a powerful one. She was alive with humor and empathy, and very much interested in the world around her. She laughed easily and warmly, and was often able to engage me as a listener.

Mature in many ways, Ruth was nevertheless very childlike. She often came to the door looking a bit disheveled (we met in her apartment), with hair wild and a floppy old house dress on. She sat with her feet on the couch, legs in an array of awkward positions.

Ruth's interpersonal style, like her way of being in the world was, at times, overwhelming. Though I felt warmly toward her, I often found myself feeling lost in the detail of her narratives, and in the manic energy of her associations and memories. My feelings of disorientation were, I suspect, similar to her own sense of being overwhelmed by the powerful feelings which drove both her inner experience and the frenzy of her daily life.

3. Negotiating Intimacy: Lisa

Lisa is an artist who has been supporting herself by working for the state. She is single, in her late twenties, and has lived in several areas of the country. Her parents divorced several years ago, and she has several siblings.

Lisa had been suffering for approximately nine years with a chronic pain condition affecting the genital area. She described her pain as a combination of intermittent stabbing and itching sensations, accompanied by painful muscle contractions in the area. After ignoring her discomfort for some years, she began several years ago to seek treatment. She recently received a diagnosis of Chronic Vestibulitis affecting the vulvar region.

Vulvar Vestibulitis has been described as a "clinical condition of unknown etiology" (Prayson et al., 1995). There is some evidence that the condition is related to

a state of chronic inflammation (Prayson et al. 1995), but the precise etiology of the inflammation is not known (Paavonen, 1995).

Like Cindy, however, Lisa was relieved to have an actual diagnosis, as she had already suffered through years of frustrating encounters with doctors who told her either that there was nothing really wrong, or, appallingly, that she should ignore the problem until she gets married. When asked what was the worst thing about having these symptoms, Lisa responded, "Not knowing if they'll ever be gone completely. . . or if they're gone, if they could recur."

Questions about treatment options, and a general sense of desperation about her condition prompted Lisa to volunteer for this study. Interestingly, however, although treatment considerations were a central focus of our conversations, Lisa reported a total of eighteen symptoms during the course of the study, with an average of 2.5 symptoms reported each week. As with Cindy and Ruth, the course of Lisa's symptoms seemed to vary with her general level of stress and emotional strain.

Like Cindy and Ruth, Lisa battled with herself over foods and remedies. She struggled throughout the period of the study to uncover the chemical source of her condition. She experimented frequently with different dietary restrictions and herbal remedies. At times, however, she reported that she had been unable to keep to her diet plan, either because she didn't feel like it, or because she got too hungry and had to gobble lots of sugary foods to make herself feel better.

As for the remedial herbs and alternative treatment modalities, such as acupuncture and chiropractic adjustments, Lisa alternated between feeling helped and frustrated with each. Cost was a critical factor throughout her decision-making process,

and her relatively precarious financial situation added to her feelings of desperation and loneliness.

In addition to her erratic eating and treatment patterns, Lisa reported that she often felt as though she were "running on empty." Her schedule was demanding. In addition to working full-time, she was studying for an advanced degree at an art institute, putting in many hours each day. She reported that her sleep was poor when she was working especially hard.

Several weeks into the study, Lisa reported that her job situation had become quite tenuous, and that her severance package was in jeopardy. This news created considerable turmoil for Lisa during the following weeks, adding significantly to her general level of stress and anxiety. Rageful and tearful outbursts, marked by paranoid worries, characterized her reactions to many of the events at work during these weeks. Though it was difficult for her to maintain her emotional equilibrium, Lisa did ultimately manage to save her severance package, leave the job, and secure new employment.

Due to the extremely private nature of Lisa's principal complaint, sharing her experiences of somatic distress with others has been particularly difficult for her. "It's too strange for people to deal with it," she said, "I really don't want to share the details." She reported that from the few friends in whom she had confided over the years, she had gotten mixed reactions, with some being supportive, and others who clearly did not want to hear any more or deal with Lisa around the problem. Her reluctance to tell others, Lisa remarked, stems from how difficult it is "to understand someone else's physical sensations."

During the period of the study, Lisa became romantically involved briefly with a man. She reported that although she talked to him somewhat about her condition, she didn't give him many details either. "It's nice to have an ear, without his being too involved. I couldn't handle his advice." With tears, she added that everyone thinks she should "do something." It is as if, she said, "they don't realize that I've already tried a lot of things. I want someone to acknowledge that there are aspects of this that are beyond my control."

And so, Lisa has suffered this physical ordeal mainly in a private silence. She referred to the pain as "an insult," and reported that the attacks made her angry unless she was really distracted. Somehow, she added, if she's busy at work, the pain "is less of an insult there."

What was striking about Lisa's way of relating both to others about the pain, and even to the pain itself, was that it matched her way of being in the world generally. Lisa lived in anticipation of rejection. Her encounters with doctors, employers, teachers, colleagues and partners were characterized by a persistent sense that she would be ignored and unappreciated. In speaking of developments at work, Lisa said the following:

> I called into work and um, my uh, boss just gave me this cryptic, I need to see you tomorrow, something came with up with your hours and it sounded like a threat of some kind. You know, in the middle of a sick day. So, I was had all these terr -- ridiculous paranoid fantasies that they actually tried to leave me off and not let me take the severance, so I made a bunch of phone calls. Tried to tell everybody that I was taking the severance so he wouldn't bother hassling me, just like to get, I don't know, sort of I had a trump card, 'cause I didn't want any. . . I was just in disbelief that any issues could come up about my performance now when they went over so thoroughly and in so many ways, and they're haggling over like a half an hour here or whatever. So, I got . . . I got just totally enraged without really knowing what was going on because she wouldn't talk about it over the phone, and I had to wait until this morning to deal with it. I

> don't know what she's thinking, feeling; not what I thought she was but, I don't know, she may also be a very good actress.
>
> Q: Why? What do you mean?
>
> A: I mean that, everybody has their own agenda to complete, you know, there are people who try to get to unionize civil servants into positions like mine, 'cause I not some sort of um. . . it's just really a brutal atmosphere. But, I have to run around telling people why they'd be stupid to want the last 6 months of my grant and that nobody could actually do what I'm doing, which is kind of true. So, I mean, it's just. . . you waste so much time explaining yourself, trying to defend your turf and, um, I'm revolted by it, it's a useless waste of energy.

Lisa repeatedly expressed great "relief" and "surprise" when she received positive feedback and acceptance. It was as if this kind of recognition, like a permanent cure to her pain problem, was never to be expected or trusted. In the following excerpt, Lisa revealed some of her self-doubts and something about the way she approached the interpersonal world:

> Yesterday, I ran into a friend of my boyfriend's that I hadn't seen in a few weeks, she's also an artist, and we had a lot to talk about, we just had a nice conversation. I realized I'd misjudged her friendliness. Last time she was in a hurry, and didn't interact much, and this time she was nice. It sort of let me trust him a little more, because if I have good contact with his friends, he gets some points, or whatever, by association. We talked about art, she seemed to see me as a colleague in a way, I hadn't realized she thought of me that way, she's got a good reputation, she's really good. I've never felt like I'm quite in her league, but she didn't act like that's the truth, so I give her a lot of credit for that. . . it was a nice surprise really, because his friends intimidate me, and it was nice that I didn't have occasion to be intimidated.

In the following example, Lisa described her muted and unexpected pleasure in receiving attention on her birthday from her new boyfriend:

> Um, I had a very nice evening with my significant other. He uh, kind of surprised me, we went up to where he lives and uh, it was very nice. He, he surprised me for my birthday, he just tried to relax me, you know. And, the next day he was gonna try and come down to be with my friends for drinks with me for my birthday, and he wasn't that clear if he'd make it. . . but he made it, so I was really happy about that.

In fact, like Cindy and Ruth, Lisa longed for the experience of being one with another person. Also like the other women in the study, however, Lisa had a particular style of representing these longings. I will characterize her narrative mode as "minimization." Whether talking about her pain condition or her daily life, Lisa spoke flatly. She acknowledged pain and disappointments, but without vitality or elaboration. In describing a weekend she spent with some old friends, Lisa said the following:

> I spent about 72 hours straight with like 5 other people, and we didn't get sick of each other, and we had a really nice time. We were able to talk about things that are pretty substantial in our lives. Maybe not like really large issues, but aspects of, you know, personal and professional life that we hadn't really caught up on in a while. And it's, everything just made sense to everybody else. Like. . . I felt like these people are closer to me than my family. We have so much more, so many more places to agree. . . (pause) But the whole weekend was, great.
>
> I got to do a lot of things that I don't normally get to do, like cook for people, and they appreciated it, and I felt generally, generally, you know, liked. . . Like I, it was a lot of freedom that I don't have in my, in (home town), just to be able to say anything to anybody and that's fine.

As this excerpt suggests, Lisa was never exuberant. Her sense of interpersonal vulnerability kept her from embracing either her desire for closeness or the pleasure she actually felt when an intimate encounter occurs. Interestingly, she described several different relationships, between other people, that she was trying either to repair or to arrange. Of great concern, for example, was the relationship between her mother and her mother's sister. Lisa expressed muted disappointment over their estrangement and wished aloud that they could reconcile before it is too late. It seemed to be safer for her to negotiate intimacy for others than for herself.

Reflective of her minimizing style, Lisa positioned herself in a posture of "pleasant surprise" when something good happened. Similarly, Lisa often expressed "confusion" over disappointing encounters with others. She repeatedly commented that

people were hard to figure out, that they weren't being straight with her. The state of confusion seemed to protect Lisa from having to confront stronger negative affects, as in the following example:

> My good friend from way back and I had a beer on Tuesday night, she confronted me about something I'd done in the 9th grade that I'd forgotten about, it's been grating for 10 years, 12 years, 14, I don't know, whatever. I do have kind of a poor memory, but that was kind of ridiculous - I believe it happened. I'm afraid I've been revisionist lately. . . what else did I forget? It's confusing, because I can't believe something I don't remember has been pissing her off for so long. I sort of doubt my recollections of things.

It is noteworthy that Lisa also seemed to be "confused" by her principal physical problem. As indicated above, she experimented with various remedies and tests, always hoping to discover the true source of her pain.

Like Cindy and Ruth, Lisa demonstrated a close connection between her characteristic style of narrative representation and her experience of somatic distress. Like her narrative style, somatic symptoms seemed to express for Lisa, and protect her from that which was too private, that which she literally could not speak about. In the following excerpt, Lisa described a somatic reaction to a film she saw with her boyfriend. What is significant here is not only the somatic reaction; also relevant is the fact that Lisa was unable to communicate verbally. Her style of keeping disturbing affects at a relatively safe distance was heightened under stress, and she was left with only her bodily reaction.

> I think it was being with my friend on Saturday, we saw really a horrifying movie it just really was disturbing and my reaction wasn't so good and his reaction was not to react at all, so I just spent a few hours really confused about everything. . . kind of like the aftermath, it was a really horrible experience. . . I didn't seem to have the vocabulary to express the nauseated quality. . . I didn't want to talk about it with him or anyone else, so had to just wait it out and be, you know, not myself for a while. Was the first time I actually thought about throwing up during a movie.

Lisa also seemed to translate rageful affects into somatic terms. During a three week period when stress at work was increasing, Lisa's HIGHEST ratings for any single somatic symptom were 7, 8.5 and 9 out of 10. Her OVERALL rating of physical distress jumped from 3, prior to the troubles at work, to 7 out of 10, when things seemed to be at their worst.

The following excerpt conveys Lisa's sense of isolation around her main physical problem as well as her muffled inner experience of living with her emotional reactions.

> My brother came up last weekend with his wife and a friend, and they were just joking around, we were at the gal's apartment, they were just joking around and, I like to cook, I had cooked for them in (other state) a lot, in August, and they enjoyed that, and (brother) said something about my cooking and this gal said, "She's talented, she can cook, she's not married yet, what's the deal?" It's like, this cute thing, supposed to be funny, and an hour later, I got this delayed reaction, I just really wanted to hurt her, she just has no idea what she's talking about. My brother has had the good sense not to ask me, because I couldn't really explain it to him, and his wife never probed me, although she's a very good friend. They were really comfortable with the comment too, so I just had a not so good reaction to her as a person, you know. My brother and his wife - they know something's up, they don't know what it is, they don't know the details, but she made the unfortunate mistake of bringing it up. . . It felt really unfair. . . I don't know who I'd be without this pain condition. (Tears) It's so much a part of my identity and my personal relationships - it's affected everything in a big way. . . There are just no words for a lot of things I should tell (my boyfriend). . .

My experiences of working with Lisa during this study were complex. Each week, I kept expecting Lisa to drop out of the protocol. She was regularly ten to fifteen minutes late coming to the interviews (interestingly, we met in my apartment, not hers), and she seemed to experience considerable distress whenever she felt emotionally

exposed. She seemed edgy and resistant. And yet, Lisa continued to come. And my interest and empathy for her grew.

During our second meeting, Lisa told me that her older sister had given birth five years earlier to a still-born baby. This was a very sad event for the family, and for Lisa in particular. She commented that although she had never dealt with it, she was interested in participating in the study, because maybe she would give herself the chance to think about this loss. I have puzzled over this disclosure repeatedly, as the experience was never raised again, My understanding, now, is that this unthinkable loss, like her own physical pain, stood as a symbol for Lisa of that which was unspeakable. I believe now that this was her way of telling each of us that we would be speaking in a language capable of masking a great deal, and that real communication and mutuality would be difficult to find.

B. Discussion of Clinical Vignettes

In reviewing the qualitative material collected during the course of this study, it became clear to me that many of the themes and concerns which emerged might be broadly grouped together under the three general concepts of Self-Regulation, Attunement and Safety. Each of these areas of functioning is intimately related to the other two. In fact, they seem to cascade down and around each other in such intricate ways that to try to delineate them seems almost foolhardy. There are certainly innumerable ways that one could try to bring order to the myriad questions and concerns raised by each subject over the course of the twenty-one interviews. This

schema is simply one attempt to create patterns of meaning out of that which is already so personally vital and significant for each individual woman.

1. Self-Regulation

As noted earlier, the capacity for self-regulation begins to develop in the first exchanges between an infant and her caretaker. In its earliest phases, self-regulation refers largely to the regulation and maintenance of physiological homeostasis. Gradually, as affects become less global and more differentiated, the task of self-regulation begins to broaden. Ideally, at this stage, infant and mother, together, come to recognize and organize both physical and emotional needs such that the child is bathed in a relatively predictable experience of physiological continuity and emotional balance.

Interestingly, all three women in this study struggled around the orderly regulation of bodily concerns and practices. Central among their concerns was the difficulty of settling comfortably into appropriate eating habits. Each woman had strong (although sometimes shifting) beliefs about which foods she should and should not eat. Nevertheless, the effort required to stick to a prescribed diet was enormous, and raised for each subject many painful and complex feelings about herself. Battles around certain foods dominated the experiences of each woman in different ways.

A related concern revolved around the use of medications and/or herbal remedies. Maintaining a consistent regimen was very difficult for everyone. Ambivalence, cost, resentment at having to take anything at all and shifting ideas about what would help the most were all disrupting factors. Thus, some of the basic

requirements of survival, knowing what to put into one's own body, when and how much, were poignant and painful challenges for each woman.

In addition to the question of what to put into her body, each subject wrestled with how much energy she could afford to expend. Without exception, each woman in the study pointed to "stress" repeatedly during the course of our weekly interviews as one of the prime culprits for her chronic somatic distress. The meaning of this term (by now, much maligned due to cultural overuse and dilution), shifted from woman to woman, and even for each woman at different moments. In general, however, what was implied was a sense of overwhelming burden, sometimes physical and sometimes emotional, from which there seemed to be little escape.

Work and personal relationships seemed at times to consume each woman. Each described the experience of going and going until, literally, there was nothing left inside for them, and they found themselves collapsed at home, sick and exhausted by all of the commitments they had made. Pulling back was not simple, however, for each took great pride and pleasure in "being productive." Terrible shifts in mood and self-esteem resulted for some when an easing up of outer demands resulted in feeling empty and useless and ungratified.

Connected to the difficulty of regulating food, medications and energy expenditure was the broader issue of healing. Perhaps it was a function of the stage of dealing with their bodies in which each woman found herself when she volunteered to participate in the study. It was striking, nonetheless, to see that each woman was consistently grappling with various choices about what would help her the most: Should I change doctors; should I get a new job, or alter my lifestyle; should I think more about

my symptoms, and rest more, or should I think less about my symptoms and throw myself even more fully into life? These are just some of the options the women considered.

Something noteworthy about these options is that they were often framed in binary terms: More or less? All or nothing? The sense I had listening to these women explore these various choices was, at times, that an inner sense of knowing, feeling for herself what was needed, and what would be right, was absent. Again, one is reminded of McDougall's description of the unique role of the mother as the one who is able to "interpret her baby's cries and gestures," and thereby lay the foundation for the infant's ability to symbolize (McDougall, 1978/1992). Why, I began to wonder, were these women unable to represent and integrate into their daily lives what it was that they needed?

2. Attunement

As with self-regulation, the concept of attunement is one that has evolved largely in the context in mother-infant research. Most eloquently explicated, perhaps, by Stern (1985), attunement refers to the experience of sharing an intimate emotional connection with another person. This connection may be communicated in words, between an older dyad, but for infants, the connection must be conveyed by way of non-verbal exchanges. Stern speaks of "vitality affects" as a way of describing the utterly enlivened and enlivening currency of this early emotional exchange. "Vitality affects" along with categorical affects, like anger and joy, are mirrored and exchanged, heightened and shaped through the mutual experience of emotional sharing.

Central to the experience of being so intimately attuned to another is the inner impression of being known, understood and seen. As noted earlier, an evolving experience of intersubjective attunement with caretakers (Stern, 1985) ultimately enables an infant, and later, a young child, to know herself. This allows her, eventually, to symbolize her own inner and interpersonal experiences, and thereby regulate physical and emotional stimulation.

It is not surprising, then, that women who demonstrated difficulties in the realm of self-regulation also lived in an interpersonal world marked by unsatisfied longings for attunement. Without exception, although with personal and idiosyncratic variation, the desire for understanding and emotional connection rang out like a plaintive song throughout each woman's accounts of her life. Whether dealing directly with the experiences of chronic somatic distress or with the more general demands of living in the world, each woman, in her own way, craved empathic mutuality, companionship, and a sense of being one with another.

Many of these longings, however, went unacknowledged. Often, they were expressed indirectly, by way of the negative affects accompanying a disappointment. Repeatedly, women told stories of being misunderstood, ignored, cheated and unappreciated, sometimes by those closest to them. Thus, even more poignant than the desire to share in an experience of attunement was the lonely harboring of that unconscious desire, silent and unspoken.

3. Safety

With the introduction of the concept of safety, I mean to imply a broad range of concerns and strategies relating to the need to ward off impingements, from inside or outside, which threaten to undermine the stability or integrity of the self.[21]

A person without defenses would be virtually incapacitated. Thus, the presence of defenses, or, to use Sullivan's phrase, "security operations" is in itself not remarkable. What is interesting is to examine what they are for a given person or group of people, and to see how they operate and shift over time. I introduce the concept of safety, then, in order to explore how it is that the women in this study handled the challenge of acknowledging to themselves and representing to others that which was most precious and private to them without risking too much.

In the discussion that follows, I will focus on each woman's style of managing affect and connecting emotionally to others. Specifically, I want to highlight the ways in which somatic symptoms and various styles of narrativity seemed to serve important security functions in helping each woman contain and survive overwhelming affects, both positive and negative.

The central fear, expressed differently by each woman, revolved around the experience of being emotionally alone. Abandonment, rejection and isolation characterized each woman's concerns about interpersonal encounters. The corollary "security operation," it seemed, was an inability to fully acknowledge either the excitement and pleasure when positive encounters occurred, or the deep hurt and

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[21] My thinking here has been influenced, in part, by the work of Harry Stack Sullivan (1953) and his discussion of the ways in which "security operations" serve to protect what he termed the "self-system."

disappointment when, in fact, each woman was left feeling unsupported, misunderstood and alone.

Eruptions as well as responses to somatic symptoms appeared to play critical roles in the managing of these unruly affects. When subjects were unable to fully acknowledge their own emotional needs, the body suddenly seemed to erupt, as if to cry out and say, "Look at me! I need to be seen, taken care of." In other cases, somatic symptoms appeared to be a direct response to emotional pain; the symptoms enabled subjects to concretize and make visible in a less threatening form the experience of emotional insult. The body was speaking its own language, its message in code.

Related to the need to safely tolerate one's affects internally was the challenge of communicating them to others. Each woman seemed to have found her own resolution to the delicate dilemma of negotiating contact with others around the private experiences of chronic somatic distress. In fact, each of these three women had a distinct narrative style which characterized her way of recounting her weekly experiences. The responses were on a continuum, from extremely verbose, manic and detailed, to flat, curt and minimizing.

More specifically, the women in this study demonstrated what I have described as three relatively distinct modes of communicating to others: disavowal, camouflage, and minimization. In the case of Cindy, she regularly hinted at feelings, but quickly disavowed the full weight of her emotional experience. Her frequent use of the phrase "I don't know" was a characteristic way of pulling back from something she had intimated, but was unwilling to fully own.

By contrast, Ruth overwhelmed herself and her listener with detail. Ruth seemed to camouflage her feelings. Affects were hidden amongst the details. Yet, in fact, Ruth's feelings were to be found precisely in the way she presented details of her memories; the flood of detail itself spoke louder than the words, and signaled an unconscious reluctance to tolerate affect. Ultimately, though, Ruth was able to express a great deal, her tendency to camouflage notwithstanding. Her defensive style was relaxed enough to allow feelings to enter, and fortunately for her, the disguise was imperfect.

Like Cindy and Ruth, Lisa was rarely able to convincingly and clearly express her pleasures and disappointments. She minimized the importance of experiences, both positive and negative. This tactic enabled her to avoid confronting strong feelings. Her emotional world was flattened out.

It seems, then, that each subject had a narrative style which enabled her to ward off a full disclosure of her inner experience. Despite their differences, all three styles could be seen as points on a continuum of avoidance. Each woman was able to preserve a kind of psychological equilibrium by keeping both extreme joy and pain out of awareness. By obscuring her own needs and reactions, however, each woman also curtailed numerous opportunities for mutuality and empathic relatedness to others. The ensuing experience of loneliness and isolation may have led, in turn, to more longing and distress, and so on. Somatic symptoms seemed to erupt amidst this cycling process of yearning and disappointment, perhaps as a testament to the unconscious emotional pain with which each woman suffered.

Finally, the narrative styles signified a different level of trust in the benevolence of others. Yet none of the modes were entirely satisfying. Like the somatic symptoms themselves, perhaps, these modes were, in effect, compromises. These various styles of narrativity, symbolization and expression, in other words, seemed to guard against impingements threatening to the self but left that self inadequately nourished.

CHAPTER SEVEN

DISCUSSION

At the end of the mind, the body. But at the end of the body, the mind.

-Paul Valery.[22]

This dissertation has two central questions at its core. First, it was proposed that an understanding of the developmental substrate of somatization could be deepened by considering the quality of an individual's capacities for affectivity and object relatedness. Second, it was proposed that an exploration of the fluctuating relationships among these factors over time might yield important insights into the idiosyncratic interactions between affectivity, relatedness and the processes of somatization.

Various strategies were devised in this study to examine each of these questions. Statistical analyses were performed comparing subjects' weekly Recent Experience Memory narratives (as scored on the EARS dimensions of affectivity and relatedness) to subjects' reported levels of somatic distress. Each subject's Best and Worst weekly REM narratives were correlated with Somatic Distress Measures so as to tease out possible relationships between somatic symptomatology and subjects' possible range of functioning under more and less stressful conditions. Clinical impressions were analyzed and compared to subjects' weekly accounts of their illness experiences and to the Best and Worst interpersonal experiences they had had each week. Finally, the longitudinal design of the study allowed for statistical analyses of temporal

[22] Cited in Morris (1991).

relationships among these factors. Results relating to each of the hypotheses tested and described above will be discussed.

A. Discussion of Findings

Descriptive Statistics

An analysis of the descriptive statistics collected from the each of the three instruments used in the weekly interviews immediately reveals that the women in this study had profoundly different phenomenological experiences of themselves in the world.

Despite their common experience of living with chronic somatic distress, subjects differed on reported levels of psychological symptoms as reported on the SCL-90-R. These indices included depression, anxiety and obsessive-compulsive behavior (Table 1). In general, Subject 2 had a more robust and adaptive profile than did Subjects 1 and 3. Even Subjects 1 and 3 differed from each other, however, with Subject 3 showing consistently lower mean scores on these indices of psychopathology than did Subject 1.

Subjects also differed in their experience of somatic distress as measured on the INI-II. Whereas Subject 2, for example, frequently reported many symptoms with relatively low discomfort ratings, Subject 3 reported few symptoms with high discomfort ratings.

Finally, subjects had different profiles of affectivity and relatedness as assessed through the scoring of their weekly Best and Worst Recent Experience Memory narratives with the EARS. Subject 2 had higher mean scores for all affect and object

relational dimensions, under Best and Worst conditions, than did either Subject 1 or 3. A finding which further distinguished Subject 2 is the fact that whereas scores dropped for Subjects 1 and 3 under the REM-Worst conditions, Subject 2 had higher mean scores for her REM-Worst narratives than she did on her REM-Best narratives.

These descriptive data point to the idiosyncratic nature of somatic and psychological experience. Common symptomatology, such as the experience of chronic somatic distress, may belie profound differences not only in the very experience of that somatic distress, but in the areas of defensive style and personality functioning as well. As the next section demonstrates, results from the more formal statistical analyses also highlight the uniquely personal nature of the relationships between affectivity, relatedness and somatic processes.

Hypotheses

Hypothesis I: The first hypothesis explored the relationship between the Illness Narrative Interview-II and the SCL-90-R. As noted earlier, the INI-II was devised in order to capture those idiosyncratic aspects of bodily experience which might slip through the items included on the SCL-90-R.

Prior to beginning correlational analyses between the factors of interest for the study (affectivity, object relatedness and somatic distress), an effort was made to identify the most useful index (or, indices) of weekly reported levels of somatic distress as reported on both the INI-II and the SCL-90-R.

Although many of the items on the INI-II were strongly correlated with the SCL-90-R Somatization subscale for most subjects, correlational analyses throughout

revealed that the INI-II variables were more strongly associated with various dimensions of the EARS than was the SCL-90-R. Out of 18 incidents of association between the EARS variables and Somatic Distress Measures (SDM) (Tables 9a-c), 15 were between INI-II indices, while only 4 were between the EARS variables and the SCL-90-R.

Similarly, when SDM were correlated with EARS scores for REM-Best and REM-Worst narratives, the SCL-90-R showed no associations at all with the EARS variables whereas INI-HIGHEST and INI-AVERAGE showed relatively strong correlations with the REM-Worst scores for all three subjects (Tables 10a-c).

What is significant about these findings is that they point to the different types of information one can elicit when using an open-ended semi-structured interview as opposed to a standardized questionnaire. When allowed to think about what had actually bothered them, subjects listed numerous symptoms not included on the SCL-90-R. It was their spontaneous descriptions and their ratings of these particular symptoms which were most strongly related to their shifting scores of affectivity and object relatedness.

This observation suggests that standardized and abbreviated checklists increasingly used to identify the presence of somatization symptoms such as those developed by Escobar et al. (1987) may catch only the most obvious signs of somatization. Such short-hand efforts to screen for somatization may, in addition, miss much of the phenomenological experience of living with chronic somatic distress, and thereby impede the development of effective treatment plans.

Hypotheses II and III: The second and third hypotheses raised the question of which of the EARS dimensions would be most strongly associated with reported levels of somatic distress. It was predicted that the affect dimensions would be more strongly related than the object relational dimensions. Statistical analyses did not support this prediction.

Descriptive analyses revealed that mean weekly scores for the object relational dimensions were generally higher than mean scores for the affect dimensions (Tables 3a-c). Object relational scores for all but one dimension (Use of an Object-Worst, where scores for Subjects 1 and 2 were 2.8 and 2.9 respectively) were in the range of Mode III on the EARS. Affect scores were lower, however. Subjects 1 and 3 had mean weekly affect scores, under the Worst arousal condition, in the Mode II range of the EARS.

In addition, the overall mean scores for the object relational dimensions with Best and Worst scores combined were higher for each subject than the combined mean scores for the affect dimensions under both arousal conditions: (Subject 1: OR=3.18, AFF=3.09; Subject 2: OR=3.75, AFF=3.49; Subject 3: OR=3.28, AFF=3.21).

These are findings that one might expect, given the literature linking somatization to disturbances in affect. The statistical analyses yielded some surprising results, however. First, contrary to widely accepted theory and to the predictions in Hypotheses II and III, the multiple regression (Tables 5a-c) and same-week correlational analyses (Tables 6a-c) found that the two object relational dimensions of the EARS (Empathic Knowledge of Others and Use of an Object) were, in general,

more strongly related to shifts in somatic distress than were either of the two affect dimensions (Affect Tolerance, Affect Expression).

These findings suggest that although the average affect score, over time, was slightly below the average object relational score for each subject, the fluctuations in object relatedness were more strongly associated with fluctuations in reported levels of somatic distress. In other words, although affectivity seemed to be slightly less well developed overall than object relatedness, somatic symptoms seemed to come and go as subjects' capacity to maintain a high level of empathic relatedness and interpersonal connections to others based on differentiation and mutuality eluded them.

These are especially intriguing findings, since most of the literature on somatization has focussed on the connection between fixed developmental deficits in the areas of affect regulation and expression and somatization (Nemiah, 1975, McDougall, 1982; Taylor, 1984).

As explicated in the literature review, however, affect regulation is born out of our earliest interpersonal experiences. Again, "affective difficulties perforce originate within a disturbed self-other differentiation sequence" (Keller, 1989, p. 61).

According to Sandler, in fact, affects are "motivated by such factors as the state of functioning of the mental apparatus and the relationship of the self with its internal objects" (Stein, 1991, p. 171). Sandler argues further that the first objects in life are "sensations of pleasure and unpleasure." Only later are these subjective feeling states transformed into more complex affective experiences, as the representations of self and other become differentiated (Stein, 1991).

Similarly, Kernberg proposes that "early affect development is based on a direct fixation of early, effectively imbued object relations in the form of affective memory" (Kernberg, 1990, p. 120). For Kernberg, affects are "the links between self and object representations" (Stein, 1991, p. 171).

These and other theorists agree, then, that affect and object relatedness develop in tandem with each other in the earliest months and years of life; during a period when affects themselves are global and diffuse, and when experience itself is largely registered on a somatic rather than symbolic level. Thus, perhaps it should not be surprising that the shifting quality of one's object representational world is powerfully tied to the ever-changing expression of one's emotional life through somatic symptoms.

Interestingly, in fact, in most cases, it was the combination of object relatedness and affectivity as measured on the EARS which was most strongly associated with bodily distress. This finding points strongly to the "affective-interpersonal features of self- and object representations" (Diamond et al., 1990), and to the complex interplay between these factors and the processes of somatization.

As for the directionality of the relationships, statistical analyses showed, surprisingly, that the strong association between object relatedness and somatic distress seemed to take different shapes with different subjects, and even along different dimensions of somatic distress for the same subject. Results from the correlational analyses (Tables 6a-c) showed that in some cases somatic symptoms increased when EARS scores dropped, (i.e., when functioning in the realm of object relatedness slipped into lower, less adaptive modes). Conversely, for others, positive correlations were

noted, such that somatic symptoms rose even as the capacity for relatedness seemed to increase.

These mixed results raise at least two possible interpretations. First, the finding of positive and negative correlations operating differently for different people suggests that somatic symptoms may not simply reflect maladaptive modes of psychological functioning, but may, instead, actually be associated with more adaptive psychological functioning in certain realms, for certain people.

Second, the fact that individual subjects showed different patterns of relationships between relatedness and somatic distress points to a critical and, perhaps, the most interesting interpretation of this finding. These results suggest that some people may be able to maintain a high level of functioning even though somatic processes may be activated at the same time.

That is, somatic processes may be so isolated from other aspects of psychological functioning that there is no apparent psychopathology visible on the surface. As with infants, it may be that the body is acting as the perceiving apparatus for the organism at that moment; perceptions and responses are on an enactive, non-verbal level (Horowitz, 1978). The somatic symptoms are visible, but their origins and their impact are safely encapsulated from other aspects of psychic life. McDougall and others have written of the "pseudo-normality" of their somatizing patients (McDougall, 1978). This finding of positive correlations lends some empirical support for these clinical observations.

Hypothesis IV: Hypothesis four predicted that subjects would demonstrate greater capacities for affectivity and object relatedness when describing the Best Recent

Experience Memory (REM) than they would when describing the Worst REM. Findings gave strong support for this prediction in the cases of Subjects 1 and 3, but not for Subject 2.

These data suggest that as Subjects 1 and 3 attempted to describe experiences which had been more stressful for them, their representational worlds shifted slightly toward less flexible, verbal and healthy representations of self and other. This finding is consistent with previous findings which suggest that psychological functioning often becomes less adaptive (Wilson, 1988), and that object representations tend to become more malevolent under stressful conditions (Tuber, 1989; 1992, and Adelman, 1993).

Conversely, experiences judged to be more stressful nevertheless generally triggered more adaptive and flexible responses from Subject 2. She seemed to be in her element in these situations, and able to rise to the occasion.

Further, it was hypothesized that scores on the REM-Worst would be more strongly associated with somatic symptoms than would scores on the REM-Best. There was partial support for this prediction.

Statistical tests revealed that there was a difference in the strength of the relationship between REM-Best and REM-Worst narratives on the one hand, and somatic distress on the other. For each subject, the REM-Worst narratives proved to have stronger relationships with reported somatic distress when same-week correlational analyses were performed. As self- and object representations shifted toward more rigid and enactive modes, somatic symptomatology increased. Interestingly, though, affectivity did not tend to decrease as somatic distress rose.

Lower to begin with, as noted above, it may be that affectivity was less volatile for these subjects than the ability to sustain empathic object relatedness to others.

It may be, furthermore, that each of the subjects in this study had considerable psychological resources, and had learned to manage extremely well in the outer world. There was for each, perhaps, a relatively high and healthy ceiling of functioning which remained fairly stable. What shifted, instead, was the floor, dropping down, particularly in the areas of empathy, differentiation and mutuality when the habitual modes of functioning were overwhelmed.

Perhaps the most interesting finding yielded from the analysis of the different associations between REM-Best and REM-Worst scores and somatic distress came from temporal analyses of the data. As noted above, the second central question of this dissertation revolved around the temporal relationship among factors. This question was addressed methodologically through the longitudinal design of the study and the inclusion of cross-lagged statistical analyses. Qualitative and quantitative data from the weekly interviews were analyzed for same-week and lagged associations in order to explore possible temporal relationships among affectivity, relatedness and reported levels of somatic distress.

Two different temporal patterns of relationships emerged regarding the interplay of somatic distress and mean weekly REM-Best and REM-Worst scores (schematized in Charts 1 and 2).

Subjects 1 and 3 showed a pattern of "delayed oscillation" between REM-Worst scores and their somatic distress (Chart 1). That is, each was on a five-week cycle, where one negative and then two positive correlations resulted in a pattern where low

capacity for affectivity and relatedness in week 1 led to high somatic symptoms in week 2. Week 2's high somatic symptoms were then followed by high psychological functioning in week 3. This then led to a drop in somatic symptoms for week 4. Low somatic symptoms in week 4 led, surprisingly, to low affectivity and relatedness in week 5, at which point, the cycle began again.

In fact, this rather perplexing-seeming pattern makes clinical sense. Low functioning in week 1 understandably predicted that somatic symptoms would rise in the following week. Symptoms having risen in week 2, the self was consolidated, the psychic system no longer overwhelmed, and psychological functioning was high in week 3. This high functioning led to a predictable drop in somatic symptoms for week 4. The most surprising finding in these results came between weeks 4 and 5, when low somatic distress in week 4 led to low functioning in week 5.

This is surprising, because intuitively, one might expect that low somatic distress would lead to a rise in psychological functioning. One possible explanation for why this did not occur may be related to the fact that somatic symptomatology had become for Subjects 1 and 3 a crucial regulator of affectivity and relatedness. When symptomatology was low, the psyche may have been missing one of its central supports and safety operations. Indeed, even these subjects' sense of identity may have become fragmented when the chronic somatic distress each had come to think of as "I" was relatively absent. If this were indeed the case, low somatic distress would naturally be followed by a drop in psychological functioning. Like a well-oiled machine, this drop would then activate somatic processes.

This interpretation seems fitting for Subjects 1 and 3, each of whom has felt her life and her identity consumed with the sudden onslaught, and eventually, the chronic burden of bodily distress. "I don't know who I'd be without this pain condition," Subject 3 (Lisa) once remarked.

As indicated in Chart 2, Subject 2 showed a different pattern when correlations between Somatic Distress Measures and REM-B scores were lagged with each other. I have called this pattern "rapid oscillation." In her case, low functioning was followed by high somatic symptoms, which were then immediately followed by low functioning in the realms of affectivity and relatedness.

For this subject, one might argue that somatic symptoms also played an important regulatory role in her psychic life. When psychological functioning was low, somatization processes were activated, and symptoms rose. Having risen, however, somatic symptoms then signaled a relative drop in affectivity and relatedness. This drop then precipitated an immediate rise in symptoms, and so on.

One could speculate that the psychological capacities of affectivity and relatedness were not needed as dearly when somatic symptoms were activated, because the symptoms themselves served to decrease stimulation by isolating Subject 2 from stressful situations and overwhelming emotional demands. In fact, this seemed to be the case for Subject 2 (Ruth), who regularly demonstrated a pattern of becoming so overwhelmed with life that she had to take a "day or two off" to regain her physical (and emotional) equilibrium.

In sum, the statistical analyses of the relationship between subjects' Best and Worst memories yielded two important findings. First, Subjects 1 and 3 (but not Subject 2) showed a decrease in their capacities for affectivity and relatedness when reporting more as opposed to less stressful interpersonal experiences. Second, the Worst, rather than the Best memory narratives, for Subjects 1 and 3 were linked most powerfully to shifts in their capacities for affectivity and object relatedness when correlations were cross-lagged. Conversely, for Subject 2, it was the Best memory narrative scores which most powerfully predicted her somatic distress.

Finally, the differences between subjects which were again noted underline the importance of recognizing the uniquely subjective nature of the relationship between bodily experience and psychological functioning.

Clinical Data

Clinical data collected during the weekly interviews with each subject also suggest that affect regulation and consistent object relatedness were central challenges for each woman. Major fluctuations in reported levels of somatic distress seemed to be closely linked with each subject's capacity to manage the emotional demands of stressful interpersonal events as reported each week. The narrative styles of disavowal, camouflage and minimization outlined above revealed various compromised attempts at intimacy.

Other findings support these data. It is interesting to note, for example, that in all three cases of parental representations as scored on the Differentiation-Relatedness Scale of Self and Object Representations, maternal representations were less adaptive

and mature than paternal representations. Specifically, subjects were not able to represent self and mother as two separate, consolidated and reciprocally attuned individuals. Instead, mothers were represented as either merged with subject (Subject 2, Level 2), "semi-differentiated" (Subject 1, Level 5), or with an "emergent, ambivalent constancy" (Subject 3, Level 6) (Diamond et al., 1993).

These findings point strongly to the importance of the quality of early interactions with the mother, and are suggestive of the role that disturbances in these relationships might play in the etiology of difficulties in the realms of affectivity and relatedness.

Furthermore, the fact that subjects represented mother and father differently may reflect each subject's tendency to divide the object relational world into good and bad objects. As the separate experiences with mother and father came to mind and were put into words, subjects revealed different relational paradigms.[23] Furthermore, the fact that each relationship was imbued with a particular affective tone again points to the important linkages between affectivity and object relations.

Finally, these findings lend further empirical support for the importance of examining differences between Best and Worst memory scores as discussed above in that these dichotomized descriptions may have tapped more and less benevolent relationship paradigms for each subject.

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[23] The Differentiation-Relatedness Scale of Self and Object Representations (Diamond et al., 1993) is sensitive enough to capture these nuances of shifting representations of self and other, and would be useful as a repeated measure in a long-term research paradigm involving somatizing subjects.

An additional measure of object relatedness revealed difficulties in the areas of empathy and relatedness for each subject. Scores on the Alienation subscale of the BORRTI were in the middle range, and were comparable to the EARS scores on the object relational dimensions.

Clinical data also revealed that each subject struggled with managing strong and unruly affects. Longings and disappointments were frequently unacknowledged. Instead, these feelings were only hinted at, woven into each subject's representational style. Furthermore, somatic distress as reported weekly appeared to peak during times when emotional demands were highest.

Alexithymia, in particular, has been linked to psychosomatic illness (Nemiah, 1975; McDougall, 1982; Taylor, 1984). As noted above, alexithymia has been defined as "a cognitive-affective disturbance that affects the way individuals experience and express their emotions" (Taylor, 1984). Literally referring to the "absence of words for feelings," alexithymia has long been associated with the affective flatness so often seen in somatizing patients.

Only one score (Subject 1, TAS-20 = 65) crossed over the 61 point cut-off, into what the scale's authors consider to be severe alexithymia (Bagby et al., 1992b). In this study, however, the alexithymia scores did show some correspondence with reported mean levels of somatic distress.

There was also correspondence between the TAS-20 scores and the overall mean scores for the affect dimensions of the EARS. The TAS-20 scores of 65, 45 and 59 support clinical impressions suggesting that each subject's capacity for affective vitality and expression was constricted, and in some way possibly related to the experience of chronic somatic distress.

The clinical data discussed here can not specify either the strength or the direction of the relationships between affectivity, object relatedness and somatic processes. Nevertheless, these qualitative findings lend support to the empirical evidence described above regarding the strong relationships found between shifts in object relatedness and somatic processes. Together, these two data sets serve to paint the phenomenological landscapes in which each of the women described has managed to navigate the emotional and relational challenges of her life.

B. Theoretical Implications of Findings

The findings of this study implicate shifting capacities for object relatedness with the unexplained eruption and remission of somatic distress. These findings thereby lend considerable support to the theoretical and clinical notions presented earlier regarding the developmental substrate of somatization. Further, the findings of this study add to current understanding of the close and complex relationship between affect development and early object relations.

Winnicott's notion that a coherent, stable and boundaried sense of self is necessary for a full and healthy integration of psyche and soma is directly related to the finding that object relatedness and somatic distress are strongly linked. A weakened

continuity of self (Zeanah et al, 1989) may unconsciously lead one to seek out ways to bolster and reestablish a sense of "I am." Both the clinical and statistical findings presented here indicate that the eruption of somatic symptoms may constitute for some people a reconstituting of the self.

Each woman, in fact, described her mother as someone who was emotionally unavailable and, in particular, insensitive to her daughter's physical and emotional needs. Perhaps, as Khan suggests (1991), there was no one sufficiently available to act as the "auxiliary ego" for these women when they were children. Instead, like so many of the patients McDougall describes, they may have experienced profound empathic failures on the part of their principal caretakers which prevented them from ever feeling truly understood and secure in the experience of trusting other people with their innermost experiences.

The adverse consequences of such empathic failures on the developing capacities for self- and affect regulation have been discussed at length (Beebe and Lachmann, 1994; McDougall, 1978; Kobak, 1987). The data collected in the current study seem to support quite strongly the possibility that significant disturbances in these areas may have occurred for each subject.

Winnicott suggested, further, that the maturational tendency toward the integration of psyche and soma must be supported by a second maturational achievement, the movement from "absolute dependence" to independence (Winnicott, 1963/1965). Object representations, as analyzed on the EARS dimensions, were generally in the Mode III range. This suggests that subjects were locked somewhere between merger and full differentiation. Qualitative analysis of the projective memory

narratives revealed more explicitly that each subject, in her own way, struggled with the inability to let herself be dependent on others. It was almost as if their experiences with "absolute dependence" had been eclipsed, leaving each feeling too unsafe in the world of 'Others' to ever again allow themselves that experience. But the desire for this state lingered, expressed, perhaps, through the body and the sense of personal victimization which comes with physical suffering.

It is true, of course, that early deprivations of this sort have also been linked to the development of myriad other types of psychopathology where there may be no evidence of somatization. However, the complex (and often non-linear) pathways which lead from early experience to personality development and defensive style remain obscure. The respective roles of temperament, organicity and mediating environmental influences are surely implicated, though not yet well understood. Early traumatic disturbances in the caretaker relationship may represent, therefore, necessary (although not sufficient) conditions for the development of a defensive repertoire which includes somatization processes.

Herman has argued that somatization must be understood in the context of an individual's traumatic life history. Yet the more recent and overt traumatic events reported by each subject do not seem to have left their imprint on the subtle shades of attunement and object relatedness exposed in the REM narratives.

Khan has suggested, instead, that the effects of invisible, but "cumulative trauma" such as those which occur when the "mother is unable to cater to the ego-needs of the child" are the types of impingements which may be felt directly in the body-ego (Khan, 1983). It is along these same lines, I believe, that attachment theorists have

suggested that attachment is truly a "representation of the history of the caregiving relationship" (Main, et al., 1985). The findings of this study suggest, in fact, that the processes of somatization themselves may also reflect profound though often silent experiences in the history of one's early emotional and interpersonal life.

C. Treatment Implications

In my last interview with Subject 1 (Cindy), she said that she had realized during that week that she needs to "work on myself" and that her husband "dampens my spirit." Her sentences were unbroken, and she stated unequivocally for the first time in our conversations how disappointed she was with her husband's emotional unavailability.

As I was walking out the door following my last interview with Subject 2 (Ruth), she remarked that an associate of hers "used to have something physically wrong with her all the time." She went on to say that since she (Ruth) had started paying attention to her own bodily processes as a result of our conversations, she had been able to help this friend. When asked what she had done differently with her friend, Ruth responded, "I'm realizing that symptoms are a way of not coping. I just started saying that to her, and she's basically stopped. It's amazing."

In our nineteenth weekly interview, after weeks of assuring me that her problems were not related to anything emotional, and that the psychotherapy recommended some years ago was not for her, Subject 3 (Lisa) made a stunning observation. She had become interested in an article written by a woman with chronic back pain who was writing about the psychosomatic origins of her pain and the relief

she had received from biofeedback treatments, something Lisa has been considering for herself. After describing the author's situation, Lisa said that she did not think that her own pain condition was about "having too much on your plate ... I don't think that nothing is there, but the fact that it won't heal is out of proportion to what the problem is, what it might be. It could be that my body is taking this little thing too personally, it's driving me nuts and then I get a spasm to try to fight it ... I'd like to find another way that's more productive."

Needless to say, these observations do not reflect radical transformations in the lives of these three women. Each continued to have somatic symptoms throughout the period of the study. What is striking, though, is that something subtle seemed to have shifted for each of them as a result of having had one hour each week in which they could speak about their physical experiences and the emotional experiences of dealing with their somatic distress.

I believe that these shifts relate directly to the findings discussed above regarding the differences between the SCL-90-R and the INI-II. Subjects were asked to speak freely, with as much time as they needed, about their somatic experiences. Each symptom was considered very seriously. Questions regarding its intensity, when it began and remitted, and what was going on at the time were asked about every complaint mentioned each week. No interpretations were offered, and none were implied. These meetings were not, in other words, structured like analytic sessions. The body, not the emotional life, was invited to spread out and allowed to take up all the room.

McDougall (1989) and Knapp (1989) have each written about the importance of paying attention to the somatic communications of their patients. I believe that the format of these interviews allowed each subject to begin to make connections for herself between her somatic distress and her emotional life. If true, this neutral yet interested stance might be an invaluable aid in working with somatizing patients in psychotherapy.

The rather striking individual differences noted even among this small sample point in a different way to the importance of subtle assessment protocols and to the need for specific treatment plans when working with somatizing individuals. In particular, those findings which revealed various temporal relationships among factors highlight the potentially very distinct ways in which somatic symptoms may relate to personality functioning in different people.

Evidence of strong associations between object relatedness and somatic distress speaks directly to the difficulties physicians and psychotherapists have noted in working with somatizing patients. In general, past therapeutic efforts have been geared toward helping patients tolerate and express more affect in the hope that increased affectivity would enable a deeper emotional connection with the treating practitioner. The findings of this research suggest, however, that more direct attention may need to be paid to the quality of relatedness in the therapeutic encounter. Until someone can feel truly safe in the room with another person, it is unlikely that affectivity will flourish.

Finally, the relatively high range of psychological functioning demonstrated by each of the subjects in this study underlines the fact that psychosomatic processes may operate in individuals without other obvious symptoms of psychopathology. The

reasons for this are not immediately clear. A wide range of functioning may reflect unstable capacities for mature affectivity and object relatedness. When psychologically shaken or overwhelmed, an individual may be unable to maintain a high level of adaptation, and shift, instead, toward more primitive modes of functioning.

On the other hand, it may be, in fact, that the processes of somatization themselves act prophylactically. Somatic symptoms may shield individuals from the experience of having their psychic systems completely overwhelmed, and thereby enable the development of mature affectivity and object relatedness to unfold with relatively few constraints.

More specifically, it may be that the regulatory functions of somatic symptoms inhere in their capacity to take on the qualities of the "bad object" from which the somatizing individual wishes to escape[24]. "A psychic retreat," writes Steiner, "provides the patient with an area of relative peace and protection from strain when meaningful contact with the analyst is experienced as threatening" (Steiner, 1993, p. 1). Like the psychic retreats described by Steiner, somatization may represent a somatic retreat, whereby symptoms defensively serve to contain the split-off experience of intolerable pain as experienced in the world of object relations and locate the bad object, instead, in the body. The locus of the pain is displaced, from the interpersonal realm to an internal arena between the self and the body. In this way, actual object relations are largely preserved, and a conscious representation of self as someone emotionally connected to (rather than disappointed by) others is protected.

---

[24] My thanks to Dr. Diana Diamond for helping me to clarify and deepen my thinking about the ways in which somatic processes may be specifically linked to difficulties in the area of object relatedness.

In fact, each subject in this study seemed to view her body, and each symptom, as a persecutory object. Further, object relational scores on both the EARS (Wilson et al., 1988) and the Differentiation-Relatedness Scale for Self and Object Representations (Diamond et al., 1993) suggest that each subject was unable to consistently integrate positive and negative experiences. This inability indicates an inadequate consolidation of object constancy as described by Mahler (1975) and others. The developmental discrepancy between maternal and paternal representations noted above is further evidence, perhaps, of each subject's tendency to divide the world into good and bad objects. When this defensive style was overwhelmed by intolerable psychic pain, however, somatic symptoms may have emerged in order to both contain and represent the split-off bad object and associated affects which each subject was struggling to avoid.

In sum, this model suggests at least a partial interpretation of why it was that shifts in somatic symptomatology were so strongly linked with the vicissitudes of object relatedness for the subjects in this study. Systematic investigation of the possibility that somatization functions in this specific regulatory fashion as a container of bad object representations would be of interest.

D. Limitations of the Study and Additional Directions for Future Research

The first and most obvious limitation of this study is that it is, essentially, a collection of three case studies. It is impossible to generalize beyond these three individuals. Although, for example, each subject in the study had a history of chronic somatic distress, their actual medical profiles were quite different. Furthermore, they

differed considerably in age, ranging from the mid-twenties to the mid-fifties. An obvious direction for future research would be to make more systematic, longitudinal observations of larger groups of subjects who have similar medical and demographic profiles, e.g., all with unexplained chronic pain, or all with a full-blown Somatization Disorder. In this way, one could begin to identify the nuances and isolate the dynamics of different somatic manifestations.

A related line of research would be to explore whether or not patterns of relationships between the fluctuations in affectivity, relatedness and somatic processes differ at all for various ethnic, cultural and clinical groups. The women in this study were all white and middle-class. Kleinman (1986) has written extensively on the different cultural manifestations of depression and anxiety, indicating, for example, that Asian women, in particular, tend to have high somatizing styles when suffering from what in a more western milieu would be expressed as depressive symptoms.

Likewise, it would be particularly useful to clinicians to explore and possibly identify different patterns of somatization in various clinical groups, e.g. depressed, anxious, personality disorder. Although such explorations were clearly beyond the scope of this study, controlled clinical trials with different cultural and clinical groups would certainly lead to a refinement of the preliminary findings noted here. Although the findings discussed above are suggestive, they can only lead to further speculation until adequate follow-up research is done.

A second limitation is that I only met with each subject twenty times. Although this was adequate for the scope of a dissertation, the fact is that twenty time points often makes it very difficult to achieve statistically significant results. Thus, as noted earlier,

a number of strong associations were found which could be pursued with additional research in order to verify if, indeed, they were statistically meaningful findings.

A third limitation to the study relates to the possibility that having the same person conduct every interview with the subjects constituted an artifact which may have influenced the results. Clearly, subjects formed relationships with the investigator which were colored by their own relationship histories and interpersonal experiences. Different results, perhaps, even, results less weighted toward the object relational dimensions, might have emerged in a more neutral interview paradigm.

Fourth, it may be that by scheduling the assessment points every week a considerable amount of data was lost relating to the immediate connections between somatic symptom eruptions and psychological functioning. A more intensive reporting of somatic symptoms and projective material, such as that which might be possible on an inpatient unit, might yield stronger associations among factors.

A final possible direction for future investigation would be to include in psychotherapy process research explicit observation of the relationship between object relatedness and somatization over the course of treatment.[25] Analysis of psychotherapy transcripts and/or repeated administration of psychoanalytically-oriented projective measures administered during the course of treatment might further elucidate the relationship between changes in object representation and relatedness and somatic symptomatology over time.

---

[25] For models of this kind of clinical research, see the studies described earlier: (Hull et al., 1992) and (Diamond et al., 1990).

E. Conclusion

This study contributes to the field of psychosomatic medicine and to psychoanalytic theory of somatization by linking the processes of somatization with recent work in the areas of affect regulation and the internalization processes of object representation.

Designed as a longitudinal study, the dissertation also represents a methodological contribution to the study of somatization. In fact, several designs were considered for this study, including multi-group designs. A time-series paradigm with a multiple case-study design was chosen, however, because the apparent unpredictability of remissions and eruptions of chronic unexplained somatic distress could best be studied, it seemed, in the context of a design into which time and change were meaningfully incorporated.

Finally, the centrality of the Epigenetic Assessment Rating Scale (EARS) in the statistical analysis of subjects' projective memory narratives enabled a developmental exploration of the capacities for affectivity and object relatedness which had not yet been applied to the empirical study of somatizing patients. Shifts toward developmentally less advanced modes of functioning in the area of object relatedness signaled, in general, a rise in physical symptoms. These results support the theoretical speculations that somatization is profoundly linked to early experience.

The finding that object relatedness was more strongly associated with reported levels of somatic distress than was affectivity is significant and intriguing. Complex relationships between shifts in object relatedness and the onset of somatic symptoms were identified. The existence of these temporal relationships between factors is of

clinical interest, both for physicians and psychotherapists, as it may begin to shed light on the often peculiar and unpredictable patterns of somatic distress reported by so many patients.

Moreover, higher levels of empathic understanding and mutuality were generally associated with lower weekly levels of somatic distress. This evidence strongly points to the possible importance of disturbed early interpersonal experiences in the etiology of the processes of somatization.

Finally, these findings point to the need for psychoanalytically-oriented psychotherapy with somatizing individuals. With this sort of developmental intervention, it may be possible to rework and rebuild problematic self- and object representations resulting from experiences of early and profound empathic failures. Perhaps after intensive reparative work of this sort, the body may be freed of its obligation to express that which was known, but unspeakable.

APPENDIX A

The Bell Object Relations and Reality Testing Inventory

(Bell, 1983)

Prepublication Edition

Borrti

(Bell, 1983)

Published by
WPS WESTERN PSYCHOLOGICAL SERVICES
Publishers and Distributors
12031 Wilshire Boulevard
Los Angeles, California 90025-1251

Answer the questions according to your most recent experience.
If a statement tends to be true for you, blacken the circle in the column headed T.
If a statement tends to be false for you, blacken the circle in the column headed F.
Please try to answer all the questions.

Name: _____

Date: _____ Sex: _____ Age: _____

T	F	
○	○	1. I have at least one stable and satisfying relationship.
○	○	2. Sometimes I think I have been possessed by the devil.
○	○	3. If someone dislikes me, I will always try harder to be nice to that person.
○	○	4. I would like to be a hermit forever.
○	○	5. I usually have trouble deciding whether something really happened or if it was a dream.
○	○	6. I may withdraw and not speak to anyone for weeks at a time.
○	○	7. Even if my perceptions are inaccurate, I am quickly aware of it and can correct myself easily.
○	○	8. I usually end up hurting those closest to me.
○	○	9. Drinking alcohol or smoking marijuana can so drastically affect my mind that I cannot be sure what is real.
○	○	10. I believe that people have little or no ability to control their sorrows.
○	○	11. My people treat me more like a child than an adult.
○	○	12. I experience hallucinations.
○	○	13. If someone whom I have known well goes away, I may miss that person.
○	○	14. I can deal with disagreements at home without disturbing family relationships.
○	○	15. I feel out of touch with reality for days at a time.
○	○	16. I am extremely sensitive to criticism.
○	○	17. Exercising power over other people is a secret pleasure of mine.
○	○	18. At times I will do almost anything to get my way.
○	○	19. I possess mystical powers.
○	○	20. When a person close to me is not giving me his or her full attention, I often feel hurt and rejected.
○	○	21. I am usually able to size up a new situation quickly.
○	○	22. If I become close with someone and he or she proves untrustworthy, I may hate myself for the way things turned out.
○	○	23. I almost never have reason to doubt the accuracy of my own perception of reality.
○	○	24. I know my own feelings.
○	○	25. It is hard for me to get close to anyone.
○	○	26. My sex life is satisfactory.
○	○	27. There is an organized plot against me.
○	○	28. I tend to be what others expect me to be.
○	○	29. No matter how bad a relationship may get, I will hold on to it.
○	○	30. I feel my thoughts are taken away from me by an external force.
○	○	31. I don't usually have strong opinions about things.
○	○	32. I have no influence on anyone around me.
○	○	33. I have the feeling that I am a robot, forced to make movements or say things without a will of my own.
○	○	34. People do not exist when I do not see them.
○	○	35. Often, I read things in other people's behavior that really aren't there.
○	○	36. I've been hurt a lot in life.
○	○	37. I have someone with whom I can share my inner-most feelings and who shares such feelings with me.

W-283AK
1 2 3 4 5 6 7 8 9
Printed in U.S.A.

T	F	
○	○	38. I believe that I am being plotted against.
○	○	39. No matter how hard I try to avoid them, the same difficulties crop up in my most important relationships.
○	○	40. I am being followed.
○	○	41. I yearn to be completely "at one" with someone.
○	○	42. I am not sure what month or year this is.
○	○	43. I am usually able to say the right things.
○	○	44. In relationships, I am not satisfied unless I am with the other person all the time.
○	○	45. I experience strange feelings in various parts of my body that I cannot explain.
○	○	46. Being independent is the only way not to be hurt by others.
○	○	47. I am a very good judge of other people.
○	○	48. Relationships with people of the opposite sex always turn out the same way with me.
○	○	49. Others frequently try to humiliate me.
○	○	50. I can hear voices that other people cannot seem to hear.
○	○	51. I am rarely out of touch with my own feelings.
○	○	52. I generally rely on others to make my decisions for me.
○	○	53. It is common for me to be convinced that people, places, and things are familiar to me when I really don't know them.
○	○	54. I am usually sorry that I trusted someone.
○	○	55. When I am angry with someone close to me, I am able to talk it through.
○	○	56. My thoughts are being broadcast so that other people know what I am thinking.
○	○	57. People are often angry at me, whether they admit it or not.
○	○	58. Manipulating others is the best way to get what I want.
○	○	59. I often feel nervous when I am around members of the opposite sex.
○	○	60. At times I feel like my body is being changed into that of the opposite sex.
○	○	61. I often worry that I will be left out of things.
○	○	62. I feel that I have to please everyone or else they might reject me.
○	○	63. People who hardly know me are reading my thoughts whenever they want.
○	○	64. Sometimes I have dreams so vivid that, when I wake up, it seems like they really happened.

T	F	
○	○	65. I shut myself up and don't see anyone for months at a time.
○	○	66. I am sensitive to possible rejection by important people in my life.
○	○	67. I am often the victim of the cruelty of other people.
○	○	68. Making friends is not a problem for me.
○	○	69. I believe that I am a condemned person.
○	○	70. I do not know how to meet or talk with members of the opposite sex.
○	○	71. When I cannot make someone close to me do what I want, I feel hurt or angry.
○	○	72. I hear voices that others do not hear, which keep up a running commentary on my behavior and thoughts.
○	○	73. It is my fate to lead a lonely life.
○	○	74. I am under the control of some force or power other than myself, which forces me to think things or have impulses that are not my own.
○	○	75. My mood affects how I see things.
○	○	76. People are never honest with each other.
○	○	77. I can always distinguish between reality and fantasy, even during the time I am going to sleep or awakening.
○	○	78. I put a lot into relationships and get a lot back.
○	○	79. I have the feeling that the world is about to come to an end soon.
○	○	80. I feel shy about meeting or talking with members of the opposite sex.
○	○	81. The most important thing to me in a relationship is to exercise power over the other person.
○	○	82. I have a good sense of direction and virtually never lose my way.
○	○	83. I try to ignore all unpleasant events.
○	○	84. I experience anxious feelings that I cannot explain.
○	○	85. When I drink or use drugs, it seems as if those around me have it in for me.
○	○	86. I pay so much attention to my own feelings that I may ignore the feelings of others.
○	○	87. I frequently don't know where I am, even in my own neighborhood.
○	○	88. I have a hard time accepting the reality of tragic events in my life, like a death in the family.
○	○	89. I believe that a good mother should always please her children.
○	○	90. Sometimes I see only what I want to see.

APPENDIX B

BIOGRAPHICAL INFORMATION

(Blaustein, 1994)

PLEASE PRINT

Today's Date: ____/____/____

month day year

Full Name _____

Home Address: _____ APT _____

City: _____ ZIP _____

Telephone: (_____) _____

Date of Birth: ____/____/____ Place of Birth: _____

month day year

Age: _____

Marital Status: (circle one)

Single Married Widowed Separated Divorced Living with Someone

Children: _____ Ages _____

Children Living With You: _____ Ages _____

Occupation:

_____

Annual Income: (check one)

____ Below $5000

____ $5000 - $10,000

____ $10,000 - $15,000

____ $15,000 - $20,000

____ $20,000 - 25,000

____ Above $25,000

Are you receiving Public Assistance? Y/N _____

Last Grade Completed in School (Degree): _____

Ethnic Background:

(Please circle the group that best describes you)

African-American Latino Caucasian

Asian Jewish Arabic Other

_____

How long have you had medical problems? _____

APPENDIX C

Consent Form for Clinical Investigation

Project Title: Coping with Frequent Illness

Subject Name: _____

a. You are invited to participate in a study of coping with frequent illness. The aim of this study is to learn more about the experience of coping with multiple medical problems, and about the relationship between physical illness and the rest of one's life. You were selected as a possible participant in this study because you have experienced multiple medical problems.

b. If you decide to participate, I will interview you once in order to see if you are eligible for the study. This interview will last between 1-2 hours, and you will be asked to answer questions and complete several questionnaires about your medical history, your past, and how you cope with your physical problems and with everyday life.

Questions answered aloud will be tape-recorded so that the material can be studied later. Your name will not be on the tape, and the tapes will be destroyed after the material has been analyzed.

If you are eligible for the study, you will be contacted by telephone. To participate in the study, you will agree to be interviewed once a week for twenty consecutive weeks. Each of these interviews will last less than one hour. In these 20

interviews, you will be asked to answer questions and complete one questionnaire about how you cope with your physical problems and with everyday life.

c. Your participation in the project involves the following risks: You may feel some mild discomfort, sadness, embarrassment or other negative feelings when answering questions about your medical history, dealing with your physical problems, or about things that have happened to you during your life. You may refuse to answer any questions.

d. The aim of this study is to improve the treatment of individuals suffering with multiple medical problems as you are. I cannot promise that you will receive any benefits from this study.

e. Any information obtained during this study and identified with you will remain confidential and will be disclosed only with your permission. The general findings from this study will be presented to several faculty members of the City University of New York who serve on the Dissertation Approval Committee of the Principal Investigator of the Study, Jeanne Blaustein. No information which could possibly identify you as a participant in this study will be included in these presentations, however. Research publications will also present only general findings, with no information which could identify you as a participant in this study. Again, throughout the study, you may refuse to answer any questions.

To further protect your confidentiality, no identifying personal data will be included on test forms, tapes, or interviews. Identification numbers alone will be used.

Only the Biographical Information Form will have the your name, and no ID number will appear on this form. Records linking names to ID numbers will be kept separately, in locked file cabinets.

f. As compensation for your participation in the study, you will receive $10 dollars for each hour of interview time and 2 subway tokens for each trip you make to the interviews.

g. If, as a result of your participation, you experience physical or psychological injury from known or unknown risks of the research procedures described, no monetary compensation is available, and you will be responsible for the costs of medical treatment, either directly, or through your medical insurance and/or other forms of medical coverage.

h. If you have any questions, please ask me. If you have any additional questions later, I, Jeanne Blaustein, (xxx) xxx-xxxx will be happy to answer them.

i. You will be offered a copy of this form to keep.

You are making a decision as to whether or not to participate. Your signature indicates that you have read the information provided above and have decided to do so. You may withdraw at any time without prejudice after signing this form should you choose to discontinue participation in this study.

Signature	Date
Signature of Investigator	Date

APPENDIX D

Debrief & Follow-up Conversation

ID# _____

Date _____

I want to get a sense of how you're doing, and also, give you some indication of where the study is going since we last spoke.

1. How are things going for you?

2. How have you been feeling physically?

3. Have you noticed anything very different from the kinds of things you and I talked about?

4. Have you made any major changes or decisions around dealing with your body?

5. Any questions for me? reactions to having participated in the study?

Where the study is now:

Questions? Reactions?

APPENDIX E

Instructions for the Five-Minute Speech Sample
(Gottschalk, 1968)

ID# _____

Date _____

I'd like to hear your thoughts about your mother in your own words and without my interrupting with any questions or comments. When I ask you to begin, I'd like you to speak for 5 minutes, telling me what kind of a person she is/was, and how you and she got along together in childhood, adolescence and adulthood. After you've begun to speak, I prefer not to answer any questions until the 5 minutes are over. Do you have any questions before you start?

I'd like to hear your thoughts about your father in your own words and without my interrupting with any questions or comments. When I ask you to begin, I'd like you to speak for 5 minutes, telling me what kind of a person he is/was, and how you and he got along together in childhood, adolescence and adulthood. After you've begun to speak, I prefer not to answer any questions until the 5 minutes are over. Do you have any questions before you start?

APPENDIX F

Illness Narrative
For Initial Screening Protocol
(Blaustein, 1994)

ID# _____

Date _____

I. History and Experience of Current Symptoms

1a. Tell me about your medical problems.

1b. Please describe your symptoms.
>probe: "hurting" as if?

1c. When did you first notice the "pain"/"aching" (use patient's words)?

1d. What was going on in your life at that time?

2. What is your idea about what might be causing the symptoms?

3. How have these symptoms affected your life?

4. How do people react to your symptoms?
Your family:
People at work:
Doctors:

>probe: What is it like for you when they react that way?

5a. Do you have a doctor whom you see regularly for these problems? Y/N

5b. (If yes) Tell me about your doctor.
-> Describe what it is like for you going to the doctor.

-> How would you describe your relationship to your doctor?
(If no) Tell me about your experiences with getting help -(Clinics, Emergency Rooms, etc.)

6. What's the worst thing about having these symptoms?

II. Family History

1. Has anyone else in your family had the symptoms you currently have?

Who?
What did they have?
What happened?
Anyone else?

2. Has anyone in your family had other symptoms or problems?

Who?	Problem?	When?

III. Past Medical History

1. Have you had other medical problems in the past, besides the ones you have now?

->Tell me about those problems:

	PROBLEM	WHEN	Tx
1.			
2.			
3.			

IV. Illness Memories

la. Please describe your earliest memory of being sick or feeling bad physically.

->What was wrong?
->How old were you?
->Who took care of you?

lb. ->How did people around you react?

lc. ->How did you react?
2a. Please describe your earliest memory of someone else being sick.
2b. -> How did people react?
2c. -> How did you rèact?

APPENDIX G

Illness Narrative - II
For Weekly Protocol
(Blaustein, 1994)

ID# _____
Date _____

1a. How have you been feeling physically this week? Tell me about it.

1b. On a scale of 1 - 10, where 1 is feeling the best, and 10 is feeling the worst, how would you rate how you have been feeling this week?

2a. Have you had any specific physical symptoms or problems since we last met? (List in Symptom Table below)

(If yes) Please describe your symptoms,

>probe: "hurting" as if?

	SYMPTOM	RATING
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

2b. On a scale of 1 - 10, where 1 is no discomfort or pain and where 10 is the most discomfort or pain, how would you rate your symptoms? (Rate each symptom mentioned in Question 2a).

2c. How has [TARGET SYMPTOM] been during the past week?

3a. When during the week did you notice these symptoms? (Ask about each symptom mentioned).

3b. What is your idea about what might be causing these symptoms?

3c. What was going on in your life at that time?

4. Are any of these new problems, that you have never felt or noticed before?

5. Did you tell anybody how you were feeling, mention these symptoms to anyone?

(If yes)

Whom did you tell?

How was it for you to tell them?

How did they react?

These days, do you usually let somebody know how you are feeling?

(If no)

How was it for you to keep this to yourself?

These days, do you usually do that?

->(If yes, ask why)

->(If no, ask why this time was different)

APPENDIX H

Medical History Questionnaire
(Cornell Internal Medicine Associates, 1994)

ID # _____

Date _____

Medical History Questionnaire

Please answer the questions as best you can.
All information is confidential.

A. 1. Do you consider yourself in good health? Yes No

2. What are your health problems?

a.

b.

c.

3. How long have you had each one?

a.

b.

c.

B. 1. Give all hospital admissions with date and reason:

a.

b.

c.

2. Have you ever had a blood transfusion? Yes No

Date(s)

3. Have you had any of the following illnesses. (Circle Yes or No. If Yes, give dates.)

Rheumatic fever	Yes	No	Date _____
Pneumonia	Yes	No	Date _____
Tuberculosis	Yes	No	Date _____
Malaria	Yes	No	Date _____
Hepatitis (Jaundice)	Yes	No	Date _____
Anemia	Yes	No	Date _____
Unusual Bleeding	Yes	No	Date _____

4.

Last Tetanus Immunization	Date _____
Last skin test for Tuberculosis	Date _____
Last Influenza Immunization	Date _____

5. Give any other serious illnesses not requiring hospitalization.

6. Do you feel that you are at increased risk for developing AIDS? Yes No

C. 1. Give state of health or cause of death in your family

	Age if Living	State of Health	If passed away Cause of Death	Age at Death
FATHER				
MOTHER				
BROTHERS				
SISTERS				
SPOUSE				
CHILDREN				

2. Have any close relatives had any of the following:

			Relationship
1.	Tuberculosis	Yes No	
2.	Diabetes	Yes No	
3.	Cancer (if yes what part of the body)	Yes No	
4.	High blood pressure	Yes No	
5.	Heart disease	Yes No	
6.	Asthma	Yes No	
7.	Mental disorder	Yes No	
8.	Thyroid disease or goiter	Yes No	
9.	Bleeding tendency or Anemia	Yes No	
10.	Arthritis	Yes No	
11.	Gout	Yes No	
12.	Migraine	Yes No	

D. 1. Have you ever lived outside the U.S.? Yes No

Dates Places

2. How many hours a day do you work? _____

3. How many hours sleep do you get? _____

4. Have you ever used any drugs or mood altering substances? Yes No

5. Do you exercise regularly? If so, describe Yes No

6. Do you use automobile seatbelts? Yes No

7. Does your diet include dairy products, fresh fruits or vegetables? Yes No

8. **FOR PEOPLE WHO SMOKE CIGARETTES**

   a. Do you now smoke cigarettes? Yes No

   b. Does the person closest to you smoke cigarettes? Yes No

   c. How many cigarettes do you smoke a day? _____

   d. How soon after you wake to you smoke your first cigarette?

      _____ within 30 minutes _____ more than 30 minutes

   e. How interesting are you in stopping smoking?

      ___ not at all ___ a little ___ some ___ a lot ___ very

   f. If you decided to quit smoking completely during the next 2 weeks, how confident are you that you would succeed?

      ___ not at all ___ a little ___ some ___ a lot ___ very

9. **FOR PEOPLE WHO DRINK ALCOHOL**

   a. Have you ever felt that you ought to cut down on your drinking? Yes No

   b. Have people annoyed you by criticizing your drinking? Yes No

   c. Have you ever felt bad or guilty about your drinking Yes No

   d. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Yes No

E. 1. Have you had any significant infections or diseases of the skin? Yes No Date _____

   2. Has your skin changed in character or texture recently? Yes No Date _____

   3. Are you bothered with sever itching? Yes No Date _____

   4. Has your hair changed in amount or texture? Yes No Date _____

   5. Has there been any change in appearance of any birthmarks, warts or moles recently? Yes No Date _____

F. 1. Do you have frequent headaches? Yes No Date _____

   2. Do you have sick headaches (Migraine)? Yes No Date _____

	3.	Have you ever been unconscious?	Yes	No	Date _____
	4.	Do you have lightheadedness or giddiness?	Yes	No	Date _____
	5.	Have you ever had fainting spells or seizures?	Yes	No	Date _____
	6.	Has any part of your body ever been paralyzed?	Yes	No	Date _____
G.	1.	Do you wear glasses?	Yes	No	Date _____
	2.	Have you ever seen double?	Yes	No	Date _____
	3.	Have you had any loss of vision?	Yes	No	Date _____
	4.	Have you had any inflammation of the eyes?	Yes	No	Date _____
	5.	Date of last eye exam _____			
H.	1.	Have you had any loss of hearing?	Yes	No	Date _____
	2.	Do you have buzzing or ringing in your ears?	Yes	No	Date _____
	3.	Did you ever have frequent or severe nosebleeds?	Yes	No	Date _____
	4.	Do you suffer from hay fever or nasal allergies?	Yes	No	Date _____
	5.	Have you had sinus trouble?	Yes	No	Date _____
	6.	Do you have difficulty in swallowing?	Yes	No	Date _____
	7.	Have you been persistently hoarse?	Yes	No	Date _____
	8.	Have you had swollen or discharging glands in your neck?	Yes	No	Date _____
	9.	Do you have any current dental problems?	Yes	No	
	10.	Date of your last dental checkup _____			
I.	1.	Have you had a goiter?	Yes	No	Date _____
	2.	Does cold or hot weather bother you excessively?	Yes	No	Date _____
	3.	Have you ever been treated for thyroid trouble?	Yes	No	Date _____
	4.	Do you perspire excessively?	Yes	No	Date _____
	5.	Are you thirsty most of the time?	Yes	No	Date _____
	6.	Have you ever had a high blood sugar (Diabetes)?	Yes	No	Date _____

J.	1.	Do you have a chronic cough?	Yes	No	Date _____
	2.	Do you raise more than one tablespoon of sputum daily?	Yes	No	Date _____
	3.	Have you ever coughed up blood?	Yes	No	Date _____
	4.	Have you ever noticed a wheeze or whistle in your chest on breathing?	Yes	No	Date _____
	5.	Have you ever had asthma?	Yes	No	Date _____
	6.	Have you had close contact with a person who had tuberculosis?	Yes	No	Date _____
	7.	Have you ever been told that you had an abnormal chest x-ray?	Yes	No	Date _____
	8.	Date of last chest x-ray _____			
K.	1.	Have you been told you have heart disease or a heart murmur?	Yes	No	Date _____
	2.	Have you been told you have high blood pressure?	Yes	No	Date _____
	3.	Do you become winded on climbing two flights of stairs?	Yes	No	Date _____
	4.	Do you have pain or a tight feeling in your chest on exertion?	Yes	No	Date _____
	5.	Do you have to sleep propped up in bed?	Yes	No	Date _____
	6.	Do your ankles swell?	Yes	No	Date _____
	7.	Do you have episodes of rapid or irregular heartbeat?	Yes	No	Date _____
	8.	Date of last electrocardiogram _____			
L.	1.	Has there been any change in your weight in the past year?	Yes	No	Date _____
		Up or down? _____ How much? _____			
	2.	Have you noticed any loss of appetite?	Yes	No	Date _____
	3.	Do any foods cause indigestion or diarrhea?	Yes	No	Date _____
	4.	Do you have indigestion or excessive gas?	Yes	No	Date _____
	5.	Do you have pain in your stomach?	Yes	No	Date _____
	6.	Do you have nausea and vomiting?	Yes	No	Date _____
	7.	Have you vomited blood?	Yes	No	Date _____
	8.	Have your bowel habits changed in the last six months?	Yes	No	Date _____
	9.	Do you have attacks of diarrhea (frequent loose stools)?	Yes	No	Date _____

10. Have you passed blood in your stools?	Yes	No	Date _____
11. Have you had black or tarry stools?	Yes	No	Date _____
12. Do you have hemorrhoids (piles)?	Yes	No	Date _____
13. Have you been jaundiced (yellow eyes & skin)?	Yes	No	Date _____
14. Have you had intestinal worms or parasites?	Yes	No	Date _____
15. Date of last test for blood in stool			Date _____

M. 1. Do you get up more than once a night to urinate?	Yes	No	Date _____
2. Do you have burning or pain when you urinate?	Yes	No	Date _____
3. Have you had infection or pus in your urine or kidneys?	Yes	No	Date _____
4. Do you have trouble starting your stream when you urinate?	Yes	No	Date _____
5. Have you passed stones or gravel in the urine?	Yes	No	Date _____
6. Have you passed blood in the urine?	Yes	No	Date _____
7. Have you had albumin in the urine?	Yes	No	Date _____
8. Do you ever lose control of your bladder?	Yes	No	Date _____
9. Have you ever had or suspected you had venereal disease?	Yes	No	Date _____
10. (MEN ONLY) Have you ever had prostate cancer?	Yes	No	Date _____
N. 1. Did you ever have painful or swollen joints?	Yes	No	Date _____
2. Have you ever had trouble with your back?	Yes	No	Date _____
3. Do you have numbness or tingling (pins and needles) in your fingers or toes?	Yes	No	Date _____

O. 1. Do you have varicose veins?	Yes	No	Date _____
2. Have you ever had phlebitis?	Yes	No	Date _____
3. Do you have pain in your legs when you walk?	Yes	No	Date _____

P. 1. Have you ever been in a hospital for mental or nervous disorder?	Yes	No	Date _____
2. Have you ever consulted a psychiatrist?	Yes	No	Date _____
3. Do you feel you need medical or psychiatric help for nerves?	Yes	No	Date _____

4. Are you depressed most of the time so that it interrupts your work? Yes No Date _____
5. Do you sleep badly? Yes No Date _____
6. Is your home life unpleasant? Yes No Date _____
7. Is your work unpleasant? Yes No Date _____

Q. 1. Do you have any allergies to food or medicine or other substances? Yes No Date _____

Please list:

R. Do you take any medicines, vitamins or laxatives on a regular or frequent basis? Yes No

Please list:

S. Have you ever been refused life insurance at normal rates? Yes No Date _____

T. WOMEN ONLY

1. Were older than 15 years when your periods began? Yes No Date _____
2. Are your periods frequently irregular? Yes No Date _____
3. Do your periods last more than 5 days? Yes No Date _____
4. Do pains with your periods frequently make you lie down? Yes No Date _____
5. Do you have bleeding or discharge between periods? Yes No Date _____
6. Have you had your menopause? Yes No Date _____
7. Have you had any vaginal bleeding since your menopause? Yes No Date _____
8. When was your last PAP test? _____
9. Have you ever had an abnormal PAP test? Yes No Date _____

10. Date of last period _____
11. Do you use birth control pills? Yes No Date _____
12. Do you regularly examine your own breasts? Yes No Date _____
13. Have you noticed lumps or nodules in your breasts?
14. Have you had any discharge from your breasts?
15. When was your last mammogram? _____
16. Have you ever had an abnormal mammogram? Yes No Date _____

LIST PREGNANCIES:

	Full term?	Living child?	Miscarriage or Abortion?
1.			
2.			
3.			
4.			
5.			

U. Please feel free to write any additional information below or on the back.

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APPENDIX I

Recent Experience Memory Test
(Blaustein, 1994)

ID# _____

Date _____

1. Please describe the best thing that has happened to you during the last week that involved at least one other person.

Please include in your description what led up to the event, what took place, and what happened afterwards.

Please include in your description what you and the other person (or people) were thinking and feeling.

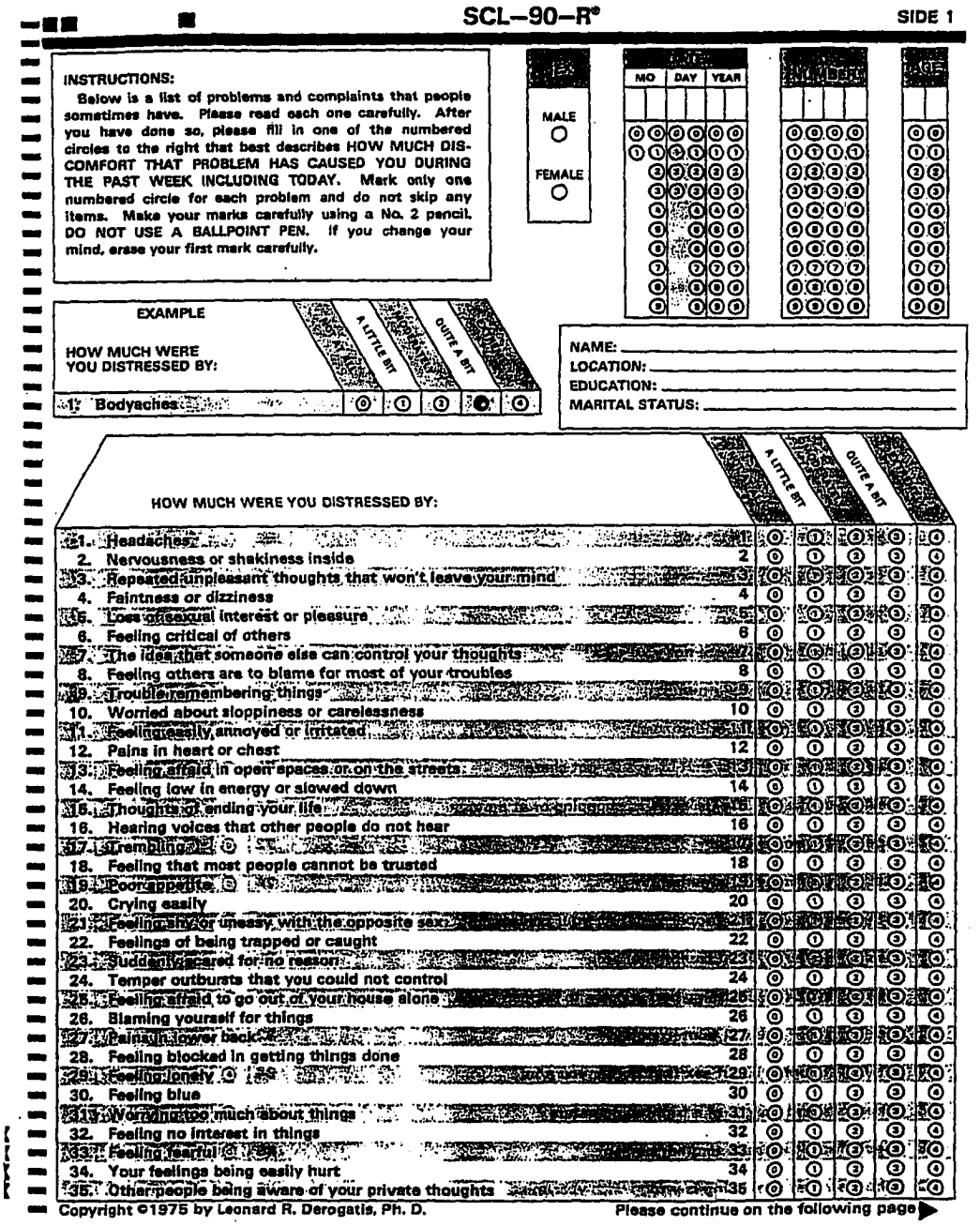
2. Please describe the worst thing that has happened to you during the last week that involved at least one other person.

Please include in your description what led up to the event, what took place, and what happened afterwards.

Please include in your description what you and the other person (or people) were thinking and feeling.

APPENDIX J

Symptom Checklist 90-Revised
(Dregoatis et al., 1975)



SCL–90–R®

SIDE 1

INSTRUCTIONS:

Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, please fill in one of the numbered circles to the right that best describes HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU DURING THE PAST WEEK INCLUDING TODAY. Mark only one numbered circle for each problem and do not skip any items. Make your marks carefully using a No. 2 pencil. DO NOT USE A BALLPOINT PEN. If you change your mind, erase your first mark carefully.

SEX: MALE ○ FEMALE ○

DATE: MO | DAY | YEAR

AGE

EXAMPLE

HOW MUCH WERE YOU DISTRESSED BY:

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Bodyaches	○	①	○	●	○

NAME: _____

LOCATION: _____

EDUCATION: _____

MARITAL STATUS: _____

HOW MUCH WERE YOU DISTRESSED BY:

		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1.	Headaches	1	○	①	○	○	○
2.	Nervousness or shakiness inside	2	○	①	②	③	④
3.	Repeated unpleasant thoughts that won't leave your mind	3	○	①	○	○	○
4.	Faintness or dizziness	4	○	①	②	③	④
5.	Loss of sexual interest or pleasure	5	○	①	○	○	○
6.	Feeling critical of others	6	○	①	②	③	④
7.	The idea that someone else can control your thoughts	7	○	①	○	○	○
8.	Feeling others are to blame for most of your troubles	8	○	①	②	③	④
9.	Trouble remembering things	9	○	①	○	○	○
10.	Worried about sloppiness or carelessness	10	○	①	②	③	④
11.	Feeling easily annoyed or irritated	11	○	①	○	○	○
12.	Pains in heart or chest	12	○	①	②	③	④
13.	Feeling afraid in open spaces or on the streets	13	○	①	○	○	○
14.	Feeling low in energy or slowed down	14	○	①	②	③	④
15.	Thoughts of ending your life	15	○	①	○	○	○
16.	Hearing voices that other people do not hear	16	○	①	②	③	④
17.	Trembling	17	○	①	○	○	○
18.	Feeling that most people cannot be trusted	18	○	①	②	③	④
19.	Poor appetite	19	○	①	○	○	○
20.	Crying easily	20	○	①	②	③	④
21.	Feeling shy or uneasy with the opposite sex	21	○	①	○	○	○
22.	Feelings of being trapped or caught	22	○	①	②	③	④
23.	Suddenly scared for no reason	23	○	①	○	○	○
24.	Temper outbursts that you could not control	24	○	①	②	③	④
25.	Feeling afraid to go out of your house alone	25	○	①	○	○	○
26.	Blaming yourself for things	26	○	①	②	③	④
27.	Pains in lower back	27	○	①	○	○	○
28.	Feeling blocked in getting things done	28	○	①	②	③	④
29.	Feeling lonely	29	○	①	○	○	○
30.	Feeling blue	30	○	①	②	③	④
31.	Worrying too much about things	31	○	①	○	○	○
32.	Feeling no interest in things	32	○	①	②	③	④
33.	Feeling fearful	33	○	①	○	○	○
34.	Your feelings being easily hurt	34	○	①	②	③	④
35.	Other people being aware of your private thoughts	35	○	①	○	○	○

Please continue on the following page ▶

SCL–90–R®

SIDE 2

HOW MUCH WERE YOU DISTRESSED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
36. Feeling others do not understand you or are unsympathetic	36	0	1	2	3	4
37. Feeling that people are unfriendly or dislike you	37	0	1	2	3	4
38. Having to do things very slowly to insure correctness	38	0	1	2	3	4
39. Heart pounding or racing	39	0	1	2	3	4
40. Nausea or upset stomach	40	0	1	2	3	4
41. Feeling inferior to others	41	0	1	2	3	4
42. Soreness of your muscles	42	0	1	2	3	4
43. Feeling that you are watched or talked about by others	43	0	1	2	3	4
44. Trouble falling asleep	44	0	1	2	3	4
45. Having to check and double-check what you do	45	0	1	2	3	4
46. Difficulty making decisions	46	0	1	2	3	4
47. Feeling afraid to travel on buses, subways, or trains	47	0	1	2	3	4
48. Trouble getting your breath	48	0	1	2	3	4
49. Hot or cold spells	49	0	1	2	3	4
50. Having to avoid certain things, places, or activities because they frighten you	50	0	1	2	3	4
51. Your mind going blank	51	0	1	2	3	4
52. Numbness or tingling in parts of your body	52	0	1	2	3	4
53. A lump in your throat	53	0	1	2	3	4
54. Feeling hopeless about the future	54	0	1	2	3	4
55. Trouble concentrating	55	0	1	2	3	4
56. Feeling weak in parts of your body	56	0	1	2	3	4
57. Feeling tense or keyed up	57	0	1	2	3	4
58. Heavy feelings in your arms or legs	58	0	1	2	3	4
59. Thoughts of death or dying	59	0	1	2	3	4
60. Overeating	60	0	1	2	3	4
61. Feeling uneasy when people are watching or talking about you	61	0	1	2	3	4
62. Having thoughts that are not your own	62	0	1	2	3	4
63. Having urges to beat, injure, or harm someone	63	0	1	2	3	4
64. Awakening in the early morning	64	0	1	2	3	4
65. Having to repeat the same actions such as touching, counting, or washing	65	0	1	2	3	4
66. Sleep that is restless or disturbed	66	0	1	2	3	4
67. Having urges to break or smash things	67	0	1	2	3	4
68. Having ideas or beliefs that others do not share	68	0	1	2	3	4
69. Feeling very self-conscious with others	69	0	1	2	3	4
70. Feeling uneasy in crowds, such as shopping or at a movie	70	0	1	2	3	4
71. Feeling everything is an effort	71	0	1	2	3	4
72. Spells of terror or panic	72	0	1	2	3	4
73. Feeling uncomfortable about eating or drinking in public	73	0	1	2	3	4
74. Getting into frequent arguments	74	0	1	2	3	4
75. Feeling nervous when you are left alone	75	0	1	2	3	4
76. Others not giving you proper credit for your achievements	76	0	1	2	3	4
77. Feeling lonely even when you are with people	77	0	1	2	3	4
78. Feeling so restless you couldn't sit still	78	0	1	2	3	4
79. Feelings of worthlessness	79	0	1	2	3	4
80. The feeling that something bad is going to happen to you	80	0	1	2	3	4
81. Shouting or throwing things	81	0	1	2	3	4
82. Feeling afraid you will faint in public	82	0	1	2	3	4
83. Feeling that people will take advantage of you if you let them	83	0	1	2	3	4
84. Having thoughts about sex that bother you a lot	84	0	1	2	3	4
85. The idea that you should be punished for your sins	85	0	1	2	3	4
86. Thoughts and images of a frightening nature	86	0	1	2	3	4
87. The idea that something serious is wrong with your body	87	0	1	2	3	4
88. Never feeling close to another person	88	0	1	2	3	4
89. Feelings of guilt	89	0	1	2	3	4
90. The idea that something is wrong with your mind	90	0	1	2	3	4

NCS Trans-Optic® E30-24169: 987

APPENDIX K

Telephone Screening Questionnaire
(Blaustein, 1994)

Subject _____

Hello, my name is Jeannie. I'd like to give you some more information about the "Coping with Frequent Illness Study" if this is a good time for you to talk.

Overview:

This study involves meeting with someone on a weekly basis to talk about how you're feeling and dealing with your physical problems, changes in your health, and general coping issues. You will be reimbursed $10 and 2 subway tokens for each hour of interview time. There are 20 weekly interviews, and an initial interview.

Are you still interested?

Every one will get an initial interview, lasting about 2 hours. You will also be reimbursed for this interview. During this meeting, I will ask you to complete several questionnaires and answer a series of questions about your medical history, your experiences with your health and illness, and about coping, and about past events in your life.

After this interview, I'll call you to let you know if you are eligible for the study. If you wish to participate, then we will set up a weekly meeting. The weekly meetings will last about one hour or less. During the weekly interview, you will also be asked to fill out one questionnaire, and answer some questions about how you've been feeling and dealing with your health and body experiences during the week.

All material will be confidential, and anonymous. All questions that are answered aloud will be tape-recorded so that they can be studied later. No names will be used.

Reimbursement includes $10 per hour of interview time, and 2 subway tokens for each interview.

DO YOU HAVE ANY QUESTIONS?

I HAVE A FEW QUESTIONS FOR YOU. WOULD IT BE ALRIGHT TO ASK YOU THOSE NOW?

1. How did you hear about the study?
2. What sorts of experiences have you had that lead you to call to participate in the study?
3. What do you hope to gain as a result of participating in the study?
4. Do you feel that you would be able to commit to a weekly meeting, once a week, for 20 weeks?

APPENDIX L

Toronto Alexithymia Scale-20

(Bagby and Taylor, 1992b)

Sex: M / F Age: Date: ID #:

T A S - 20

Using the scale provided as a guide, indicate how much you agree or disagree with each of the following statements by circling the corresponding number. Give only one answer for each statement.

Circle 1 if you STRONGLY DISAGREE
Circle 2 if you MODERATELY DISAGREE
Circle 3 if you NEITHER DISAGREE NOR AGREE
Circle 4 if you MODERATELY AGREE
Circle 5 if you STRONGLY AGREE

	Strongly Disagree	Moderately Disagree	Neither Disagree Nor Agree	Moderately Agree	Strongly Agree
1. I am often confused about what emotion I am feeling.	1	2	3	4	5
2. It is difficult for me to find the right words for my feelings.	1	2	3	4	5
3. I have physical sensations that even doctors don't understand.	1	2	3	4	5
4. I am able to describe my feelings easily.	1	2	3	4	5
5. I prefer to analyze problems rather than just describe them.	1	2	3	4	5
6. When I am upset, I don't know if I am sad, frightened, or angry.	1	2	3	4	5
7. I am often puzzled by sensations in my body.	1	2	3	4	5
8. I prefer to just let things happen rather than to understand why they turned out that way.	1	2	3	4	5
9. I have feelings that I can't quite identify.	1	2	3	4	5
10. Being in touch with emotions is essential.	1	2	3	4	5

	Strongly Disagree	Moderately Disagree	Neither Disagree Nor Agree	Moderately Agree	Strongly Agree
11. I find it hard to describe how I feel about people.	1	2	3	4	5
12. People tell me to describe my feelings more.	1	2	3	4	5
13. I don't know what's going on inside me.	1	2	3	4	5
14. I often don't know why I am angry.	1	2	3	4	5
15. I prefer talking to people about their daily activities rather than their feelings.	1	2	3	4	5
16. I prefer to watch "light" entertainment shows rather than psychological dramas.	1	2	3	4	5
17. It is difficult for me to reveal my innermost feelings, even to close friends.	1	2	3	4	5
18. I can feel close to someone, even in moments of silence.	1	2	3	4	5
19. I find examination of my feelings useful in solving personal problems.	1	2	3	4	5
20. Looking for hidden meanings in movies or plays distracts from their enjoyment.	1	2	3	4	5

APPENDIX M

Trauma History Questionnaire

(Green, in development)

TRAUMA HISTORY QUESTIONNAIRE

The following is a series of questions about serious or traumatic life events. These types of events actually occur with some regularity, although we would like to believe they are rare, and they affect how people feel about, react to, and/or think about things subsequently. We are interested in learning whether and how often these events have happened to the individuals in our study because we feel that it will help us understand how people deal with current stresses in their lives, and will assist us in developing better services for all of our patients. The questionnaire is divided into questions covering crime experiences, general disaster and trauma questions, and questions about physical and sexual experience.

For each event, please indicate (circle) whether it happened, and if it did, the number of times and your approximate age when it happened (give your best guess if you are not sure). Also note the nature of your relationship to the person involved, and the specific nature of the event, if appropriate.

Crime-Related Events

			If Yes	
			# of Times	Approx. Age
1. Has anyone ever tried to take something directly from you by using force or the threat of force, such as a stick-up or mugging?	No	Yes	_____	_____
2. Has anyone ever attempted to rob you or actually robbed you (i.e. stolen your personal belongings)?	No	Yes	_____	_____
3. Has anyone ever attempted to or succeeded in breaking into your home when you weren't there?	No	Yes	_____	_____
4. Has anyone ever tried to or succeeded in breaking into your home while you <u>were</u> there?	No	Yes	_____	_____

General Disaster and Trauma

5. Have you ever had a serious accident at work, in a car or somewhere else?	No	Yes	_____	_____

<u>If yes</u>, please specify

_____

			If Yes	
			# of Times	Approx. Age
6. Have you ever experienced a natural disaster such as a tornado, hurricane, flood, major earthquake, etc., where you felt you or your loved ones were in danger of death or injury? If yes, please specify _____	No	Yes	_____	_____
7. Have you ever experienced a "man-made" disaster such as a train crash, building collapse, bank robbery, fire, etc., where you felt you or your loved ones were in danger of death or injury? If yes, please specify _____	No	Yes	_____	_____
8. Have you ever been exposed to dangerous chemicals or radioactivity that might threaten your health?	No	Yes	_____	_____
9. Have you ever been in any other situation in which you were seriously injured? If yes, please specify _____	No	Yes	_____	_____
10. Have you ever been in any other situation in which you feared you might be killed or seriously injured? If yes, please specify _____	No	Yes	_____	_____
11. Have you ever seen someone seriously injured or killed? If yes, please specify _____	No	Yes	_____	_____
12. Have you ever seen dead bodies (other than at a funeral) or had to handle dead bodies for any reason? If yes, please specify _____	No	Yes	_____	_____

			If Yes	
			# of Times	Approx. Age
13. Have you ever had a close friend or family member murdered, or killed by a drunk driver?	No	Yes	_____	_____
If yes, please specify relationship (e.g. mother, grandson, etc.)_____				
_____				
14. Have you ever had a spouse, romantic partner, or child die?	No	Yes	_____	_____
If yes, please specify relationship				
_____				
15. Have you ever had a serious or life-threatening illness?	No	Yes	_____	_____
If yes, please specify relationship				
_____				
16. Have you ever received news of a serious injury, life-threatening illness or unexpected death of someone close to you?	No	Yes	_____	_____
If yes, please indicate nature of event and relationship _____				
_____				
17. Have you ever had to engage in combat while in military service in an official or unofficial war zone?	No	Yes	_____	_____
If yes, please indicate where				
_____				

Physical and Sexual Experiences

			If Yes	
			Was it repeated?	Approx. how often & what Age(s)
18. Has anyone ever made you have intercourse, oral or anal sex against your will?	No	Yes	_____	_____
If yes, please indicate nature of relationship with person (e.g., stranger, friend, relative, parent, sibling)_____				

			If Yes	
			Was it repeated?	Approx. how often & what Age(s)
19. Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat? If yes, please indicate nature of relationship with person (e.g., stranger, friend, relative, parent, sibling)_____	No	Yes	_____	_____
20. Other than incidents mentioned in 18 and 19, have there been any other situations in which another person tried to force you to have unwanted sexual contact?	No	Yes	_____	_____
21. Has anyone, including family members or friends, ever attacked you with a gun, knife or some other weapon?	No	Yes	_____	_____
22. Has anyone, including family members or friends, ever attacked you without a weapon and seriously injured you?	No	Yes	_____	_____
23. Has anyone in your family ever beaten, "spanked" or pushed you hard enough to cause injury?	No	Yes	_____	_____
Other Events				
24. Have you experience any other extraordinarily stressful situation or event that is not covered above? If yes, please specify _____ _____	No	Yes	_____	_____

APPENDIX N

Psychological Dimensions Assessed by the EARS, excerpt from The EARS Administration and Scoring Manual (Wilson et al., 1988).

Psychological Dimension 1- Affect Tolerance. Tolerance is a formal dimension of affective life that is central to the clinical situation (Krystal, 1975).

The way in which a person manages their affective arousal can take many forms. Through development and early socialization, a person comes to possess characteristic ways of tolerating emotions. These range from highly unsocialized and immature forms, such as simple avoidance of unpleasure and dedifferentiation and somatization of affects, to a mid-range where one-sided and highly polarized emotional experiences are the rule, to more sophisticated and mature modes in which the nuances of one's emotional life are largely integrated, modulated, and accepted. Depression and anxiety tolerance are psychological acquisitions that are important in assessing a patient's treatability. In telling TAT stories, a subject must confront both the affective situations which the cards portray and the feelings which the act of telling a story evokes. A subject's ability to modulate affective arousal will shift from card to card, depending upon the meaning each card has for the individual. These shifts provide us with useful diagnostic information, as they suggest how the subject reacts to and tolerates different kinds of affective arousal across degrees of stress. It should be noted that the absence of an affective tone in the response calls for a similar inference as the presence of a

strong or muted tone. For example, the absence of an affective tone can be seen in the type of polarization characteristic of Mode II.

Mode I: The subject's response indicates an extreme intolerance for affect. This may be manifest in either the respondent's reaction to the TAT card or in the story content. Persons may be prone to explosive outbursts or impulsivity. Affects may be discharged through direct action designed to avoid unpleasure. There may be rapidly shifting and fragmentary affect states.

Mode II: The subject's response indicates a minimal affect tolerance which may be discernible through the polarization of affect states. These polarized affect states may be highly charged. The cohesiveness of the narrative may suffer from this attempt to keep contradictory affects apart. In the story, the resulting manifestations of affect may be confused, bland, glib, logically contradictory or idealized/grandiose. The response may reflect an oscillation between extreme positive and negative affective experiences.

Mode III: The subject's response indicates a rudimentary integration of opposing affects. Either positive or negative affects predominate. Though the non-dominant affects are minimized, they are not absent.

Mode IV: The subject's response indicates a simultaneous conscious representation of multiple affective experiences. This simultaneous representation produces conflict and anxiety but is tolerated. Affect states do not impede problem solving and working toward a resolution of the conflict.

Mode V: The subject's response indicates an acceptance of conflictual affect states. The acceptance of these states lends themselves to creative management of these affects, for example through sublimation.

Psychological Dimension 2: Affect Expression. Affect expression is a dimension that refers to how emotions come to play a role in a communicational matrix with important others. A central feature of the task presented by the TAT is for the subject to describe what the characters are feeling. A subject's response in this way provides us with clues to conscious and unconscious aspects of their affective life and how affects function as communications or "signals". The expressed affects in the response--their intensity and their differentiation (global or specific)--are indicators of a person's modal affective ties to objects. Throughout development, a person's affective expèriences are refined and differentiated, usually parallel to formative object relational phenomena, and certain general affective patterns are developed that determine, in part, their typical affective experiences.

Mode I: The subject's response indicates global and undifferentiated affects organized around unpleasure or overstimulation. Discrete affects are not yet differentiable from the experience of global unpleasure. Sleeping or expressions of rage may be actions expressing unpleasure or its relief. Affects are undifferentiated and fragmented and can serve to obliterate the experience of self.

Mode II: The subject's response indicates discrete affects in highly polarized and charged form. These affect states stem from a disruption of self-cohesion. The typical

affects expressed in this mode may be helplessness, primitive guilt which is manifest in a sense of badness of the self, rage which is destructive to self and other, free-floating anxiety, and positive feeling that has as its basis a fundamental need-gratifying dependency on others.

Mode III: The subject's response indicates affects stemming from illusory beliefs about the self or other. The typical affects expressed in this mode may include: The emptiness coming from failed grandiose aims, anger over others, noncompliance, idealized love and affection, pleasure in self importance, and hypersensitive reactions to criticism such as vindictiveness and envy.

Mode IV: The subject's response indicates any of a full range of affects and diverse affect states may contradict one another. The typical affective experiences of this mode may be loss of self esteem, quilt over failure to live up to expectations, joy taken in achievement and competition, conflictual love or eroticism, jealousy, or feelings about ego-ideal ambitions and conflicts. The respondent may express anxiety provoking but modulated forms of anger, sadness, or other emotions.

Mode V: The subject's response indicates affects stemming from the tolerable frustrations and conflicts of consciously lived experiences. The typical affective experiences of this mode tend to be acceptable and ego-syntonic. Mature forms of grief, anger, sadness, happiness, joy, and love, are all handled with an acceptance and wisdom appropriate to the situation at hand.

Psychological Dimension 7: Empathic Knowledge of Others. Throughout development the ability to know other people and empathize with them evolves (Bergman and Wilson, 1984). Early on, empathy is little more than a contagion of affect (i.e., if one infant in a nursery cries, neighboring ones will cry too). Later, one learns to know and understand others on the basis of stereotypic functions and roles, and later still, as individuals with separate psychologies and perspectives. The TAT stories a subject tells will reveal his or her level of empathic knowledge of others, by the way the characters understand one another and the way he or she understands them and the story's hero.

Mode I: There is no description of internal mental states depicted in the response. Empathy is expressed only as a contagion of action or affect without a further elaboration of internal states. People are understood only in terms of external physical characteristics.

Mode II: People are recognized as somewhat separate, and internal states are understood solely on the basis of external characteristics. Because of the incomplete differentiation, there may be a tendency for the other to be known and recognized through projection of one's self characteristics. The internal states of others may be perceived in global terms. e.g., unpleasure versus pleasure or good versus bad.

Mode III: People and their internal states may be stereotyped according to function or role. There is some recognition of the inner life of the other, but the other is not recognized as having a rich, complex, or unique psychological existence. Self-

gratification may provide the basis for selective empathy, which is the knowing of selected "parts" of the other. The selective empathy of Mode III can at times result in a stark contrast, between a psychological understanding of need-gratifiers (who are well understood) and more peripheral characters (who are less well understood). This is to say, people are known in large part because of their capacity to gratify basic needs, and those who cannot are not deemed worthy of the empathic effort.

Mode IV: Others are understood as having a relatively independent and rich psychological existence. External characteristics, functions, and internal states can be combined in the understanding of people but the failure to fully reconcile contradictory elements within a person or between people prevents a complete integration.

Mode V: Others are understood and accepted as having independent and integrated psychological existence. Both enduring and changing qualities of the individual are interwoven in the response.

Psychological Dimension 8: Use of an Object. Interpersonal relationships serve a variety of aims and ends. These can range from the use of another for the sole purpose of self enhancement, through mutual enhancement of both parties, and leading to intimate collaborative relations. Interpersonal relationships evolve during development from basic dependency through mature intimacy. In truly mutual and mature relationships, the lower level functions are epigenetically subsumed, served in a silent fashion. However, when a person has difficulty forming intimate relationships, the more dependent functions noisily cry out for attention. Under these conditions,

interpersonal relationships become focussed on lower level uses of the objects in a person's life. The interpersonal relationships in a person's TAT stories reflect his or her usual use of objects and patterns of interpersonal contact. This will be seen too, in his or her use of the examiner and relationship to the hero of his story. Interesting comparisons can be made between the way an individual uses objects and the way he understands them (see Dimension 7, above).

Mode I: The response indicates a solely physical use or representation of the object to enhance the self. There is no enduring use of people beyond continuous physical processes. The onset of traumatic overstimulation or displeasure preempts any further use of objects.

Mode II: The object is used for, or the self is enhanced by, a life-sustaining, parasitic, need-gratifying relationship, or objects are avoided because they threaten a fragmentation of self-experience.

Mode III: The object is used for, or the self is enhanced by, realistic or unrealistic feedback in the service of self-esteem maintenance and regulation. Thus, the object may be minimized or avoided in the pursuit of the maintenance of primary illusions.

Mode IV: Objects are used for, or the self is enhanced by, healthy competition, non-destructive rivalry, allegiances, ambitiousness, mature intimacy, or pedagogy. Some interpersonal relationships may be restricted to protect against anxiety provoking conflict.

Mode V: The object is used unselfishly for the enhancement of others as well as the self. This is attained through sustained, cooperative relationships leading to mutual gain and satisfactions. Interaction with objects may be restricted to avoid impinging upon others' autonomy.

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