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Psychological Components in Chronic Urticaria

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PSYCHOLOGICAL COMPONENTS IN CHRONIC URTICARIA

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CHAPTER I

THE PROBLEM AND DEFINITION OF THE TERMS USED

There has been wide recognition for a number of years that psychological components play a part in the etiology and treatment of some cases of chronic urticaria. Divergent opinion has been expressed regarding the importance of these components and their specific indentification. Most contentions in this area are supported by meager experimental evidence and the formulations are too often based on the superficial observation of a large number of cases or on the intensive study of the individual case.

The hypothesis of this research is that significant psychological components exist in patients with chronic urticaria and that these components are amenable to precise delineation.

This study presents a combined statistical, psychometric and clinical approach to the field of psychosomatic disorders in general and to the problem of chronic urticaria particularly. Hypnotic and psychoanalytic procedures were utilized to supplement evidence procured by traditional objective instruments. The sample of twenty-two cases is large enough to minimize the criticism of the individual case

study and yet the series is limited enough in number to allow for a depth of knowledge regarding each patient.

According to Jones (1) urticaria is defined as :

> Hives or nettle rash. Skin condition characterized by the appearance or intensely itching wheals or welts with elevated usually white, centers and a surrounding area of erythema. They appear in crops, widely distributed over the body surface.

Within this study chronic will be defined as a condition of not less than three months duration. This definition is consistant with the usage of the term by the American College of Allergists and by most of the investigators mentioned in this report, such as Kraft (2) and Steinhardt (3).

Psychological components which are significant are those emotional factors which bear directly on the etiology and treatment of the physical symptom. The multiphasic aspect of urticaria makes it impossible to extract a single necessary and adequate case for its production, therefore a significant component is one which when varied will cause a concomitant variation in the urticaria.

Angioedema or by more traditional usage called angioneurotic edema is closely related to urticaria and these two conditions are sometimes investigated together, Steinhardt (3), Siagel and Bergeron (4), Graham (5), Wittkower (6) and (7). Although this study deals only with urticaria the following statements are included

for the sake of clarificaiton:

> Kraft (8) has referred to angioedema as "deep hives." Jones (1) defines the condition as: Edema marded by acute, transitory, localized swelling, usually about the face; the lesions resemble those of urticaria, but are larger and of less distribution. Some cases are hereditary, others appear due to food allergy. Syn., giant urticaria, giant edema.

CHAPTER II

HISTORY OF THE PROBLEM

The information pertinent to this subject lends itself to a three-way division: The general area of psychosomatic medicine and its development within the medical profession, the application of these concepts to the field of allergy and lastly, the study of chronic urticaria from the psycho-biologic point of view.

I. THE GENERAL AREA OF PSYCHOSOMATIC MEDICINE

> Psychosomatic is defined by Jones (1) as: Of or pertaining to the mind and body, as in affections with an emotional background having both mental and bodily components. Especially relating to a system of medicine which emphasizes the interdependence of mental processes and physical or somatic functions.

As a practical philosophy the psychosomatic concept is older than the history of medicine and as ancient and ubiquitous as magic and religion. From the frozen waste lands of the Arctic, Freuchen (9) to the Polynesian areas of the Pacific, Malinowski (10) to the primitive regions of the Dark Continent, LeCrone (11) and Barkhuus (12) people at all levels of cultural development have given recognition to the mind-body relationship. Representatives of the medical pioneers of every age have lent support for this theory from Hippocrates (13)

of old Greece to Paracelsus of the Renaissance, Pachter (14) to the moderns. Recently the psychosomatic concept has been applied to infra-human species, as with the encouragement of gastric ulcers in Rhesis monkeys, Brady (15). Even micro-organisms have not been immune from study in this regard, Montague (16). Formalized scientific interest in this field has mushroomed in recent years. The material which follows sketches the significant landmarks in the development of this concept.

Since concepts embodied in a modern philosophy of psychosomatic medicine are essentially psychoanalytic in orientation the contributions of Sigmund Freud are salient. The hysterias, although they are not strictly psychosomatic disorders, were the first to be scrutinized under the penetrating light of the then embryonic psychoanalytic science. Breuer and Freud (17) in their historic work reminded the medial profession that certain physical symptoms could be emotionally determined. Wilhelm Fliess, one of Freud's earliest supporters, was possibly the first to ascribe psychological components to nasal disfunctions, Bonaparte, Freud and Kris (18). The gastro-intestinal and the genito-urinary were the first organ systems to be studied from this frame of reference, Freud (20) being concerned with the former and Ferenczi (21) with the latter. Then as the psychoanalytic movement gained momentum it grew away from the field of medicine as other aspects of lifewere studied. Family, social and personal difficulties were seen from the point of view of analytic psychology as the foundations for the psycho-biologic approach which we have today were being laid.

As psychoanalysis matured there was a move to integrate this approach with the main branch of medicine. This was especially true in the United States. Alexander (22, 23, 24) was a central figure in this effort. As a former student of Freud with a firm medical orientation he has done much to popularize the bio-psychological basis for the consideration of many here-to-fore "purely physical" manifestations. Through his influence the classical psychoanalysists were introduced to the revolutionary idea of modifying their intensive-extensive psychoanalysis to provide for psychotherapy, Alexander and French (23). Psychotherapy, rather than classical psychoanalysis, is the basic tool for most of the treatment and much of the research in psychosomatic medicine. Clear accounts of this use of psychoanalytic psychotherapy are described by Deutsch and Murphy (25) and by Wolberg (26) of the Post-Graduate Center for Psychotheraphy in New York. Aside from the development of "brief psychotherapy", Alexander (22) provided the guidance for the psychosomatic exploration of metabolic and endrocrine disturbances, circulatory malfunctioning and joint and muscle symptoms.

Some of the physicians and a few allied scientists who were involved in treatment or research on these topics provided themselves with a forum for reciprocal communications with the establishment in 1938 of the American Psychosomatic Society. The official organ of the Society is Psychosomatic Medicine, a bi-monthly journal devoted to the

publication of original investigations in this field. The history of psychosomatic medicine in the United States, and to some extent in the world, is reflected in the publications and proceedings of this group.

During this era the "classic" works were produced, almost all of them by Freudian psychoanalysts. Deutsch (27) wrote her two volume treatise on the psychology of women including many allusions to the effect of various emotions on the feminine reproductive cycle. Dunbar (28) wrote for the layman as well as the professional and did much to familiarize the general reading public with psychosomatic theories.

Another milestone of progress was the creation of the Institute of Psychosomatic Medicine in Chicago. In 1950 a separate building was erected on the grounds of Michael Reese Hospital for research and treatment. The unit was under the direction of Grinker who worked closely with Alexander. Grinker had been a neurologist and had published a basic text on this subject, (32), which is still in use. The affiliation of the Institute with both the Chicago Institute of Psychoanalysis and the Michael Reese Medical Center has done much to close the gap between a physical and a psychological approach to somatic illness. This group has produced new ideas and has used the talents of many different professions. Bio-Chemistry, Sociology, Psychology, Analysis and Medicine, etc.

As non-medical specialists became interested in this broader concept of illness the psychosomatic team approach developed. Borrowed

partly from the established psychiatric team of psychiatrist, social worker and psychologist and in part developed independently, the team usually includes a medical specialist for the type of physical problem being considered, sometimes a surgeon, a social worker, a psychologist and a psychotherapist. Others may be added depending on the demands of the particular work. In Chicago, Grinker and Robbins (29) and Grinker (30) evolved this teamwork and later the concept of coordinated practice was utilized at Massachusetts General Hospital in Boston, Miles, Cobb and Shands (33). The team has become accepted practice in many parts of the country and is carried over to the teaching of medical students and graduate physicians. Witmer (34) edits the records of a three week course for general practitioners which was offered on an experimental basis in April of 1956. Physicians and social workers led the seminars.

Social workers began to make a contribution to the field of psychosomatic medicine by encouraging the enlargement of the psycho-biologic base to a psycho-socio-biologic concept. The psychologists who have done outstanding work in this area have usually been therapists. The National Psychological Association for Psychoanalysis in New York under the direction of Theodore Reik (35, 36, 37) has broken new ground in psychosomatic technique. Lindner (38) for example utilized hypnotherapy for the treatment of occular-motor disorders. The work of this organization is published in their quarterly journal, the Psychoanalytic Review.

II. PSYCHOSOMATIC ALLERGY

From one view point psychosomatic allergy was officially born in 1950 when the American College of Allergists established as its twelfth standing committee, the Committee on Psychosomatic Allergy. The twelve people who have served on this committee since its inception have probably contributed the major interest to this field in the United States. Those whose work has related to this study are Abramson (39), Baruch (40), Kaufman (42), Miller (40), Steinhardt (3) and Kraft (43, 44, 45, 46, 47).

The committee in 1952 sent a questionnaire to the membership of the College. There were four hundred and fifty-four questionnaires returned with the following indications. First, the replying members thought that psychological techniques would be helpful to them in their practice of allergy and those techniques which they had utilized had been of assistance. Secondly, they felt that they would like to learn more specific techniques for use in their practice. In view of the interest which was shown from the year 1952 there has been a separate workshop on psychosomatic allergy held at the annual meetings of the College. Further details of this planning are available in Abramson (39).

The publication of the American College of Allergists, Annals of Allergy, reflects the thinking of the allergy specialists in this country. A survey was made of every issue of the Annals since the

first issue in July, 1943. The number of original articles was tabulated and the number of articles relating in some manner to psychosomatic allergy was counted. If the paper referred to psychological factors in anything other than an incidental manner, even to disparage their importance, the article was considered to be "psychosomatic." Table I summarizes this information.

It may be significant that, in spite of the fact that there is almost universal acceptance of the idea that emotional factors play some role in the genesis or treatment of allergic diseases, there is relatively little research on the subject. Of a total of 1161 original publications in Annals of Allergy since the first copy in 1943 through the year 1958 only 27 of these have had as a major concern psychological phenomena. The interest was quite low regarding psychosomatic implications until 1950 when there was a "flurry" of four papers printed. This was the year prior to the forming of the Committee on Psychosomatic Allergy. The first several years following the workshops seemed to indicate a greater awareness of these psychobiological concepts. Then interest appeared to wane. There was some indication, however, that the authors became more sophisticated psychosomatically as reflected in the content of some of the papers even though they were not directly involved with psychosomatics.

To balance this picture of the more traditional somatically oriented allergic specialist a parallel survey of Psychosomatic

TABLE I

SURVEY OF ARTICLES ON PSYCHOSOMATIC ALLERGY PUBLISHED IN ANNALS OF ALLERGY AND PSYCHOSOMATIC MEDICINE

YEAR	ANNALS OF ALLERGY		PSYCHOSOMATIC MEDICINE	
	TOTAL	PSYCHOSOMATIC ALLERGY	TOTAL	PSYCHOSOMATIC ALLERGY
1939			38	1
40			33	1
41			34	3
42			34	1
43	24	0	30	0
44	54	2	27	0
45	50	1	41	1
46	55	0	43	1
47	70	0	44	3
48	87	2	40	3
49	89	0	46	2
50	110	4	49	1
51	103	4	33	3
52	86	2	45	0
53	81	4	45	1
54	82	3	41	2
55	79	1	40	3
56	66	2	39	0
57	58	1	47	2
58	67	1		
	1161	27	715	28

Medicine, the publication of the American Psychosomatic Society, was made from the first issue in the inaugural year of 1939 through 1957. Again the total number of original articles was tabulated. This was compared to the total number of articles that were related to allergic manifestations. This material also is shown in Table I. Of a total of seven hundred and fifteen articles there were twenty-eight about allergic or related problems. Except for the lead article in the first issue which investigated fifty cases of bronchial asthma from a psychosomatic point of view the major portion of the investigators concern themselves with dermatological difficulties which could be considered to be peripheral to the field of allergy. It is later that illnesses more classically allergic in nature are reported. The abrupt jump in the number of articles per year of publications is a result of the shift from a quarterly to a bi-monthly schedule and the consequent addition of two issues per year.

A review of developments within the area of psychosomatic allergy would not be complete without a mention of the three"teams" which are attempting to develop a practical clinical approach on the basis of the various theories which have been formulated. In Columbus, Ohio, John Mitchell has a part-time psychologist seeing some of his allergic patients on a diagnostic and supportive therapy basis. This team is the least active of three groups. However, Dr. Mitchell has done much to encourage the use of simple psychometric procedures as part of the routine allergic work-up. He is originator of the Multiple

symptomatology Inventory used in this study. The combination most active through the years has been the husband and wife team of Hyman Miller and Dorothy Baruch in Beverly Hills, California. Dr. Baruch is a psychonalytically oriented psychologist who works primarily with children and their parents. They have done much with the allergic child, (40). In Indianapolis the author has had the opportunity to be associated with Bennett Kraft and for the past four and a half years has contributed toward the diagnosis and brief and intensive treatment of the adult allergic patient (44, 45, 46, 47, 48).

Concurrently with many of the developments mentioned formerly are the studies, primarily analytical, by French and Alexander (49) under the auspices of the National Research Council on the problem of bronchial asthma. Many of the aforementioned references relate in part to aspects of allergic problems, for example: Alexander and French (24), Funkenstein (50), Alexander and French (23) 291-324. Another innovation of recent origin is the use of group psychotherapy as an adjunct to the treatment regime of allergic patients. An interesting account of this work together with a critical evaluation of the therapeutic results is the work of Solare and Crocket (51) of Glasgow, Scotland.

The application of psychosomatic principles to allergy is a new frontier in medicine. The interaction of emotional with physiological dynamics needs to be understood with far greater precision

in order to provide a more effective therapeutic approach.

III. THE SPECIFIC AREA OF CHRONIC URTICARIA

As the literature on the general topic of chronic urticaria is surveyed it appears that nearly every author accepts the fact that psychological components have some importance in the genesis or cause of this dermatosis. However, when it comes to the delineation of the specific factors involved there is little agreement. The literature indicates there is hardly a conflict experienced by man which is not implicated in some manner. Environmental stress, over-work, parental rejection, parental over-protection, masturbation, marital discord, physical strain and nervous constitution are only a few examples of the many classifications of these allegedly causative influences. The typical article is descriptive of the physical symptoms and is meticulous in suggesting a detailed somatic regime for the relief of discomfort. Rehberger (52), an example of this point of view, includes a note in passing that emotional instability is sometimes of etiological significance. The current research in this area often assumes a precise physical frame of reference with histological, bio-chemical and physiological studies of the various lesion producing mechanisms. Winkelman (53) of Mayo Clinic discusses the wheal producing agents in great detail together with treatment recommendations of the most precise nature with the additional recommendations that the patient establish a regular routine of daily life.

A few investigators have endeavored to bring the psychological components into perspective and it is these reports which have more meaning in terms of this study. The earlier publications include those of Saul and Bernstein (54) and Oberndorf (55) who in 1941 and 1942 respectively report in Psychosomatic Medicine the fact that particular emotional settings effect the direct production of urticarial symptoms. Dutton (41) is one of the first allergists to publish observations in this regard in 1947. In 1950 Funkenstein (50) and (56) notes that on a study of several individual cases asthma and urticaria do not appear to co-exist with psychosis and that in these patients the allergic illness acted as a psychotic equivalent. This is a direct statement of the theory that hives can come to the service of psychological homeostasis. In the same year Graham (5) and Graham and Wolf (57) reported on the use of structured interviews with a small series of patients in an attempt to study experimentally the effect of life stress in the patho-genesis of hives.

The possible psychoanalytic meaning of skin disfigurement concomitant with urticaria is discussed by Wittkower (6) and then these theories are supported by a study of thirty-five patients (7) with both urticaria and angioneurotic edema, 1952 and 1953. In Germany, Haverlandt and Feer (58) did parallel studies with twenty patients in 1953. Somewhat more superficial psychologically, their results agree with Wittkower. Three allergists in 1954 made detailed statistical studies of the problem, Steinhardt (3) studied records

of five hundred adult patients with either chronic urticaria or angioedema or both, and Siegel and Bergeron (4) reviewed the records of one hundred and fifty cases of urticaria and angioedema in children and young adults. These studies indicated the growing emphasis on a psychological understanding of these patients and of the effort to develop the means to clarify these emotional factors. In this regard Schneider (59) wrote from England of her study of nine chronic urticaria patients and her attempt to formulate a sharp dynamic profile. One of the most recent publications is also from England, Rees (60) reviewed some of the literature in the field in an effort to establish a base of common agreement regarding the importance of the various etiological factors in both chronic urticaria and angioneurotic edema.

In spite of the interest in selected circles in the psychosomatic study of the problem of chronic urticaria the latest publications which are available show a strong somatic approach with a disregard of the emotional components as in the research of Moretti and Martinez of Uraguy (61), Brown from New York (62) and Liebeskind of Israel (63).

CHAPTER III

METHODOLOGY

This research concerned twenty-two patients with chronic urticaria who were studied and treated in a private allergy practice. Data for the study were collected by the use of both psychometric and clinical methods and were compared with similar data collected by the same methods from normal control groups and allergic control groups. The results of each method were interpreted independently and then combined into a unified psychological formulation.

Generally the psychometric procedures were part of the initial diagnostic evaluation and the clinical procedures were part of the treatment regime. Except for the fact that several of the hives patients were requested to return after their discharge from treatment for a follow-up examination or for an additional psychometric test they followed a routine that was identical to that pursued by the other allergic patients in this setting.

I. THE SUBJECTS

The twenty-two persons in this series consist of successive referrals over a four year period. They were not subject to selection

on any basis other than the presentation of chronic urticaria as their primary physical complaint. All the cases were of over three months duration and each was subjected to detailed allergic and physical investigation by Dr. Bennett Kraft. They were all under allergic management either prior to, concurrently with, or subsequent to the psychological work. Some of the patients had been known to Dr. Kraft for years before being studied or treated psychologically, and some have been contacted as long as a year following their discharge from treatment in an effort to determine the current status of the dermatosis.

The several control groups used were randomly selected from this same treatment setting and were patients who had been under a similar regime of cooperative allergic-psychotherapeutic management. They manifested various other allergic symptoms as the primary complaint and were matched for age and sex distribution with the urticaria group.

Although there was no attempt to choose these urticaria patients there are several reasons why they may represent a select group. First, the individuals in whom attacks of hives obviously followed the ingestion of certain foods or drugs would be less likely to be referred for treatment. The connection between the symptom and the precipitating agent would probably be discovered by the family physician or by the patient himself. Second, knowing the orientation of this treatment setting some physicians refer patients because these patients have recognizable emotional components in their symptomatology.

A profile of the series studied is shown in Table II. The group consists of nine men and thirteen women. The differential sex incidence is strinkingly similar to that found by other authors in samples from different parts of the world, as reported in Rees (60), Menagh (64), Urbach (65), Fink and Leslie (66) and Stokes (67).

As a group they present no striking uniqueness from other allergic patients as to age, sex and marital status. There appears to be no major difference between the men and the women with regard to the onset and duration of symptoms, the number of psychotherapeutic interviews or the clinical improvement.

With ten of the patients the duration of the illness was less than one year; in seven, more than five years, and the remaining five had hives between two and five years. As to the age at onset, there was a considerable range between fifteen and fifty-seven years with most of the patients in the twenty to forty age group. Additional data regarding the patients studied is found in Table XI in the Appendix.

II. INSTRUMENTS AND PROCEDURES

Psychometric Instruments and Procedures

Multiple Symptomatology Inventory. The first psychometric instrument presented to the patients was the Multiple Symptomatology Inventory which is a check-list of forty-five common physical symptoms

TABLE II

PROFILE OF CASES STUDIED

	MEN	WOMEN	TOTAL
URTICARIA PATIENTS	9	13	22
Age on examination			
under 20	1	0	1
20-29	3	3	6
30-39	2	6	8
40-over	3	4	7
Age at onset of urticaria			
under 20	2	2	4
20-29	3	3	6
30-39	2	5	7
40-over	2	3	5
Duration of urticaria			
less than one year	4	6	10
1-2 years	2	0	2
2-3 years	0	1	1
3-4 years	0	1	1
4-5 years	0	1	1
over 5 years	3	4	7
Marital status			
single (widowed and divorced)	2	4	6
married	7	9	16
Number of psychotheraputic interviews			
1	0	2	2
2	2	1	3
3	3	2	5
4	1	2	3
5 or more	3	6	9

divided into five categories. Table III shows the categorized list of symptoms used on this inventory.

As part of the initial work-up all allergic patients were given this list during their first office visit. The nurse usually handed the form to the patient with the remark, "Here is a list of symptoms which most people have experienced, please check the ones which have troubled you." This procedure was not instituted for this research and for a number of years these data has been somewhat casually accumulated with no specific purpose in mind. The control groups chosen were a group of twenty-five allergic, but non-urticaria patients, who were matched for age and sex to the urticaria group and a group of twenty-five non-allergics. The non-allergics were those who were not currently or have not in the past been treated for allergy. These allergic controls were selected from the patients who had been through the same office routine as the urtiçaria group. The non-allergic controls were selected from a group of approximately forty who had completed the inventory for the author. There was an attempt to match this group for age and sex distribution as closely as possible.

The mean number of symptoms indicated by each group was compared statistically and the probability was computed regarding the significance of these mean differences. To reduce the possibility that the allergic complaints would distort the results the data is compared in three ways. First the total group of symptoms is used as the basis of

TABLE III

CATEGORIZED LIST OF SYMPTOMS USED ON THE MULTIPLE SYMPTOMATOLOGY INVENTORY

ANXIETY

Fatigue
Headache
Nervous Tension
Restlessness
Sleeplessness
Nightmares
Dreams
Dizziness
Butterflies in Stomach
Fainting Spells
Weak Spells

GASTRO-INTESTINAL

Poor Appetite
Excessive Appetite
Indigestion
Belching
Gas
Cramps
Constipation
Diarrhea
Itching Rectum
Nausea
Vomiting

RESPIRATORY

Nasal Obstruction
Sneezing
Sighing
Wheezing
Asthma
Cough
Heaviness in Chest
Lump in Throat
Conscious of Heartbeat

DERMATOLOGICAL

Blushing
Pimples
Rash
Eczema
Hives
Welts After Scratching
Itching
Burning
Sweating Hands

GENITO-URINARY

Painful Menstruation
Frequent Urination
Itching Vagina
Arthritis
Aches and Pains

comparison. Next to reduce the effect of the physical complaints only the group of anxiety symptoms was used as the basis of comparison. Lastly, to reduce the effect of the skin disorders of the urticaria group and the respiratory disorders of the allergic controls a combination of anxiety and gastro-intestinal symptoms was utilized for comparison.

Bell Adjustment Inventory. Like the preceeding instrument the Bell Adjustment Inventory is part of the routine of the initial work-up and is administered to all of the new allergy patients. It was completed by twenty-one of the twenty-two patients in the study. The only teenager in the study, Mr. J., sixteen years old, did not use the adult form of the inventory and was therefore not included in these statistics. The mean scores obtained in the various areas of adjustment were compared with the mean scores of the well-adjusted controls. The norms for the well-adjusted controls were obtained from the Manual for the Adjustment Inventory, Bell (68). The statistical significance of these mean differences were computed by the methods presented in Garrett (69) and Townsend (70). At the time of this writing, data is being collected on five-hundred allergic patients which will form a more appropriate basis for comparing these scores, Blumenthal and Kraft (48).

Minnesota Multiphasic Personality Inventory. The MMPI was administered specifically for research purposes to eleven of the urticaria patients and was not a part of the regular office routine. It

is unfortunate that only half of the series were able to take this test. The remainder had been discharged from treatment before the MMPI was instituted. Three patients, Dr. N., Mr. L. and Mrs. G., returned after discharge to complete the Inventory. Others, Mrs. H., Mrs. E. and Mr. J., were administered the test after they had begun psychotherapy. The remaining five took the test during the diagnostic evaluation. Since the MMPI was first introduced it has become standard practice to administer the test to all allergics who are referred for psychological evaluation and/or therapy. A composite MMPI score was obtained by combining the scores and calculating a mean score for either the total group or a mean for men and separate mean for women on those items which were scaled differently for the sexes. These composite scores of the urticaria patients were compared with the MMPI scores of ninty-eight normal and thirteen psychotic controls. These controls scores were obtained from Shaffer and Shoben (71) and are consistant with the values in Hathaway and McKinley (72). Because the MMPI was administered to many of the group after or during treatment it is suspected that the results may reflect the effects of treatment in addition to the other considerations.

Clinical Methods and Procedures

Detailed exploration of the patient's life history. This is a routine procedure with all allergic patients who are referred to the psychotherapist. One of the purposes of this exploration is to assess the various factors in the patient's life as to their possible bearing

on the production, maintenance or exacerbation of the symptoms.

The exploration involves the accumulation of facts from the medical record and from personal interviews with the patient regarding his personal, familial, social and vocational adjustment. These facts are related to the medical history so that a chronological, psycho-socio-medical profile is developed indicating possible inter-relationships of these various sets of events. Particular emphasis is placed on the events and circumstances immediately preceeding and following the onset of physical illness generally, and exacerbation of the urticaria particularly. Effort is made to elicit not only the easily remembered detail but also information which is apparently forgotten. Periods of change and stress are explored as well as the more commonly thought of "problem areas". A change of jobs, a move to a new house or a different community, a death, birth or marriage are examples of the typical circumstances of life which are so common to everyone as to be overlooked as unimportant. The individual impact of these events is evaluated as to their possible medical reverberations. The author has developed this procedure which is explained further in Blumenthal (44, 45, 46).

Selective association. This is another routine diagnostic and treatment method used with the allergic patients referred for psychotherapeutic evaluation. This procedure utilizes a limited free-association technique. This approach has been investigated by Deutsch and Murphy (25) and Wolberg (26) and involves the patient's expressing his

thoughts and feelings without regard for logic, contunity or social propriety about a specific subject. This technique is used in conjunction with other clinical methods particularly with the detailed exploration of the patient's life situation and usually permits of a fairly rapid identification of many of the patient's major personality characteristics. These productions are often understood using the principals of projective psychology and interpreted psychoanalytically as in Freud (73), Alexander and French (23) and French (74).

Non-structured interview. This was a routine procedure used with every case in this series as well as with the other allergic patients. The non-structured interview is a common counseling tool and is used in combination with other clinical techniques. The purpose of the method is to evoke from the patient an unstudied reaction to what to him is a unique situation. Effort was made to present the situation similarly to the various patients so that their responses could be compared. The interview with Mrs. H. in the appendix is an example of the manner in which this method was employed.

Hypnosis. With seven patients in this series hypnotic procedures were employed experimentally for diagnosis and treatment. Sometimes a major portion of an interview would be conducted hypnotically and at times it would assume only minor importance. As it was injected into the usual psychological approach for research purposes it was subordinated to the more basic psychotheraputic plan.

The procedure has been in part developed by the author, Beiman and Blumenthal (75) and (76), and is based on the hypnoanalytic principles of Lindner (38) and the clinical techniques of Cooke (77), Rhodes (78), and Erickson (79) and on the hypnodiagnostic methods of Rosen (80). Clues gained by the other methods to topics needing further elucidation are explored hypnotically using a projective approach. A trance state of varying depth is produced in the interview setting without the use of any mechanical equipment. Methods of relaxation from Jacobson (81) usually commence the "naturalistic" induction, Erickson (79). Several examples of the use of hypnosis as a clinical instrument can be found in the Appendix - the interviews with Mrs. S. and Mrs. D.

The patients were generally placed in the trance while they were sitting in their chair. The procedure would be varied to utilize whatever motivations, mannerisms or subject matter important at the time could be mobilized to facillitate a trance. Usually the following process was involved. The patient was asked to relax, fixate his attention on his hands or a spot on the wall or the floor. The trance was induced by a series of "tests" beginning with the inability to unclasp the hands through arm levitation and inability to open the eyes. The patient was then helped to speak with disturbing the trance and then encouraged to fantasy himself in a motion picture theater and to imagine the blank screen as it would appear before the movie had begun. He was then instructed to envision a person

seated on the stage by the screen. He would not know this person but the suggestion was given that he would be about the same age and sex of the patient, and that the envisioned person was uncomfortable. It was suggested that the patient would know what was the matter with the person. When asked, the patient would usually respond that the person had the hives. The patient was then told that on a given signal, such as a count to five, that a movie would begin. He would not know the characters in the movie but the story would relate to why the person on the stage had hives.

After the fantasies had been produced it was suggested that upon awakening the patient might elect either to remember all that had occurred or forget any part or all of it. Afterwards a period of time was always allowed to examine the patients' feelings regarding the hypnotic experience and/or the specific content thereof.

Psychoanalytic psychotherapy. Psychoanalytic principles form the basis of all of the clinical methods used in this study. Psychoanalytic psychotherapy refers specifically to psychotherapy based on psychoanalytic theory and technique as defined and described in Alexander and French (23), Wolberg (26) and Fromm-Reichman (82). Psychotherapy according to English and English (83) is:

> The use of any psychological technique in the treatment of mental disorder or maladjustment ..... Nearly always personal consultation is a part of the technique, sometimes the whole of it .... The term should be reserved for treatment by a professionally trained person.

Although this paper is not primarily concerned with therapy the response to psychotherapy is an important tool of diagnostic value. Insights gained through this method are therefore included in this study.

CHAPTER IV

RESULTS OF THE RESEARCH

Psychometric Results

Multiple Symptomatology Inventory. The urticaria patient group when compared with either the allergic or the non-allergic control groups indicate a significantly greater number of physical complaints than either of these other groups. This is true using any of the three combinations of inventory items as the basis of comparison, the total symptom group, the anxiety symptoms or the anxiety plus gastro-intestinal symptoms. Table IV shows the results of these various comparisons. Considering the total list of forty-five symptoms the hive patients checked a mean of 12.63, the allergics a mean of 9.28 and the non-allergics a mean of 5.24 symptoms. These mean differences are significant at less than the .01 level. Considering just the anxiety items the hive cases checked a mean of 4.43, the allergics a mean of 3.20 and the non-allergics a mean of 2.16 symptoms. These mean differences are significant at less than the .05 level for the allergic group and less than the .01 level for the non-allergic group. The combination of the anxiety and gastro-intestinal symptoms yield a mean of 6.52 for the urticaria patients, 4.48 for the allergics and 2.06 for the non-allergics. The significance levels are less than .02 and less than .01 for

the allergic and non-allergic comparison respectively. Figure 1 illustrates these results by the use of bar graphs. The complete tabulation of the Multiple Symptomatology Inventory items checked by the three groups is listed in Table XI in the appendix. These results are consistent with a recently reported study by Rees (60) who used sixty-eight urticaria and/or angioneurotic edema patients and one hundred controls. Utilizing a list of fifteen neurotic symptoms he found the dermatosis patients have a significantly greater incidence of neurotic symptoms than the normal group.

Bell Adjustment Inventory. Comparing the urticaria patients with the well adjusted controls the urticaria patients yield scores in the area of health, social and emotional adjustments which are significantly higher than the scores of the well adjusted group. There is a trend to lower scores in the area of home adjustment. The vocational adjustment scores are possibly not comparable because of lack of information regarding the criteria for the well-adjusted controls in this area. Reference to Table V which tabulates this data indicates the hive patients score means of 7.35, 7.80 and 9.10 in the health, social and emotional areas respectively. This is compared with means of 3.86, 4.96 and 4.86 for these same areas for the well-adjusted group. These mean differences are significant at less than .01, .02 and .01 levels respectively. In other words the urticaria patients judge themselves to have significantly more problems in the areas of health, social and emotional adjustments than do the well-adjusted controls. The urticaria

patients score a mean of 2.95 in the area of home adjustments as compared with a mean of 4.50 for the controls. This mean difference is significant at a level between .05 to .10. There is a tendency therefore for the hive cases to consider themselves to have fewer problems at home than the control group. Although the data may not be comparable the hive patients yield a mean of 2.75 in the vocational area as compared to 3.72 for the well-adjusted individuals, indicative of a possible tendency to envision themselves better adjusted vocationally. Figure 2 utilizes bar graphs to compare the well-adjusted and urticaria groups on the basis of these five areas of adjustment.

Minnesota Multiphasic Personality Inventory. T-scores made by the eleven urticaria patients who took the MMPI are listed in Table VI. These scores are then combined to yield composite scores for the men and the women and were appropriate composite scores for the total group. Table VII compares the composite scores for the male patients with composite scores of ninty-eight normal men and thirteen psychotic men. Figure 3 plots these three groups of composite scores on the standard MMPI grid. The urticaria patients have a generally elevated profile which deviated markedly when compared with the normal group yet none of the scores in the clinical areas are in themselves strikingly abnormal.

Clinical Results

Detailed exploration of the patient's life situation. In this

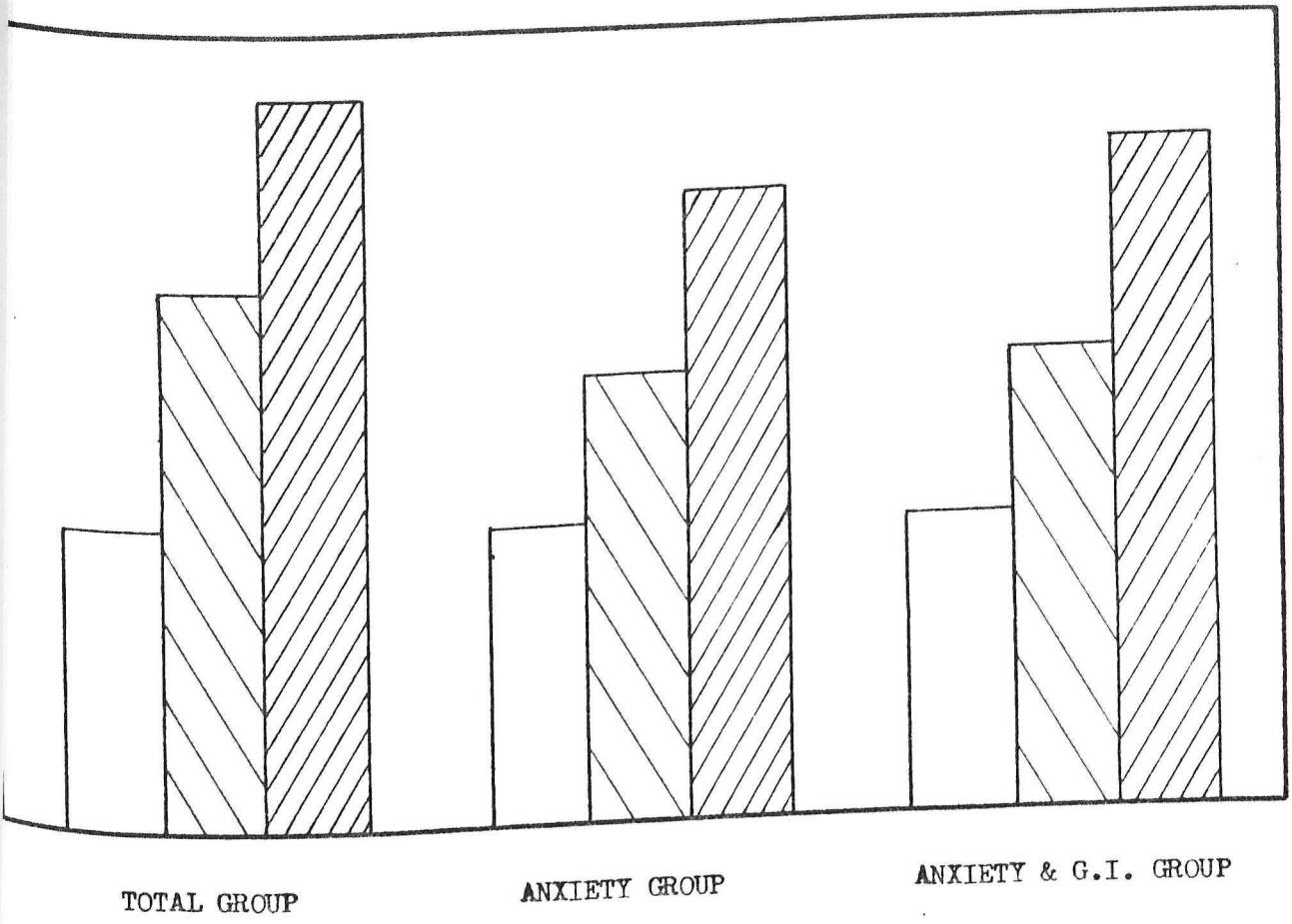
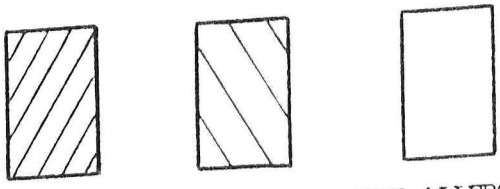


FIGURE 1

MULTILPE SYMPTOMATOLOGY INVENTORY SCORES OF URTICARIA PATIENTS COMPARED WITH SCORES OF ALLERGIC CONTROL GROUP AND NON-ALLERGIC CONTROL GROUP



treatment setting it is the usual procedure for the allergist, during the initial interview with the patient, to allow about a half-hour for the patient to discuss his complaints in his own words and to describe as much about himself as he cared to. During this initial period of relatively undirected self-expression the author has found that patients often reveal many important facts about themselves. The significance of this material is sometimes lost to both the patient and the interviewer and may never again come to light. The recordings of these first visits with the physician were carefully examined in view of the preceding considerations. This examination proved to be the most productive aspect of this clinical procedure.

In common with allergic patients generally the urticaria patients represented a wide variety of social, economic, educational and family backgrounds. It is interesting to note that periods of physical illness are often coincident with periods of environmental stress and that occasionally there is a shift from one symptom emphasis to another. It is not unusual, for example, that asthma would disappear only to have migraine headaches occur as a kind of symptoms equivalent. With the patients under study several mentioned that they used to have bad tempers or they were depressed prior to the onset of the hives. This fact has been noted by several other researchers Stokes, et al (67), Rees (60), Graham and Wolf (57), Wittkower (6) and Macalpine (84), etc.

The most outstanding result was that in every case the patient

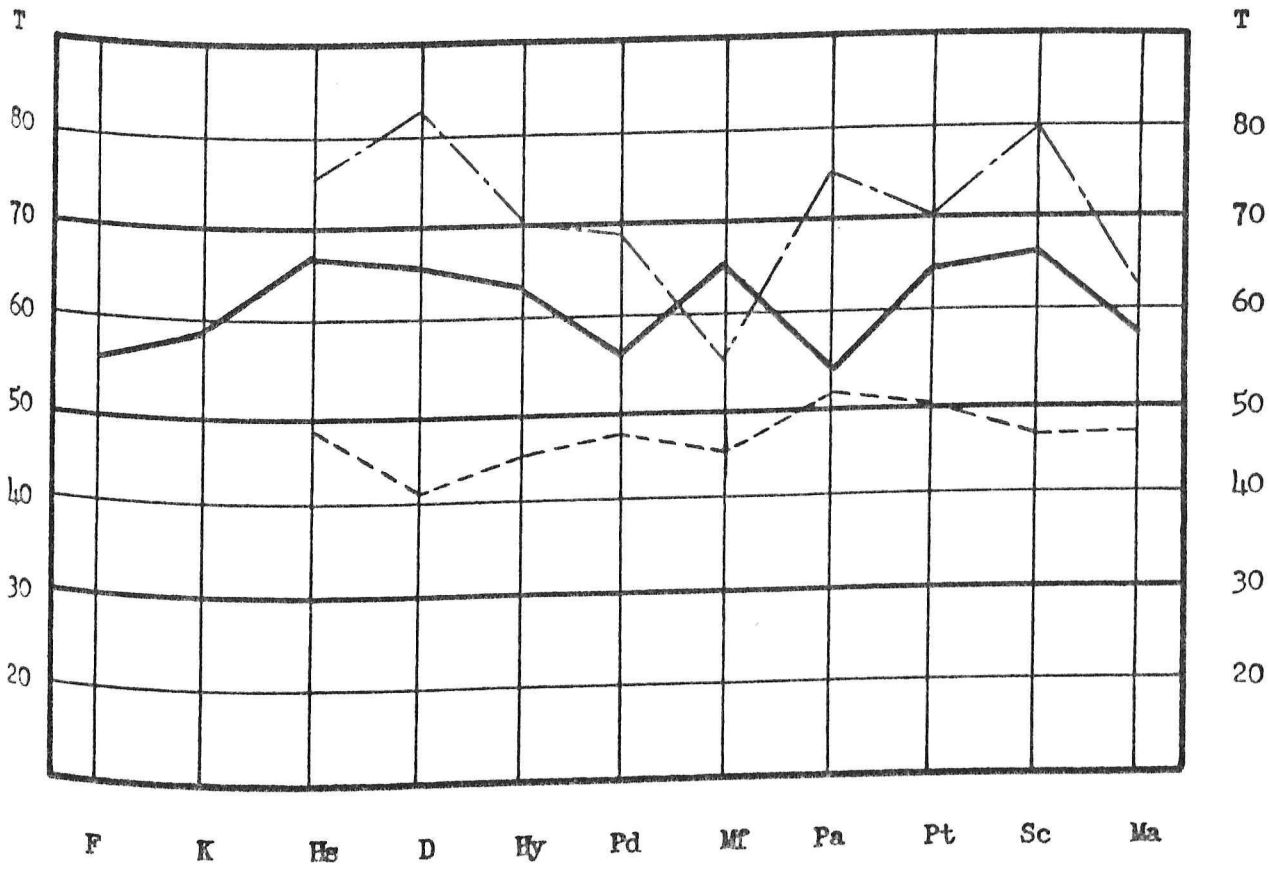


FIGURE 3

MINNESOTA MULTIPHASIC PERSONALITY INVENTORY SCORES OF THE URTICARIA PATIENTS COMPARED WITH NORMAL AND PSYCHOTIC CONTROLS

URTICARIA PATIENTS ————————

NORMAL CONTROLS - - - - - - - -

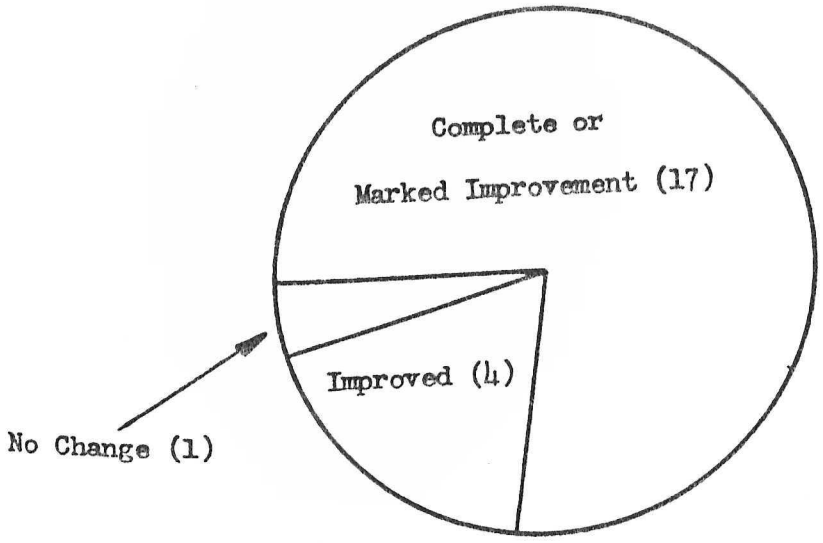
PSYCHOTIC CONTROLS —— - ——

spontaneously expressed concern during the first medical interview regarding a change in his life situation which appeared to be concurrent with the onset of the urticaria. Some patients implied a cause and effect relationship between the two sets of events, others did not relate them. Table VIII indicates the array of circumstances which impel modifications in the lives of the urticaria patients. Nine patients mentioned illness or death in the immediate family, six mentioned moving to a new home and the remainder mentioned a variety of other circumstances. The only exception was the recording of the physician's interview with the adolescent boy. In this case no environmental occurance was mentioned. This is the only situation in which the patient was not interviewed alone and in this case his parents were the primary informants. All of the investigators who have made more than the most superficial of statistical studies have found this concurrence of environmental change and symptom onset in at least some of the cases and two, Wittkower (6) and MacAlpine (84) felt that it existed in every case.

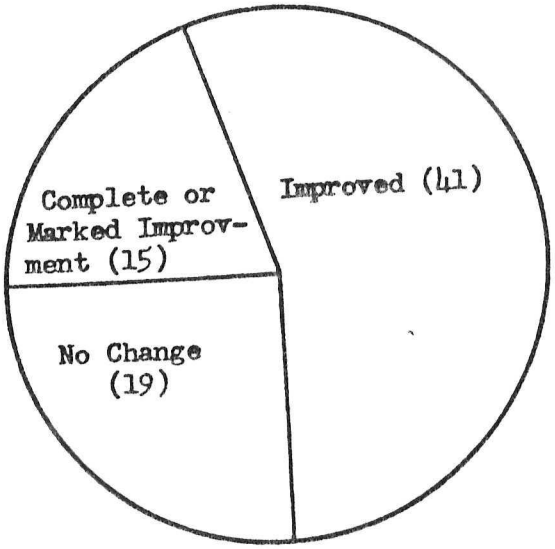
Psychoanalytic Psychotherapy. These patients had suffered with their hives long enough to have experienced the gamut of usual medical procedures without obtaining satisfactory clinical improvement. With the incorporation of psychotherapy into their treatment regime or with the use of psychotherapy as the only treatment procedure all but one patient improved clinically after a mean of six interviews. Table IX compares the clinical improvement of these urticaria patients with

seventy-five allergic patients who followed a similar treatment regime and Figure 4 displays these data graphically. One urticaria patient failed to improve after two interviews. He did not keep subsequent appointments. This is compared with nineteen of the allergics who failed to improve after an average of two interviews. Three urticaria patients showed some improvement during a mean of three interviews as compared with forty-one allergic patients who showed some improvement during eleven interviews. Eighteen of the hive patients either lost the symptoms entirely or indicated marked improvement during six interviews compared with fifteen allergics who indicated a similar degree of improvement during twenty-one interviews. In other words, proportionately four times the number of urticaria patients showed marked improvement to total loss of symptoms in about a half of the interviews when compared with the allergic patient group.

The average interview count, as seen in Table IX, excludes two patients who at the time of this writing have been seen for fifteen and thirty interviews each. Clinically, they are classed as improved. Both of these patients are borderline psychotics whose psychological pathology was exascerbated as their hives improved. These two people, Mr. J., the adolescent boy and Mrs. H., were continued in psychotherapy because of the emotionally difficulty primarily rather than securing the improvement of the hive condition. In these instances each showed a marked increase in anxiety together with alternating depressions and hostile outbursts. It was felt necessary to allow



TWENTY-TWO URTICARIA PATIENTS



SEVENTY-FIVE ALLERGIC PATIENTS

FIGURE 4

A COMPARISON OF CLINICAL IMPROVEMENT OF THE URTICARIA PATIENTS WITH ALLERGIC PATIENTS FOLLOWING A SIMILAR TREATMENT REGIME

some of the physical symptoms to return as a necessary compromise to maintain homeostasis. Their MMPI records are available in the appendix.

Hypnosis. Hypnotic procedures were used with seven patients during one or more interviews. The two interviews included in the appendix with Mrs. S. and Mrs. D. are examples of results obtained by this method. Verbatim notes were taken by the therapist during these interviews. The fantasy productions would have as their theme the intense frustration of being unable to achieve a given task and/or the anger underlying the frustration. The hives appeared to be reduced in redness or to disappear entirely with the ventilation of emotion. The following excerpt from a hypnotic interview with Mrs. E. demonstrates this transition from frustration to hostility and then to a more realistic appraisal of circumstances. Mrs. E. is a fifty-one year old widow who has had almost continuous hives for three years.

> (Upon entering the trance the patient began to sob.) "Rockets and atomic bombs shooting out into space. We will all be killed, oh God, what will happen! The big white light, the sun, stars and earth, what will become of it?..... This frightens me so much. The universe is so big, what is man trying to do to all of us?..... I want to get away from it all. I want to be alone. I want some peace but I'm living in the middle of the struggle. Life is so hard, all I want is peace of mind." (The patient is asked what troubles her.) "I've become a heathen almost, gotten away from church. All I think about is myself....just think about....material things.....home, clothes, food. God's been so far away, I can't reach him." (The patient is struggling with something in silence.) "Oh, a bad thought....I can't talk about it, I can't!" (After more inner struggle she continued.) "I get mad at people. Mad at having to be nice to people. I don't want to be nice to them at all. I hate them sometimes. Hate having to be so damn nice to them. At the store I'd like to throw their damn money in their faces. The customer isn't always right. Maybe I don't have to please them all the time, at least not in my personal life. I don't have to try all the time if they don't try with me."

Another patient, a forty-six year old single woman, Miss M., has a different type of fantasy. She has virtually been abandoned by her siblings and must support her invalid mother alone and care for their farm on her salary as a factory worker. After twelve years of continuous hives she gains complete relief in five interviews and at this writing has had no hives after six months. The following is an excerpt from one of the hypnotic sessions:

> (The patient resists seeing a picture on the hallucinated movie screen. She insists she sees nothing. After some prodding the nothing changes to clouds drifting by. She is obviously struggling against even this indirect expression of emotional freedom.) "I see horses running. A large pack in a wide field. It's a beautiful sunlit day." (It is interesting that this patient cannot tolerate being in the open country. She drives with the car windows rolled up.) "There is a big white horse. He stands out among the others. He raises his head and looks around. He's a white stallion. All the rest are black and smaller. They're racing. He's so free....carefree.....I'd like to be that way." (At this point the patient began to sob for a long time and then after she was awakened remarked that she had never known she felt that way. A discussion of her practical circumstances ensued during which she realized she had fought so hard against recognizing her dissatisfactions. She hadn't taken time to enjoy the resources that were available to her.)

Mr. C., a twenty-six year old electronic technician began to have hives four months prior to this interview. He and his wife had decided to attempt to conceive a child. The following fantasy was produced under hypnosis:

> "My stomach is tightening up. I'm being punched in the stomach. I'm getting dizzy now. I'm spinning around, my head is spinning on a point." (The patient stirred in his chair with apparent anxiety.) "I'm going to fall off. Someone's pushing me off. They're holding me around my neck. They're hanging on to me. I can't keep my balance, I'm going in different directions." (The patient is prodded to identify who is clutching at him.) "I can't

see. It's small but it's heavy.....It's a child." (The patient is calmed, reassured that he will not fall and that the spinning is stopping. He expresses the feeling that he is sick from being dizzy. A week later the hives have cleared up although they tend to return if he eats certain foods.)

These examples might continue, however, they are all strikingly similar. Some, like the last one, served primarily a cathartic value. Others, as in the first two examples, provided the patients with the opportunity to develop some beginning insight.

Non-structured interview. In every case a major portion of the diagnostic interview were structured in a manner that would allow for spontaneous expression of feeling. The idea was quickly conveyed that the interviewer was not interested primarily in a recital of physical symptoms and the patient was almost forced to project his anxieties into the interview setting. About half of the patients when asked what really caused their symptoms would respond, after a period of tense silence, by crying. When little direction in the form of specific questioning was offered the patients would tend to become anxious and occasionally begin to tear or cry. Thirteen of the twenty-two people in this series cried during the first two interviews. This is a notably high proportion. An almost universally heard comment was, "Am I telling you what you want to know", or "What else shall I tell you." Without a strong directional lead they were obviously uncomfortable yet tried to cover their discomfort and anger by comments such as, "I'm very nervous when I talk to strangers", or

"Doctors and people like that make me uncomfortable". Sometimes the emotion was further depersonalized by, "I'm just nervous today" and in about half of the situations the hives serve as the focus of the displaced affect with the comment, "My hives make me nervous."

Experience shows the remarkable consistancy of these reactions seems unique to this group. Asthmatic patients for example when asked what really causes their asthma often reply with a more openly hostile comment such as, "You're the doctor, tell me", or there is a silence and no direction is offered they are apt to make a more aggressive demand, "Well say something."

The tears and the discomfort are later utilized in treatment with the urticaria patients and provide a means of getting more directly at basic psychological issues. The psychotherapist, working in primarily a physical treatment center, has to undo the mental set of concentrating on purely physical reactions such as diet, responses to atmospheric changes and reactions to dust, etc. This type of approach helps to establish the psychological orientation.

Selective association. As a standard procedure in the evaluation and treatment of patients with suspected psycho-physiological disorders selective association was used with all the urticaria patients in this group. The following excerpts from interviews are representative of the results obtained. They become more significant as they are compared with the more usual verbalizations of these patients which tends strongly to

deny difficulty especially if it involves others. Mrs. S., the 35 year old housewife, came to her third interview complaining of a severe headache and a bad flare-up of her hives. She felt that this was due to her menstrual period and wanted to dismiss the symptoms with this explaination. When encouraged to associate to these symptoms she said the following:

> "I remember going to the party last night, my husband had been drinking too much and making fun of the children. At the party he tried to be the center of attention all of the time. It was humiliating the way he acted. He must always have things his way, he won't let me offer any ideas, he will not stand for any interference in what he wants to do. At the party he wouldn't let anyone talk or do anything without him. I had to drive home he got so drunk. He spoiled the party.... I was so up-set with him. I wanted to tell him how much I resented what he had done but I didn't .... I was afraid he would be mad at me. I didn't want him not to like me .... I wanted him to love me when the first baby was born but he just brought his friends over and ignored me. If it hadn't been for the baby I would have run away. .....I don't want to think of these things. If I do think of them I'll cry and then that will make him angry....I don't cry anymore.

Mr. G., a 24 year old man who had hives since his marriage seven months previously, produces the following associations: He had been concerned regarding his mother-in-law's hostile attitude toward him which would yield to no friendly gestures on his part.

> "The hive I have in the corner of my eye is the same as the first hive I got. I was in my wife's mothers house....reading a magazine...her mother was talking to her. I tried not to hear the bad things she was saying to my wife about me....I don't think about them at all. At night I've had trouble sleeping...For about seven months I've not been able to go to sleep easily. The hives come in the corner of my eye at night....I must have bad dreams because I wake myself up. My wife says I cuss in my sleep. I never cuss when I'm awake....I'm not mad at anyone.

Another patient, Mrs. C., a 33 year old housewife, was asked about the first attack of hives eleven months prior to treatment and to mention the thoughts as they occurred to her:

> "I was very up-set that day.....The landlady had phoned. She told me that I was mutilating her house....I'd put a clothes line in the yard and attached one end to the house....When she hung up the phone I could hardly breathe./ Dad had just died the week before.... I don't want to get mad at anyone, I can't get mad..... Father liked me, and I wanted to please him....I never saw him mad. I can't be angry. (At this point the patient begins to cry.).....I Haven't cried for so long.

After surgery necessitated many changes in her life Mrs. K., developed urticaria. Through it all she was able to express almost no dissatisfaction with the impact these events had made. During the second visit she says these things in answer to a question regarding her feelings about psychological treatment:

> "I'll bet you hate to see me come into your office. (This was probed and revealed these comments.) I never dislike people. My whole family is like that, we like everyone. Its too bad to be angry at anybody. (These statements are gratuitus denials since no interpretation of anger had been made) My sisters were good sweet little things who can have children. I can't have children because of an operation....I don't want to think about myself too much. I don't want to come here. I don't want to find out about myself....Maybe I'll talk myself into doing bad things, maybe into even disliking people.

Dr. N., a 36 year old psychologist, after finding that when he cried his hives would disappear produced the following associations to his dread of tearing with some people:

> "These people are men, remind me of my father. When I tear I hate them. I want to knock them down and stamp on them....bite them. I want to knock them down and stamp on them....bite them. I want their love but I hate them for not caring about me enough. I want their love but I hate them for not caring about me enough. I want their love but I can't get it. They can't tolerate any deviation from what they

want. I can't be what they want....Damn it....damn it .... Damn it I want their love but I can't make myself do the things I 'll have to do in order to get it.

Mrs. D. was not re-elected to office in a civic organization that was important to her. These associations result from questioning in this area:

"Others would have minded not being elected, but not me. I just don't care about things that would up-set others. I have no hard feelings. (Since no interpretations regarding negative feelings were made these free denials seem important.) I never feel angry.....(At this point the patient cries.).....I don't know why I did that. I never cry or even feel like it. Its the hives. I'm crying because I don't know what causes them.

Mr. P., 44 years old, began a recent exacerbation of a chronic hive condition after he moved from his father's farm. He says this:

"I hope my father still likes me, I want his affection so much ..... I try to do what Dr. Kraft (The allergist who is treating him) wants me to do. I like Dr. K. so much....I hope that I did what you wanted me to do today.... I hope that I made a good impression.

Later this same man said,

"I don't like to think about some things. I want to be happy so that people will like me. I've prayed to get rid of my hives, so hard I've prayed. Maybe God is punishing me. Maybe He doesn't like me."

For the past five years Mrs. F. has had hives. This 37 year old housewife produced the following associations in regard to her move to a different state which puts her nearer to her parents and stirs old memories:

" I want to forget all my life at home. Mother and Dad had king-size fights, its silly to go through life making yourself unhappy. I

don't want to think about it. There is no anger in my home....In the last several years I've had some pretty bad thoughts about them .....but you shouldn't feel that way about anyone. I try not to think angry or feel angry.... I have to work so hard at not feeling that way, especially in the last several years its so difficult to keep these thoughts away.

Mr. W., a 25 year old man who began to have hives following his marriage told the following:

"My hives were bad the day after our last talk, I felt so guilty. I shouldn't have said those things about my wife. I almost cried last week but I can't cry with anyone around. I can't show tears or any expression of strong feeling on my face. People won't like me if I have strong emotion, I know I'll drive them away."

Mr. A., a 40 year old engineer, had the following association to the hives which occur when he thinks about his promotion at work:

"I'm so afraid that the boss will ask me questions I can't answer. All the engineers, all of them graduate engineers but me, have a weekly meeting....All of them sit like judges waiting for me to make a mistake....They are waiting to judge me and then if I fail that makes me feel so bad....In school I couldn't recite in front of the class....I felt the same way when my father would ask me things. I've just got to have the right answer.....I suppose that they, (the engineers) are all like my father to me.

These types of associations permeate the recordings of the talks with these patients. The dominant theme of the interviews is represented in these and similar productions.

CHAPTER V

INTERPRETATIONS OF THE RESULTS

I. INTERPRETATIONS OF THE PSYCHOMETRIC RESULTS

Multiple Symptomalogy Inventory. The high scores made by the urticaria patients lead to the interpretations that they feel themselves to be under considerable real or imagined stress. This effect may be a function of the personality factors involved which enhance susceptability to stress.

The scores suggest also powerful physical reverberations to stress. These people may have a tendency to develop somatic symptons rather than "acting out" behaviorally or emotionally. This pattern of somatized anxiety may be related to the repression found in hysteria.

These patients seem to be depending heavily on internal adaptation to stress rather than utilizing more aggressive externalized methods of meeting anxiety.

Bell Adjustment Inventory. The generally higher scores made by this urticaria group as compared with the well-adjusted controls may be indicative of a stress reaction. Since they must score their own problems the results point to their being at least partly aware that all

is not well.

Their insight may be limited by the tendency to deny difficulty in areas which might distress others. It would be unlikely that they would evaluate themselves as having health, emotional and social problems without concomitant anxieties regarding home and work. This pattern may indicate a need to present themselves in as favorable a light as possible.

The emphasis seems to be concentrated on internal rather than external adaption to stress.

Minnesota Multiphasic Personality Inventory. The MMPI protocols lend themselves to the following interpretations: The four validity scales, Question (?), the Lie (L), The Validity (F) and the K (K) scores indicate that generally the patients took the test well and that the scores are likely to be valid. The combination of the K and Ego Strength (Es) scales indicate the patients have from moderate to good ego capacity. The elevated Hypochondriasis (Hs) and Psychasthenia (Pt) scores suggest a tendency to make internal rather than external adaptions to stress with resultant accompanying somatic symptoms. High Hysteria (Hy) and Depression (d) scores show a possible need to repress hostility and conceal negative feelings for fear of loss of love. The repression might be akin to that found in hysterics. The low Paranoia (Pa) scale indicates a tendency to depreciate self and possibly a lack of assertiveness. A "it's my fault" attitude found often with High Hysteria scores.

The elevated Interest Scale (Mf) reveals that these men have many traits associated with femininity. They are sensitive and possibly weak in relations with other men. The counterpart to these scores in the women reveal a tendency to be dependent and clinging. These interpretations are made according to the MMPI manual by Hathaway and McKinley (72) and Hathaway and Meehl (85).

The general overall elevation of the profiles suggests that these people feel themselves to be under considerable real or imagined stress. Some of these elevated scores are such that could be reduced by psychotherapy, while other scores indicate deep personality characteristics rather than reactive traits.

From the test results it would seem that these patients possess the qualifications for good psychotherapy candidates as they indicate the ability to form object relationships, have good ego strength and are uncomfortable because of feelings of depression and anxiety.

The test group is representative of a wide variety of psychiatric classifications from normal to near psychotic. There is no single diagnostic category however that appears unique to this group. Diagnostic categories were evaluated according to the manual of The American Psychiatric Association (86) and Noyes (87).

II. CLINICAL INTERPRETATIONS

Detailed exploration of the patient's life situation. With every

adult patient the environmental circumstances were modified, creating a stressful situation for the patient. This change occurred together with the first appearance of the hives. They were changes which were of such a nature as to remain essentially unresolved and were described in such a manner as to lead to the suspicion that they still were a source of stress for the individual. Even though some patients verbalized no relationship, the fact that these situations occurred concomitantly with the physical complaints and were discussed together with the symptoms is interpreted as implying a relationship of some unique significance.

Hypnosis. By the use of hypnotic methods some of the urticaria patients were provided the opportunity of expressing the frustration and anger which otherwise would be unacceptable to their super-ego. Several of them were able to gain the freedom from the necessity of controlling these powerful affects long enough to reappraise their difficulties and take a more effective approach. The results verified the psychometric conclusions that these were people under pressure. That this pressure centered around the environmental changes revealed when the histories were reviewed supports the conclusion that these changes are of critical importance in the genesis of the symptom.

The hives would disappear or be reduced as a result of the ventilation of emotion connected with this external tension. The need to be good appeared to be a reaction formation against these negative

feelings which were expressed in the angry and sadistic fantasies. The anger was seen as a threatening emotion which need to be hidden and the people seemed helpless to express themselves aggressively.

The hypnosis brought to light problems which were not recognised as such during the waking state. Many of the patients expressed the idea that tension over the environmental circumstances was an effect of the hives rather than vice versa.

Non-structured interview. On the assumption that the microcosm of the non-structured interview accurately reflects the macrocosm of the patients' pattern of life adjustment the following assumptions are possible. They have an investment in maintaining for themselves and conveying to others the concept that they are "good"people; devoid of negative feeling and personal anger. They are distressed when they are unable to know what is expected of them and when they feel others may be dissatisfied with their behavior. When they are unable to determine in which direction to move and when escape is impossible they use the hives to rationalise their anxiety.

When allowed the freedom and the opportunity to express themselves they often begin to cry spontaneously without knowing why. As the tears are accepted other material follows which can then be utilised for further treatment.

This need to appear without aggressive feeling is a common factor

indicated by several of the other clinical and psychometric procedures. The theme is seen as being one of internal adjustment by repressing assertive emotion at the sacrifice of external effectiveness.

Selective association. These associations were characteristically concerned with the fear of loss of love. Love was threatened because the assumed demands of others could not be met. Back of the feeling of lack of achievement was frustration and back of the fear of loss of affection was anger.

These patients repressed their dissatisfaction with those around them and sacrificed their own emotional well being to avoid evoking displeasure in others. They would avoid crying even though they were occasionally aware of wanting to cry and they deny themselves any recognition of the underlying hostility. This hostility was perceived as being particularly dangerous.

The mechanism of internal adaption to stress is utilized and there appeared to be some equivalence between the repressed emotions and the urticaria.

Psychoanalytic Psychotherapy. The dramatic response of these patients to psychotherapy as indicated by the clinical improvement is strong support for the hypothesis that significant psychological components are involved in the etiology of the urticaria. The question of permanence of relief is not of major importance in this regard. Whether or not a symptom recurs is dependent on many factors. The total

personality, degree of environmental stress and the presence of other disturbances. Recurrence of symptoms after psychotherapy does not argue against their origin being partially in the psychological sphere. Psychogenic symptoms can recur without discrediting the concept of psychological origin in the same manner that organic lesions may return despite correct diagnosis and treatment.

Prompt response to supportative and clarifying psychotherapy is indicative of fairly healthy personality structure with the ability to form object relationships and the capacity of ego flexibility. Factors which are consistant with effective adjustment generally to life's problems.

In several instances it was felt that the urticaria functioned to defend the patient against psychotic tendencies and that care needed to be taken to understand the powerful emotional forces which the urticaria helped to contain. Relief of physical symptoms was limited by psychological pathology. Funkenstein (50) and (56) discusses the phenomenon of the psychotic equivalents of various allergic symptoms.

III PSYCHOLOGICAL FORMULATION

This formulation represents one possible way of combining the results of the various clinical and psychometric procedures used in this study. There was a range of personality types represented in this series of patients from normal to psychotic in terms of formal psychiatric classification. The importance of personality appears to lie not so much

in a specificity of type as in the manner by which it determines reactions to stress and the degree to which adequate and effective expressions of emotions are facilitated. In other words, these people are characterized by a type of reaction rather than a type of personality.

In the immediate or past history of every adult urticaria patient was a stress producing external event which acted on the particular personality attributes of each patient in a manner that produced either the initial onset of the urticaria or a precipitation of a chronic condition. The concept of stress is meaningful only as it is related to the personality of the individual. The same factors may be stressful to some and not to others or may be stressful at one time to an individual and not at another time.

These stress producing external situations were such that they were not sufficiently resolved to enable the patients to feel a release of tension. Even though the unexpressed emotion involved in these difficulties were repressed the problem acted as a continuous source of tension to which there appeared to be no escape. With the onset of the hives the patients occasionally reported some degrees of relief of tension. They felt better emotionally at the cost of feeling worse physically. In other words the anxiety had been somatized.

By making an internal adaption to stress rather than the more aggressive externalized adjustments they inadvertently impede the resolution of the very problems which caused them the tension. Their

defenses are organized around a passive dependent core in which they deny themselves the expression of hostility and repressed feelings of anger. Because of their strong need for love and their inability to tolerate any real or suspected denial of affection they are excessively sensitive to feeling hurt. Although resentment may be acknowledged they refuse to recognize the anger in themselves and fear is their conscious attitude toward any open display of aggression. Even to think hostile thoughts appeared threatening.

All of these people seldom cried especially since the onset of the urticaria and they were ashamed of their tears. When they could shed tears of frustration and hostility or produce other outward expressions of anger the hives soon disappeared. Their defense against rejection by attempting to please had for the most part been rewarding. They were reasonably successful people who had attained gratification by being good. There were however indications that this conscientous over activity and self-driving attitude was conducive to states of prolonged tension. The men showed some vocational handicap because of their lack of aggressiveness and painful self-consciousness. In every case the symptom developed during an impasse. Love and affection were sought to meet their dependent needs but through a change in external circumstances they felt unable to achieve according to expected standards. They perceived the situation as one in which their need for approval and love would not be met. To fail to achieve love or to lose it was unbearable. The reality situation appeared to make escape

impossible and their personalities made expression of hostility intolerable. Hives appeared as the escape mechanism. The patients internalized the seemingly impossible external stress by the use of the urticaria reaction.

That there exists an equivalency between the skin condition and the repressed affect is seen in the direct relationship between the expression of tears and anger and the observed and reported diminution of the urticaria. The opportunity and freedom to express themselves, even though initially disturbing, helped the patients to clarify the difficulties which had produced the urticaria and frequently enabled them to mobilize unexpected personal resources to cope with these difficulties more effectively. As the hitherto unresolved situations were settled the hives were no longer needed and they improved or disappeared entirely.

CHAPTER VI

SUMMARY AND CONCLUSIONS

Summary. The subjects for this study were twenty-two patients who had suffered with chronic urticaria for periods of at least three months to more than fifteen years. The purpose of the research was to determine if there were significant psychological components in chronic urticaria and if these components existed could they be specifically identified.

The patients selected were all referred by an allergist in private practice and were under continuous medical supervision. Control groups were chosen from this same allergic practice and were patients manifesting other types of allergic symptoms who had been handled in the same manner as the urticaria patients. Non-allergic controls were also used.

This history of psychosomatic medicine was reviewed with emphasis on the development of psychosomatic allergy and the application of these concepts to the specific symptom of chronic hives. The two-fold research approach employed both psychometric and clinical methods and attempted to fill the gap between the individual case studies and the large series statistical studies already reported in the literature.

The psychometric procedures utilized were The Multiple Symptomatology Inventory, The Bell Adjustment Inventory and The Minnesota Multiphasic Personality Inventory. The clinical procedures included a detailed evaluation of the patients life situation, selective association, structured interviews, hypnosis and psychoanalytic psychotherapy.

The results of each experimental procedure were interpreted separately and then combined into an integrated formulation.

Conclusions. There were significant psychological components in these twenty-two patients with chronic urticaria and these components could be specifically defined. Some of the important factors indicated by the study are: No clinical personality type was found, although almost all of the patients had certain characteristics in common. Generally, they felt themselves to be under rather intense environmental stress and reacted as if they were under stress. Some change in external circumstances was perceived as a threat to them and for a variety of reasons these patients attempted to make internal rather than more aggressive external adaptations to this stress. The situations were never completely resolved and yet the conscious awareness of difficulty was repressed. The hive reactions appeared to cover an underlying feeling of anger. If this anger could not be adequately accepted depression usually followed the removal of the symptom.

The urticaria might be said generally to mask a depression, and on two occasions it served as a psychotic equivalent. The use of psychological methods alone, after the patients had failed to respond sometimes to years of medical management, brought complete or marked relief to twenty-one of the twenty-two patients in an average of six interviews. The condition can best be understood as one facet of the individuals total psycho-biological response to his life situation, that somatic symptoms can provide an avenue of expression for emotional and social difficulties just as neurotic, psychotic and psychopatic acting-out do.

A difficulty is dealing with situations which involve the expression of anger is common to many disorders. The feature particular to these patients is a failure to recognize hostile feelings to any significant extent, even though they feel hurt, frustrated and helpless.

APPENDIX

TABLE IV

MULTIPLE SYMPTOMATOLOGY INVENTORY SCORES OF URTICARIA PATIENTS COMPARED WITH SCORES OF ALLERGIC CONTROL GROUP AND NON-ALLERGIC CONTROL GROUP

SYMPTOM CATEGORY	URTICARIA N: 21	ALLERGIC N: 25	NON-ALLERGIC N: 25
Total			
M	12.63	9.28	5.24
σ	3.77	3.84	3.42
t	-	3.35	6.49
S.L. *	-	less than .01	less than .01
Anxiety			
M	4.43	3.20	2.16
σ	1.97	1.88	1.62
t	-	1.23	3.81
S.L.	-	less than .05	less than .01
Anxiety and G.I.			
M	6.52	4.48	2.96
σ	2.81	2.56	2.34
t	-	2.04	4.47
S.L.	-	less than .02	less than .01

* Significance Level

TABLE V

BELL ADJUSTMENT INVENTORY SCORES OF THE URTICARIA PATIENTS COMPARED WITH THE SCORES OF WELL-ADJUSTED CONTROL GROUPS

	WELL-ADJUSTED CONTROLS[a]			URTICARIA PATIENTS				
ADJUSTMENT AREA	N	M	σ	N	M	σ	t SCORE	LEVEL OF SIGNIFICANCE
Home	61	4.50	3.28	21	2.95	3.09	1.87	between .05 - .10
Health	49	3.86	2.58	21	7.35	3.44	4.01	less than .01
Social	46	4.96	3.12	21	7.80	4.75	2.39	less than .02
Emotional	45	4.86	3.42	21	9.10	5.94	2.92	less than .01
Vocational	44	3.72	3.02	21	2.75	-	b	b

[a] Norms for well-adjusted persons are taken from: Bell, H. Manual for Adjustment Inventory, Adult Form. New York: Psychological Corporation.

[b] The t-score and level-of-significance were not computed as it was not clear that the norms available were comparable to the urticaria patients.

TABLE VI

T-SCORES MADE BY THE URTICARIA PATIENTS ON THE MINNESOTA MULTIPHASIC PERSONALITY INVENTORY

LIST OF PATIENTS	INVENTORY SCALE												
	L	F	K	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Es*
Women													
Mrs. E.	53	62	42	58	63	53	55	53	67	66	75	55	33
Miss M.	56	53	59	72	71	70	69	55	70	46	78	58	41
Mrs. G.	50	46	57	56	55	61	43	43	47	56	49	55	40
Mrs. H.	63	76	53	70	69	73	76	37	73	81	86	53	29
Mrs. S.	56	46	46	56	67	52	43	45	62	61	47	50	38
Mrs. D.	56	48	59	42	53	63	53	45	53	45	46	55	39
Mrs. K.	73	60	51	66	73	58	48	51	65	53	60	38	30
Men													
Mr. J.	70	70	46	80	82	69	60	71	53	87	73	43	29
Dr. N.	47	58	70	59	65	62	62	74	47	69	96	58	52
Mr. L.	50	48	55	52	58	64	55	61	50	48	42	55	47
Mr. A.	53	50	62	72	53	56	55	55	65	54	53	75	42
MEAN SCORES													
Combined	57	56	54	-	-	-	56	-	59	-	-	54	38
Men	55	57	58	66	65	63	56	65	54	64	66	58	42
Women	58	56	52	61	65	62	55	47	62	60	64	52	36

Note: Six sets of scores have different scales for men and women and can not properly be combined.

* This is the raw score since norms for this scale are not available.

TABLE VII

MINNESOTA MULTIPHASIC PERSONALITY INVENTORY SCORES OF THE URTICARIA PATIENTS COMPARED WITH NORMAL AND PSYCHOTIC CONTROLS[a]

INVENTORY SCALE	URTICARIA PATIENTS	NORMAL CONTROLS[b]	PSYCHOTIC CONTROLS[b]
Hs	66	49	75
D	65	41	82
Hy	63	45	70
Pd	56	49	68
Mf	65	45	55
Pa	54	52	75
Pt	64	50	70
Sc	66	48	80
Ma	58	48	63

[a] Only the scores for the men are used and compared with the composite scores of 198 normal man and 13 psychotic men.

[b] These values are taken from the chart in: Shaffer, L. F. and Shoben. E. J. Psychology of Adjustment. Boston: Houghton Mifflin, 1956, page 327. These composite scores agree by inspection with the scores published in: Hathaway, S. R. and McKinley, J. C. Atlas of the MMPI.

TABLE VIII

CHANGES IN PATIENTS' LIFE SITUATIONS CONCURRENT WITH ONSET OF URTICARIA

	PATIENT	CHANGE
1.	Mrs. G.	Illness and subsequent death of husband.
2.	Mrs. S.	Husband stopped working nights.
3.	Mrs. T.	Impotence in husband following heart attack.
4.	Mrs. E.	Male friend pressuring for sexual intiacy without marriage.
5.	Miss M.	Sister moved from home leaving patient to care for mother.
6.	Mrs. D.	Was not re-elected to office in civic organization.
7.	Mrs. C.	Father who lived with patient had stroke and died.
8.	Mrs. H.	Moved from home town.
9.	Mrs. K.	Had surgery which forced changes in routine of living.
10.	Mrs. V.	Husband incapacitated with Addison's disease.
11.	Mrs. B.	Adopted baby and quit working.
12.	Mrs. A.	Hysterectomy plus serious illness of young daughter.
13.	Mrs. F.	Moved to another state plus death of several family members.
14.	Dr. N.	Opportunity to leave job for further graduate study.
15.	Mr. L.	Sudden death of wife.
16.	Mr. M.	Ex-tuberculosis patient whose sister died suddenly of tbc.
17.	Mr. R.	Promoted to supervising engineer.
18.	Mr. Q.	Bride's mother creates open rift with him.
19.	Mr. C.	He and wife decide to have a child.
20.	Mr. P.	Moved from father's home.
21.	Mr. W.	Left the service and was married.

TABLE IX

A COMPARISON OF CLINICAL IMPROVEMENT OF THE URTICARIA PATIENTS WITH ALLERGIC PATIENTS FOLLOWING A SIMILAR TREATMENT REGIME

SYMPTOM STATUS	URTICARIA PATIENTS			ALLERGIC PATIENTS		
	Number	%	Mean number interviews	Number	%	Mean number interviews
No improvement	1	4	2	19	25	2
Improved	3	14	3*	41	55	11
Marked improvement to total loss of hives	18	82	6	15	20	21
Total	22	100	6	75	100	11

* This mean excludes two psychotic patients who were seen for 15 and 30 interviews where the goal of psychological support was seen as being more important than symptom removal.

TABLE X

SUMMARY OF ADDITIONAL DATA ABOUT THE URTICARIA PATIENTS

	PATIENT	AGE	MARITAL STATUS	SYMPTOM DURATION	SYMPTOM CHANGE	NUMBER OF INTERVIEWS	MMPI	BELL	HYPNOSIS
1.	Mrs. G.	57	W	4 yrs.	2	4	X	X	
2.	Mrs. S.	35	M	15 yrs.	2	11	X	X	X
3.	Mrs. T.	53	M	5 yrs.	2	4	X	X	
4.	Mrs. E.	51	W	3 yrs.	2	40	X	X	X
5.	Miss M.	46	S	12 yrs.	2	6	X	X	X
6.	Mrs. D.	38	M	2 yrs.	1	2	X	X	X
7.	Mrs. C.	33	M	11 mos.	1	3		X	
8.	Mrs. H.	28	M	9 mos.	1	30	X	X	X
9.	Mrs. K.	38	M	11 mos.	2	9		X	
10.	Mrs. V.	28	M	3 mos.	2	3		X	
11.	Mrs. B.	41	M	5 mos.	2	1		X	
12.	Mrs. A.	43	M	4 mos.	2	1		X	
13.	Mrs. F.	37	W	5 yrs.	2	5		X	
14.	Dr. N.	36	M	10 yrs.	2	24	X	X	
15.	Mr. L.	50	W	18 mos.	2	3	X	X	
16.	Mr. M.	35	M	5 mos.	2	3		X	
17.	Mr. Q.	24	M	7 mos.	0	2		X	X
18.	Mr. R.	40	M	2 yrs.	2	2		X	
19.	Mr. C.	26	M	6 mos.	2	3	X	X	X

TABLE X CONTINUED

PATIENT	AGE	MARITAL STATUS	SYMPTOM DURATION	SYMPTOM CHANGE	NUMBER OF INTERVIEWS	MMPI	BELL	HYPNOSIS
20. Mr. P.	44	M	15 yrs.	2	4		X	
21. Mr. W.	25	M	8 mos.	2	7		X	
22. Mr. J.	16	S	5 yrs.	1	15	X		

SYMPTOM CHANGE- 0: no change, 1: improved, 2: marked improvement or loss of symptoms.

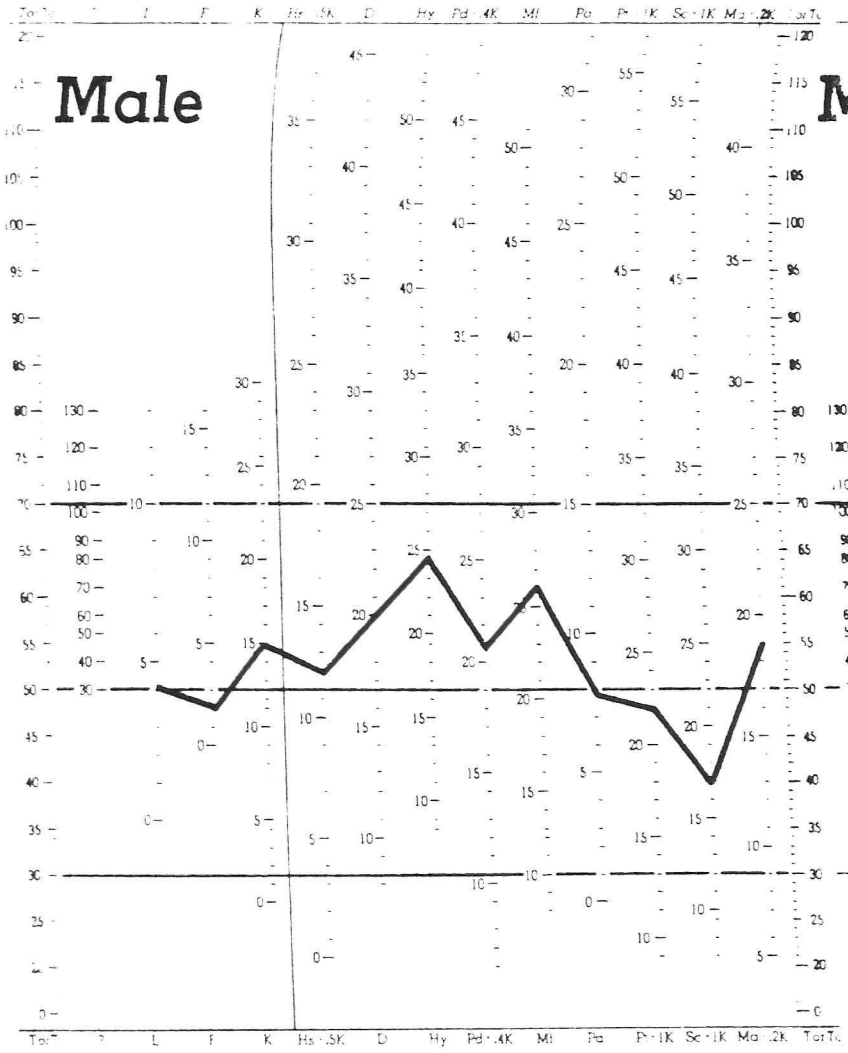
MARITAL STATUS- M: married, W: widowed, S: single.

TABLE XI

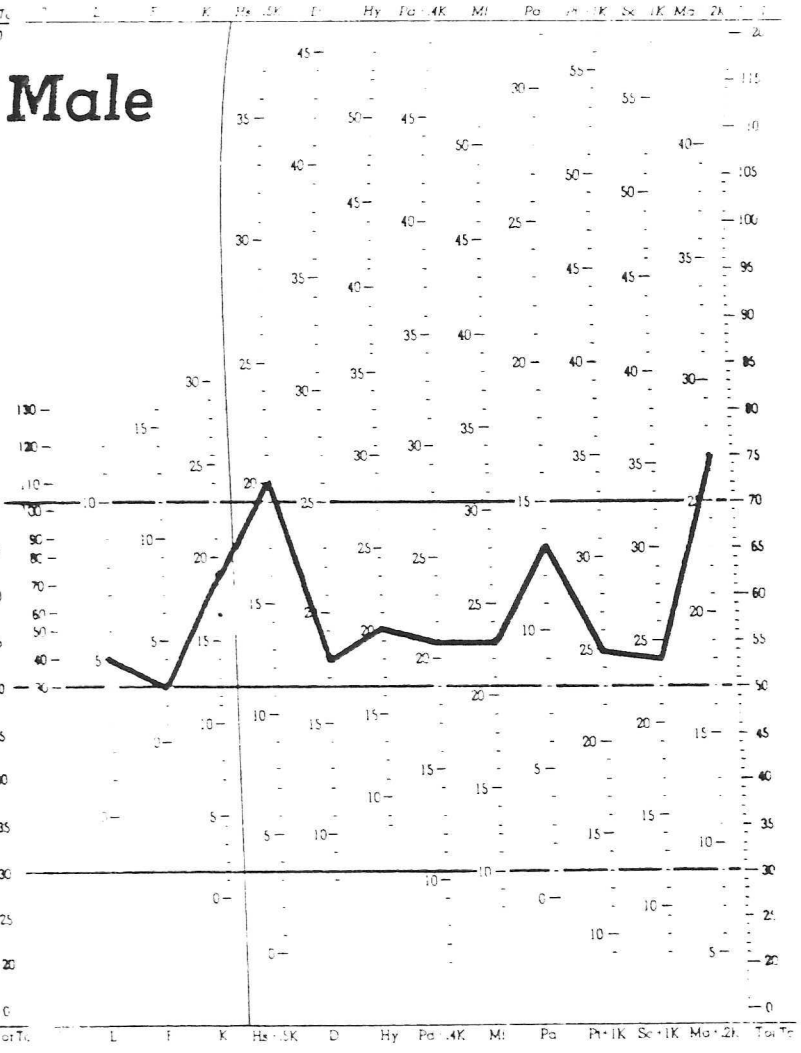
MULTIPLE SYMPTOMATOLOGY ITEMS CHECKED BY URTICARIA PATIENTS AND THE ALLERGIC AND NON-ALLERGIC CONTROLS

SYMPTOM	URTICARIA:21	ALLERGIC:25	NON-ALLERGIC:25
1. Fatigue	17	17	10
2. Headache	10	15	7
3. Nervous Tension	18	13	11
4. Restlessness	14	8	6
5. Sleeplessness	9	13	6
6. Nightmares	3	1	2
7. Dreams	7	6	7
8. Dizziness	6	4	1
9. Butterflies in Stomach	4	1	4
10. Fainting Spells	2	0	0
11. Weak Spells	3	2	0
12. Nasal Obstruction	5	14	0
13. Sneezing	6	18	8
14. Sighing	4	4	1
15. Wheezing	3	11	3
16. Asthma	1	10	1
17. Cough	3	14	5
18. Heaviness in Chest	3	8	0
19. Lump in Throat	4	2	0
20. Conscious of Heartbeat	10	5	3
21. Poor Appetite	3	2	3
22. Excessive Appetite	7	7	3
23. Indigestion	5	2	2
24. Belching	3	2	2
25. Gas	8	5	3
26. Cramps	2	2	2
27. Constipation	7	4	1
28. Diarrhea	1	0	1
29. Itching Rectum	5	7	3
30. Nausea	2	1	0
31. Vomiting	1	0	0
32. Painful Menstruation	3	5	4
33. Frequent Urination	6	2	4
34. Itching Vagina	2	0	0
35. Arthritis	2	4	2
36. Aches and Pains	3	6	3
37. Blushing	3	5	4
38. Pimples	6	6	5
39. Rash	4	1	1
40. Eczema	2	0	0
41. Hives	18	1	1
42. Welts after Scratching	12	0	2
43. Itching	12	1	3
44. Burning	5	0	0
45. Sweating Hands	12	3	7
TOTALS	265	232	131

MINNESOTA MULTIPHASIC PERSONALITY INVENTORY PROFILES



Mr. L.



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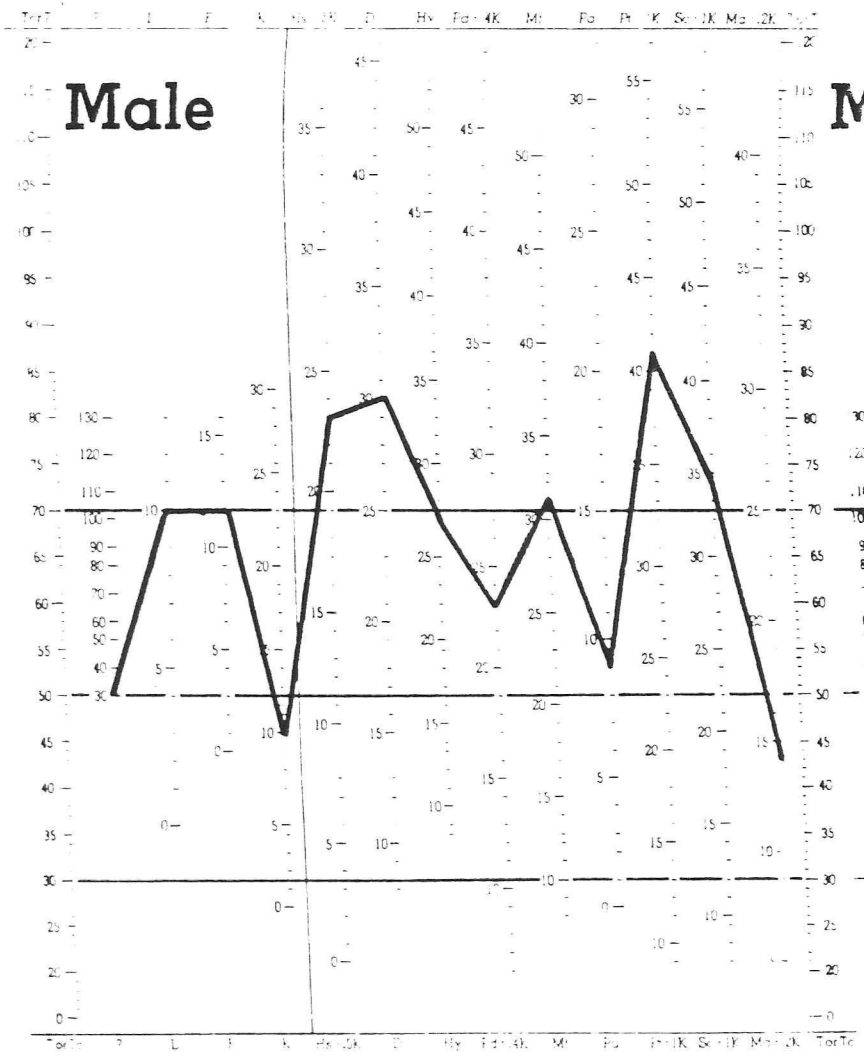

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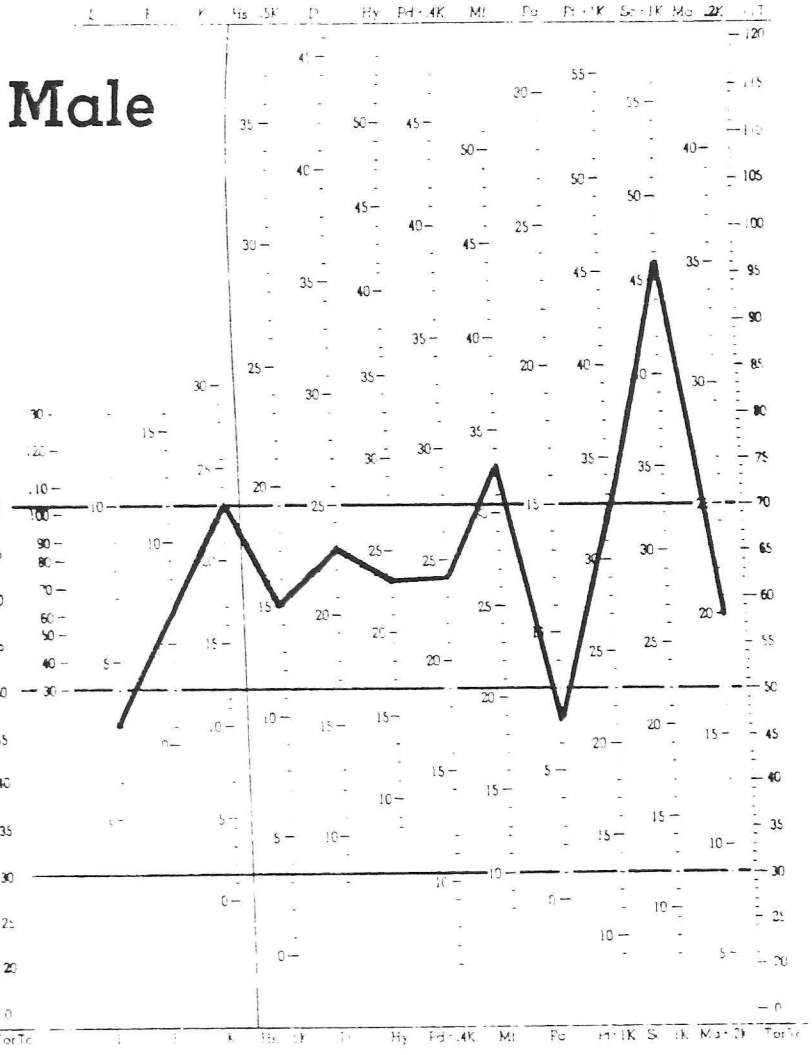
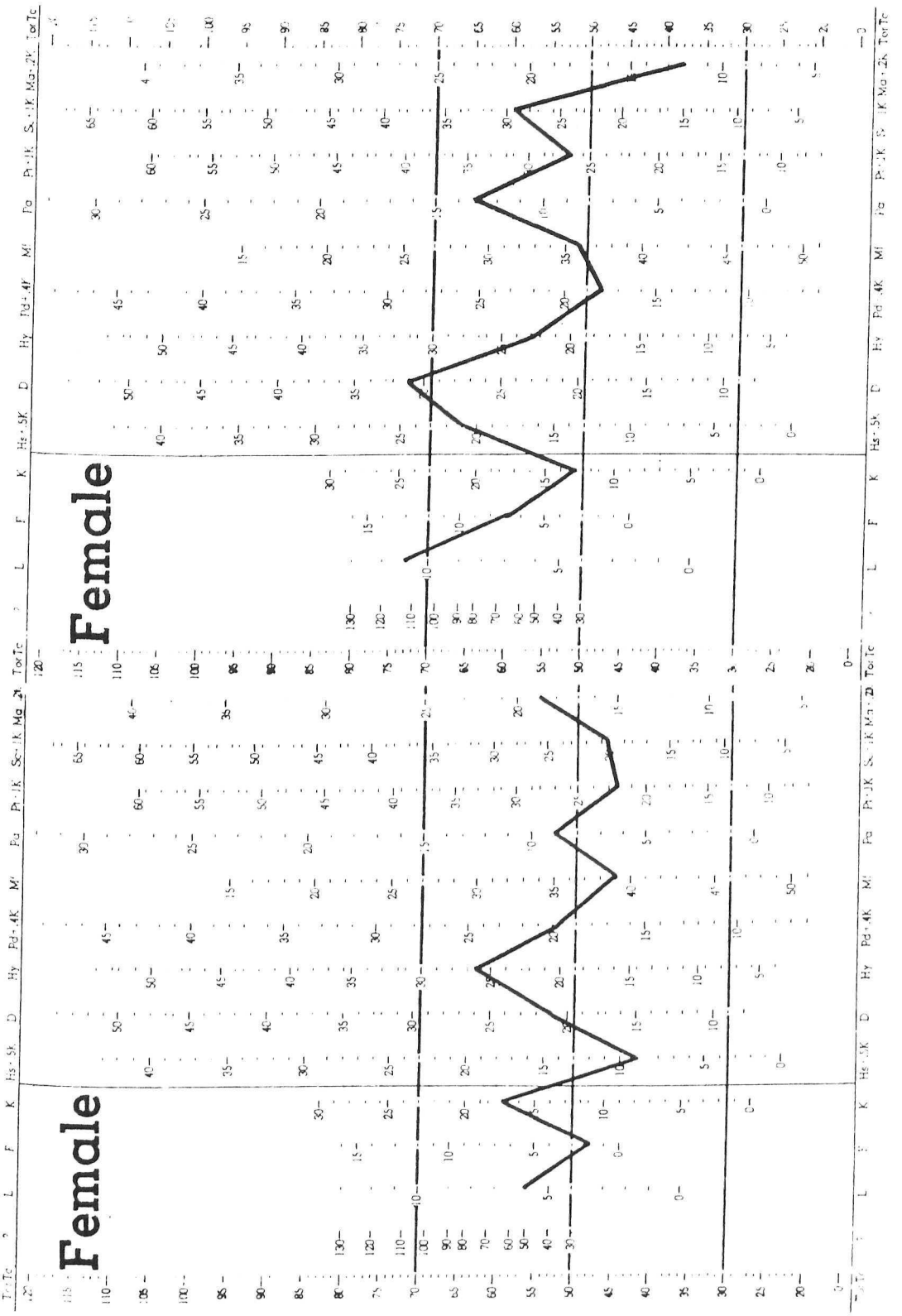


Dr. N.

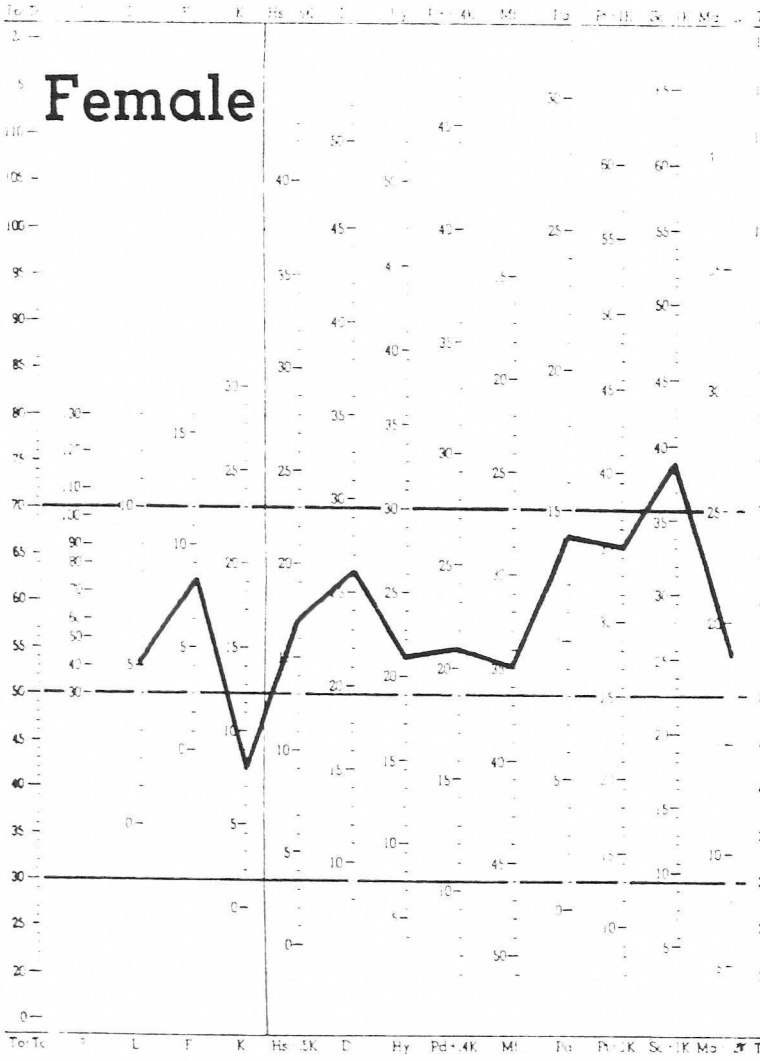
MINNESOTA MULTIPHASIC PERSONALITY INVENTORY PROFILES

MINNESOTA MULTIPHASIC PERSONALITY INVENTORY PROFILES

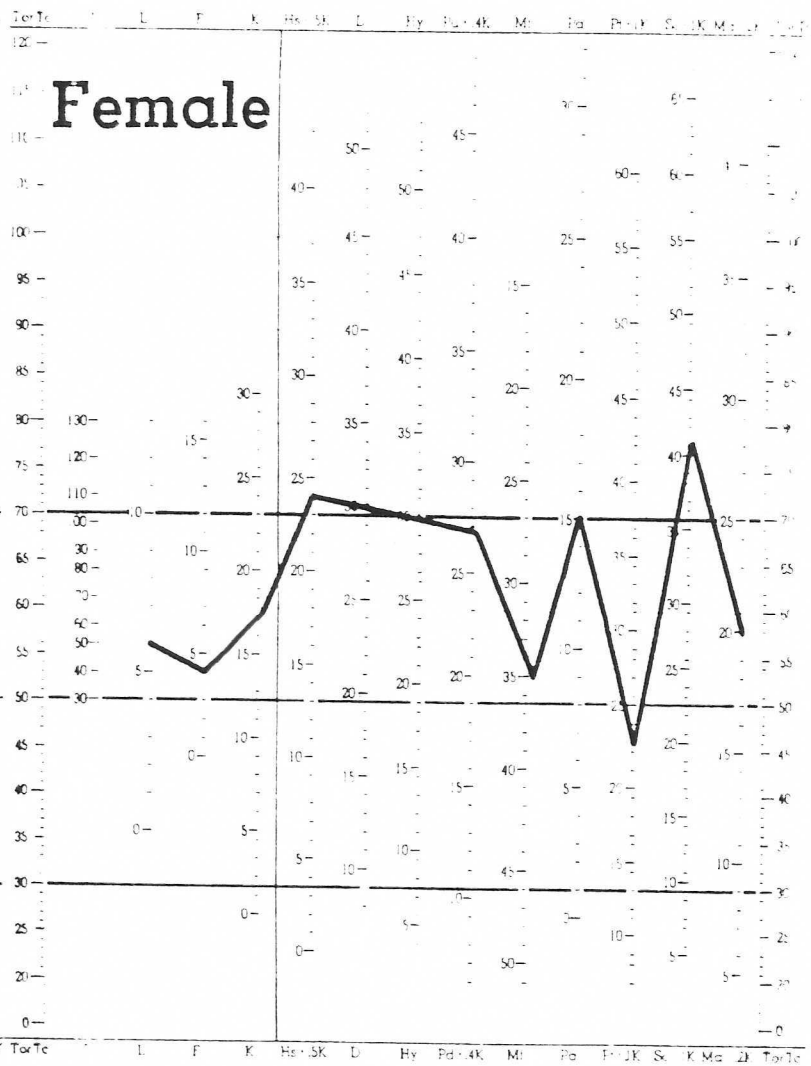


Mrs. D.

Mrs. K.

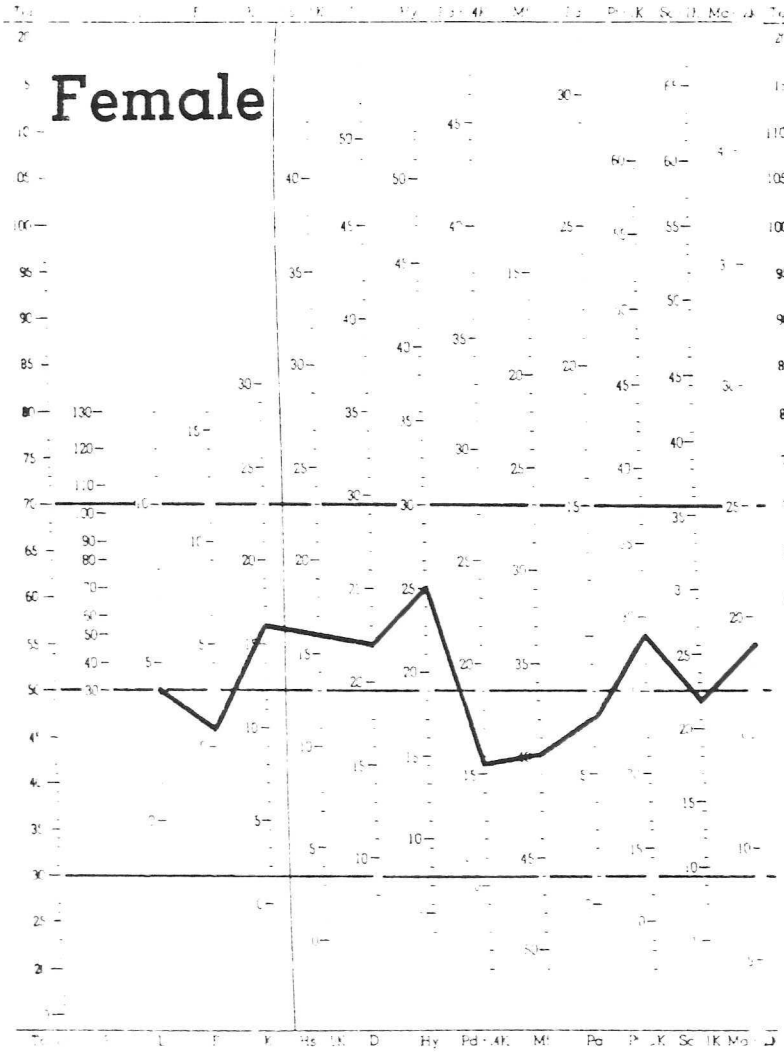


Mrs. E.

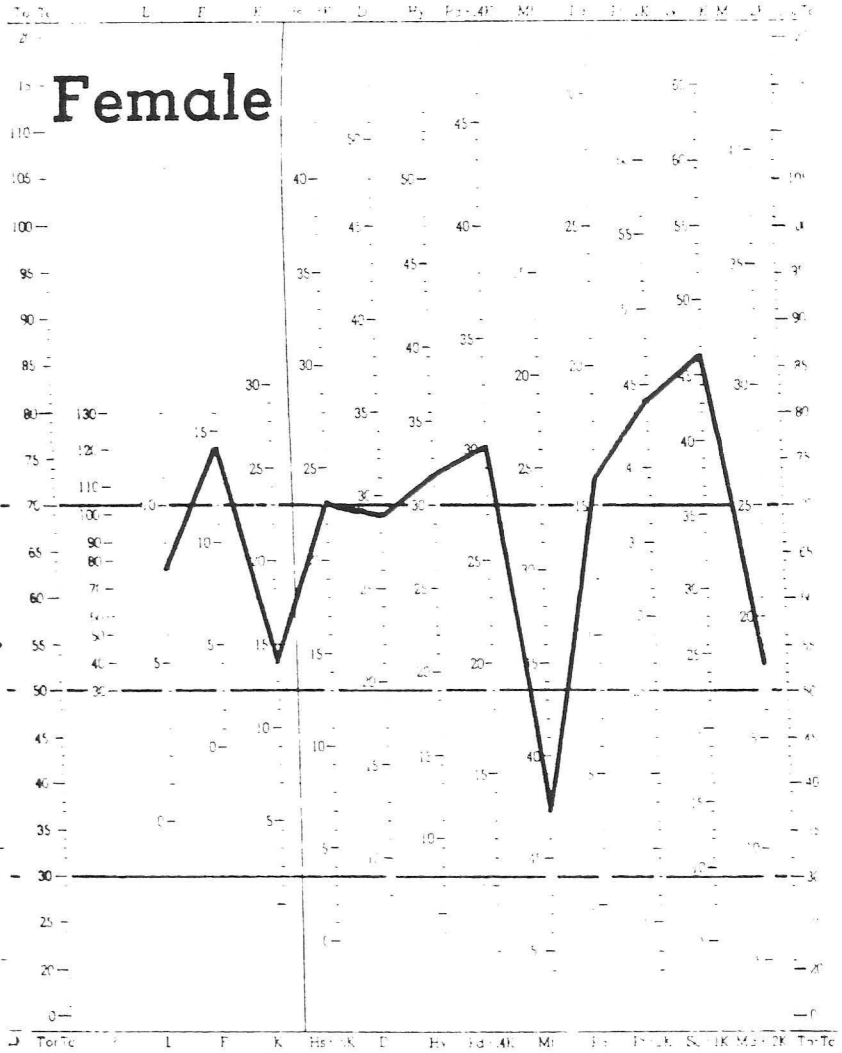


Miss M.

MINNESOTA MULTIPHASIC PERSONALITY INVENTORY PROFILES

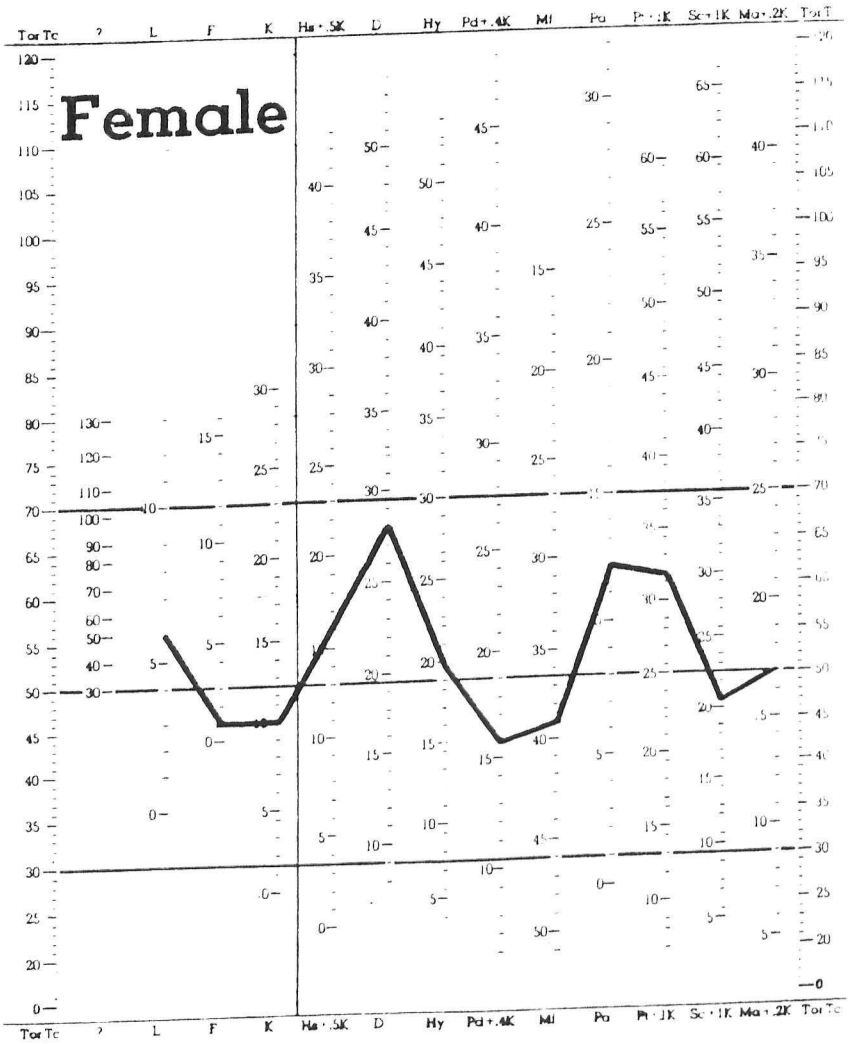


Mrs. G.



Mrs. H.

MINNESOTA MULTIPHASIC PERSONALITY INVENTORY PROFILE



Mrs. S.

EXAMPLE OF THE USE OF HYPNOSIS

INTERVIEW WITH MRS. S.

This thirty-five year old woman is seen for the third time. She has had urticaria continuously for a year and periodically for fifteen years. Her hives are much better, although she has several large hives on her right hand. She works as a stenographer and the hives interfere with her work. The patient is put into a hypnotic trance and tells the following story as she hallucinates a motion picture screen.

A woman is seen in an office hard at work. The woman has much work to do. She is attempting to catch up with all of the reports which must be typed and do everything else expected of her but the hives on her hand keep her from doing this work properly. The supervisor asks her when she will complete her work as much depends on her. Others also ask about the work but the woman is doing her best. (How does the woman feel?) She is nervous. She is trying so hard but just can't do the work. (What is she nervous about?) She wants to get ahead. (If she is doing her best why is she so nervous?) She thinks that they expect too much of her. (Do they?) No, but anyone who hasn't done the work doesn't know how hard it is. Others are just sitting around and talking. They could help her but they won't. She helps them, but now when she needs assistance they ignore her. (What does the woman feel like doing?)

She would like to be able to do the work without their help. (The patient obviously blocking expression of anger. She is encouraged to express the emotion that is beneath the nervousness.) She resents not having their help. She would like to tell them no when they ask for her assistance with their work. She would like to shout at the man who is working across the aisle. (As the patient continues to ventilate negative feeling toward her co-workers the hives get noticeably better.) At this point she is brought out of the trance and it is suggested that she may recall as much of this talk as she cares to. A moment or two is allowed for her to orient herself to the awakened state. She obviously has recalled all that she said. Prior to the hypnosis the patient had been questioned as to the events of the day which may have contributed to the hives. None of this material had been related, however. She said that when we had previously explored these events she had forgotten how she had felt.

The patient doesn't like to talk of things that show she may not be doing a good job at work. She wants the people at the office to like her and she wants the therapist to feel that she is able to perform adequately. Being unable to do the work at the office without assistance appeared to her to reflect failure. (At this point the patient cries.) She didn't want anyone to know how inefficient she felt she had been. After the tears she could discuss her feelings about work and about the feelings of failure both in relation to the people at work and to the therapist. In every situation she feels she

must achieve yet must hide feelings of frustration and resentment when the standards are set too high.

When the interview is over, it is apparent that she has full movement of the fingers and the thumb and the several large hives have disappeared entirely.

EXAMPLE OF THE USE OF HYPNOSIS

INTERVIEW WITH MRS. D.

Another woman patient, in her middle thirties, had been free of hives for several weeks and came in with several hives on her arms and face. After discussing the events of the last few days, she was unable to produce any significant reason for the hives occurring. A hypnotic trance was induced. It was suggested that she would feel herself in a motion picture theater looking up at a blank motion picture screen. The movie has not begun yet. When the movie would start she would see a picture of hives. She would not recognize the characters in the movie. The movie begins. She sees a woman doing housework. There are stacks and stacks of ironing around, clothes all around and racks of clothing to be done. The washer is running. The dryer is running. There are clothes everywhere. It is a beautiful day outside. Everybody is outside having fun but this woman stands in the middle of the piles and piles of clothes and she irons and irons and irons. Nobody helps her. The stacks of clothing are getting larger all the time. She unloads the washer and there are more clothes to do. Then she has to mend. There is never any time to do anything that she wants. The washer, dryer, ironing, mending, folding and putting them away. There are two children that need to be taken care of and they keep demanding attention. The woman can't get her laundry

done. She wants to fall into bed but she can't. When she finally does allow herself to go to sleep she awakens tired as if she hasn't been to sleep at all and she must begin the washing and ironing and the endless process begins again. (She is questioned as to what the woman would really like to do.) The woman would like to watch television, she would like to read, she would even like to do some other kind of work besides the laundry. She doesn't like to iron. She would like to have a garden with pretty flowers. She would like to work in the garden. (There is a long silence.) She is so tired. (It is suggested that the tired feeling covers up an emotion, covers up what the woman would really like to do, and if she watches the screen the movie will continue and she will see what the woman would really like to be doing.) She is just sitting there. She is relaxing. (Why is she relaxing?) So her hives will go away. (Does she have hives?) Yes. If she has hives then she doesn't need to worry about relaxing. If she has hives she can allow herself to relax. She can let the work go because she cannot do the work, especially the ironing, when she is ill with hives. She can go to bed then. She can let her housework go and she doesn't have to feel guilty. (Is this the only time she can relax, when she has hives, so she won't feel guilty?) Yes. If she doesn't have hives she will have to worry about the work. If she has the hives she can't work and she doesn't have to worry. If there is nothing wrong with you, then you must work. There is no reason why you shouldn't work, unless you are sick. (At this point the patient was awakened and was able to recall what she had said in the trance.) She

remarked that she did not know this was bothering her and spontaneously mentioned that she felt much better. The hives had disappeared during the course of the interview.

EXAMPLE OF A STRUCTURED INTERVIEW

INTERVIEW WITH MRS. T.

The patient is a fifty-three year old woman, who has had hives for five years. This is the first interview. Most of the background information was secured by the therapist prior to the interview using the information in the medical record. After rapport was established with the patient and a bit of explanation provided her for the interview with the psychotherapist and several routine questions had been asked, she was questioned about dreams. She mentioned that she had a dream that preceeding night and began to relate a dream to the therapist. The interview had been structured in such a way that there was a sharp difference between the patient's interview with the psychotherapist and the interview with the allergist. In contrast the psychotherapist asked fewer questions and purposefully provided the patient with fewer landmarks or signposts as to what they were going to do. The dream provided the opportunity for free expression of feeling, which apparently distressed the urticaria patient. She did not know how to behave in order to gain approval. The patient found that she had difficulty as she continued because the therapist just listened without indicating that he was approving or disapproving of her story. Finally she stopped, found it difficult to continue, floundered around obviously waiting for some cue from the

therapist, then burst into tears. Prior to this she had mentioned that she had not cried for years. After she cried the therapist questioned her as to the way she was feeling and she said, "I am so fearful of making mistakes". She felt badly about her inability to express herself. Everybody else in the family had a good education. Her brother is a physician, her sister a teacher. She had to stay home and take care of the children while the mother went to work. She was the eldest of three children and she had to put them through school. Now she can't express herself. She can't do what is expected of her. She feels beneath people. She feels beneath me. How can she as an uneducated person please me? She feels she cannot express herself adequately. Her vocabulary was too limited. "You will think poorly of me and won't want to talk to me".

At this point she continued to express her feelings of inadequacy and insecurity. Emotions which led her to withdraw from social contacts and plagued her with feelings of doubt about herself could not be assuaged. Although it did not show itself to others, she had a strong inward nervousness. The patient spontaneously expressed a feeling of relief at being able to talk about these feelings and to be able to cry. During the week following this interview she had no hives.

BIBLIOGRAPHY

BIBLIOGRAPHY

1. Jones, H. W. (ed.) New Gould Medical Dictionary. Philadelphia: Blakiston, 1949.

2. Kraft, B. Personal communication to the author.

3. Steinhardt, M. J. Urticaria and angioedema. Annals of Allergy, 1954, 6, 659.

4. Siegel, S. C. and Bergeron, J. G. Urticaria and angioedema in childrem and young people. Annals of Allergy, 1954, 3, 241.

5. Graham, D. The pathogensis of Hives: experimental study of life situations, emotions and cutaneous vascular reactions. Life Stress and Bodily Disease, research publication of the Assoc. for Research in Nervous and Mental Diseases. Baltimore: Williams and Wilkins, 1950, 987.

6. Wittkower, E. Skin and psyche. Urol. and Cutan. Rev., 1952, 56, 94.

7. Wittkower, E. Studies of the personalities of the patients suffering from urticaria. Psychosomatic Medicine, 1953, 2, 116.

8. Kraft, B. Personal communication to the author.

9. Freuchen, P. Artic Adventure. New York: Halcyon House, 1938.

10. Malinoski, B. Magic, Science and Religion. Meridian Books: New York, 1955.

11. LeCron, L. M. Experimental Hypnosis. New York: MacMillian, 1952.

12. Barkhuus, A. Native Medicine in Ethiopia. Ciba Symposia, 9, 1947

13. Hippocrates. Ancient Medicine and Other Treatises. Chicago: Henry Regnery, 1949.

14. Pachter, H. M. Magic into Science. New York: Henry Schuman, 1951.

15. Brady, J. V. Ulcers in "executive " monkeys. Sci. American, 1958, Vol. 199, 4, 95.

16. Montague, A. The Bio-Social Nature of Man. New York: Grove Press, 1955.

17. Breuer, J. and Freud S. Studies in Hysteria. Boston: Beacon Press, 1958.

18. Bonaparte, M., Freud, A. and Kris, E. (ed.) The Origins of Psychoanalysis. New York: Basic Books, 1954.

19. Freud, S. A General Introduction to Psychoanalysis. New York: Boni and Liveright, 1930.

20. Freud, S. The Problem of Anxiety. New York: Norton, 1936.

21. Ferenczi, S. Sex in Psychoanalysis. New York: Brunner, 1950.

22. Alexander, F. Psychosomatic Medicine. New York: Norton, 1950.

23. Alexander, F. and French, T. M. Psychoanalytic Psychotherapy. New York: Ronald Press, 1946. Emphasis on " Variations in Goal and Technique in the Treatment of Psychosomatic Disorders, 291.

24. Alexander, F. and French, T. M. Studies in Psychosomatic Medicine. New York: Ronald Press, 1948, emphasis on 424-454.

25. Deutsch, F. and Murphy, W. F. The Clinical Interview, Vol. II. New York: International Uvin. Press, 1955.

26. Wolberg, L. R. Technique of Psychotherapy. New York: Grune and Stratton, 1954.

27. Deutsch, H. The Psychology of Women, Vol I and II. New York: Grune and Stratton, 1945. Emphasis on first half of Vol. II.

28. Dunbar, F. Mind and Body. New York: Norton, 1947.

29. Grinker, R. R. and Robbins, F. P. Psychosomatic Case Book. Philadelphia: Blakiston, 1954. This publication reports on the work done at the Institute of Psychosomatic Med. in Chicago.

30. Grinker, R. R. Psychosomatic Research. New York: Norton, 1953.

31. Grinker, R. R. and Spiegel, J. P. Men Under Stress. Philadelphia: Blakiston, 1945.

32. Grinker, R. R. and Busy, P. Neurology.

33. Miles, H. V., Cobbs, S. and Shands, H. C. Case Histories in Psychosomatic Medicine. New York: Commonwealth Fund, 1947.

34. Witmer, H. L. (ed.) Teaching Psychosomatic Medicine. New York: Norton, 1952. One area of this course emphasized the problem of asthma.

35. Reik, T. Ritual. New York: Farrar, Straus & Co., '56.

36. Reik, T. Masochism in Modern Man. New York: Farrar, Straus & Co., 1953.

37. Reik, T. Listening With the Third Ear. New York: Farrar, Straus & Co., 1949.

38. Lindner, R. M. Rebel Without a Cause. New York: Grune and Stratton, 1944.

39. Abramson, H. A. Report of the committee on psychosomatic allergy. Annals of Allergy, 1953, 3, 366.

40. Miller, H. and Baruch, D. W. Resent advances in the psychosomatic concept of clinical allergy. Excerpta Medica, 1958, IIIrd International Congress of Allergology Edition, 19.

41. Dutton, L. O. Etiology of chronic urticaria. Annals of Allergy, 1947, 5, 376.

42. Kaufman, W. A commonsense approach to psychotherapy in allergic practice. Annals of Allergy, 1953, 3, 291.

43. Kraft, B. Application of psychodynamic concepts to allergy. Annals of Allergy, 1950, 5, 664.

44. Kraft, B., Howell, J. H. and Blumenthal, D.L. A Psychotherapists integration into an allergic practice. Annals of Allergy, 1957, 2, 168.

45. Kraft, B. and Blumenthal, D. L. Interprofessional cooperation in the treatment of a case of bronchial asthma. Annals of Allergy, 1956, 6, 537.

46. Kraft, B., Blumenthal, D. L. and Countryman, F. W. Suicide by Asthma. Annals of Allergy, 1959, 1.

47. Kraft B. and Blumenthal, D. L. Psychological components in chronic urticaria. Excerpta Medica, 1958, IIIrd International Congress of Allergologists Edition, 321.

48. Blumenthal, D. L. and Kraft, B. The use of the Bell Adjustment Inventory as a method of predicting success in the treatment of asthmatics. In preparation.

49. French, T. M. and Alexander, F. "Psychogenic Factors in Bronchial Asthma", Psychosomatic Medicine Monographs, 1 and 2, Wash. D. C.: National Research Council, 1941.

50. Funkenstein, D. H. Psychophysiologic relationship of asthma and urticaria to mental illness. Psychosomatic Medicine, 1950, 6, 377.

51. Sclare, A. B. and Crocket, J. A. Group psychotherapy in bronchial asthma. Journal of Psychosomatic Research, 1957, 3, 157.

52. Rehberger, G. E. Quick Reference Book for Medicine and Surgery. Philadelphia: Lippincott, 1949, 1187.

53. Winkelmann, R. K. Chronic urticaria. Proceedings of the Staff of Mayo Clinic, 1957, 13, 329.

54. Saul, L. J. and Bernstein, C. Emotional settings of some attacks of urticaria. Psychosomatic Medicine, 1942, 3, 349.

55. Oberndorf, C. P. Comments on emotional settings of some attacks of urticaria, Psychosomatic Medicine, 1942, 4, 324.

56. Funkenstein, D. H. Variations in response to standard amounts of chemical agents during alterations in feeling states in relation to occurrence of asthma. Assoc. for Research in Nervous and Mental Diseases, Research Publication, 1949, 29, 566.

57. Graham, D. T. and Wolf, S. Pathogensis of urticaria. J. A. M. A., 1950, 143, 1396.

58. Haberlandt, W. F. and Peer, H. Urtikaria und allergie als psychosomatisches problem. Zeitschrift fur Psychotherapie, 1953, 3, 117.

59. Schneider, E. Psychodynamics of chronic urticaria and angio-neurotic oedema. Journal of Psychosomatic Research, 1957, 2, 172.

60. Rees, L. An aetiological study of the psychodynamics of chronic urticaria and angioneurotic oedema. Journal of Psychosomatic Research, 1957, 2, 172.

61. Moretti, J. A. and Martinez, D. L. A. Urticaria. Excerpta Medica, 1958, IIIrd International Congress of Allergology Edition, 140.

62. Brown, F. R. Seasonal urticaria due to pollen sensitivity. Excerpta Medica, IIIrd International Congress of Allergology Edition, 141.

63. Liebeskind, A. Chronic urticaria (allergic and non-allergic). Excertpa Medica, 1958, IIIrd International Congress of Allergology Edition, 141.

64. Menagh, F. R. Etiology of angioneurotic oedema. J. A. M. A., 1928, 90, 668.

65. Urbach, E. Allergy (second edition). London: Wm. Heineman, 1946.

66. Fink, A. J. and Laslie, L. N. A critical review of 170 cases of urticaria and angioneurotic oedema following patients for a period of 2-10 years. J. Allergy, 1934, 5, 615.

67. Stokes, J. H. and Kulchar, G. V. The effect on the skin of emotional and nervous states. Arch. of Derm and Syph., 1935, 31, 470.

68. Bell, H. Manual for the Adjustment Inventory, Adult Form. Stanford: Stanford Univ. Press, 1938.

69. Garrett, H. E. Statistics in Psychology and Education. New York: Longmans, Green and Co., 1957.

70. Townsend, J. C. Introduction to the Experimental Method. New York: McGraw-Hill, 1953.

71. Shaffer, L. F. and Shoben, E. J. Psychology of Adjustment. Boston: Houghton Mifflin, 1956, 326-328.

72. Hathaway, S. R. and McKinley, P. E. Minnesota Multiphasic Personality Inventory Manual. New York: Psychological Corp., 1951.

73. Freud, S. Basic Writings of Sigmund Freud. New York: Modern Liberary, 1938, emphasis on "Interpretation of Dreams", 181.

74. French, T. M. Integration of Behavior, Vol. II. Chicago: Univ. of Chicago Press, 1954.

75. Beiman, J. A. and Blumenthal, D. L. "The Use of Hypnosis in the Psychosomatic Treatment of Occular Squint", section in Psychosomatic Opthomology, Schlaegel, T., Jr. (ed.), Baltimore: Williams and Wilkins, 1957, 214.

76. Beiman, J. A. and Blumenthal, D. L. Hypnosis in the correction of occular squint. Optometric Weekly, 1958, 41, 1895.

77. Cooke, C. E. Hypnotism Handbook. New York: Griffin, 1956, 12-30.

78. Rhodes, R. H. Hypnosis: Theory, Practice and Application. New York: Citadel Press, 1950.

79. Erickson, M. H. Naturalistic techniques of hypnosis. Amer. J. Clinical Hypnosis, 1958, 1, 3.

80. Rosen, H. Hypnotherapy in Clinical Psychiatry. New York: Julian Press, 1950.

81. Jacobson, E. Progressive Relaxation. Chicago: Univ. of Chicago Press, 1948.

82. Fromm-Reichman, F. Principles of Intensive Psychotherapy. Chicago: Univ. of Chicago Press, 1950.

83. English, H. B. and English, A. C. A Comprehensive Dictionary of Psychological and Psychoanalytic Terms. New York: Longman, Green and Co., 1958.

84. MacAlpine, I. Psychiatric observations on facial dermatoses. British J. of Dermatology, Vol 65, 1953, 5, 177-182.

85. Hathaway, S. R. and Meehl, P. E. An Atlas for the clinical Use of the MMPI. Minneapolis: Univ. of Minnesota Press, 1951.

86. Amer. Psychiatric Assoc., Mental Hospital Service. Mental Disorders, Diagnostic and Statistical Manual. Wash. D. C.: Amer. Psych. Assoc., 1952.

87. Noyes, A. P. Modern Clinical Psychiatry. New York: Sanders, 1952.

74. French, T. M. Integration of Behavior, Vol. II. Chicago: Univ. of Chicago Press, 1954.

75. Beiman, J. A. and Blumenthal, D. L. "The Use of Hypnosis in the Psychosomatic Treatment of Occular Squint", section in Psychosomatic Opthomology, Schlaegel, T., Jr. (ed.), Baltimore: Williams and Wilkins, 1957, 214.

76. Beiman, J. A. and Blumenthal, D. L. Hypnosis in the correction of occular squint. Optometric Weekly, 1958, 41, 1895.

77. Cooke, C. E. Hypnotism Handbook. New York: Griffin, 1956, 12-30.

78. Rhodes, R. H. Hypnosis: Theory, Practice and Application. New York: Citadel Press, 1950.

79. Erickson, M. H. Naturalistic techniques of hypnosis. Amer. J. Clinical Hypnosis, 1958, 1, 3.

80. Rosen, H. Hypnotherapy in Clinical Psychiatry. New York: Julian Press, 1950.

81. Jacobson, E. Progressive Relaxation. Chicago: Univ. of Chicago Press, 1948.

82. Fromm-Reichman, F. Principles of Intensive Psychotherapy. Chicago: Univ. of Chicago Press, 1950.

83. English, H. B. and English, A. C. A Comprehensive Dictionary of Psychological and Psychoanalytic Terms. New York: Longman, Green and Co., 1958.

84. MacAlpine, I. Psychiatric observations on facial dermatoses. British J. of Dermatology, Vol 65, 1953, 5, 177-182.

85. Hathaway, S. R. and Meehl, P. E. An Atlas for the clinical Use of the MMPI. Minneapolis: Univ. of Minnesota Press, 1951.

86. Amer. Psychiatric Assoc., Mental Hospital Service. Mental Disorders, Diagnostic and Statistical Manual. Wash. D. C.: Amer. Psych. Assoc., 1952.

87. Noyes, A. P. Modern Clinical Psychiatry. New York: Sanders, 1952.