Diagnosis by Inclusion: The Perspective of a Behavioral Medicine Practitioner*

Ian E. Wickramasekera

It is not enough to tell patients that because you have failed to find a somatic explanation for their somatic symptoms, they should be treated by the psychological techniques of behavioral medicine. Patients need to be shown that specific psychophysiological causes of their problems do, in fact, exist.

Why Patients Come to See Us

Patients may be referred to a behavioral medicine practitioner for a variety of reasons. Generally, the bulk of these referrals come from physicians with patients who present chronic physical complaints in the absence, on repeated investigations, of physical findings. The referrals may also be patients whose somatic complaints have been unresponsive to multiple, conventional chemical/surgical interventions.

Often, the referrals are poorly made—in the sense that patients are given inadequate information about what to expect from behavioral medicine. Without rapid and effective patient reorientation by the behavioral medicine practitioner, these patients are unlikely to make or keep an appointment, or if they come in, to return after the first visit.

Poor referrals can be reduced to several subtypes.

First, a physician may refer a patient who has been unresponsive to a variety of chemical and surgical interventions, simply to get rid of a nuisance. These “dumped” patients, if they follow through on the referral and are still fighting for their health, are frequently defensive, skeptical, pessimistic, and angry in the initial interview. They are intimidated and immobilized by their symptoms and have spent large amounts of money, time, and energy in an elusive quest for a medical solution to their problem. The referral to the psychologist or psychiatrist who is a behavioral medicine practitioner is seen by the patient as a challenge to the authenticity of his or her symptoms. These patients require rapid reorientation. Their need to validate the authenticity of their physical symptoms must be rapidly defused.

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Ian E. Wickramasekera, Ph.D., is professor of psychiatry and behavioral sciences at Eastern Virginia Medical School (in Norfolk, Virginia) and is the director of the school’s Behavioral Medicine Clinic and Stress Disorders Research Laboratory.

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by the practitioner’s acceptance up front of the reality of their complaints. The patients should be invited to present their impressive medical portfolio (a folder with a record of numerous medical tests, surgeries, and prescriptions, etc.) and be invited, as well, to provide their “organ recital,” the presentation of the multiple organic complaints from which they suffer. The practitioner should then empathetically reflect the patients’ feelings of disappointment, betrayal, anger, and hopelessness about the failure to resolve their somatic symptoms.

A second set of patients is referred, because they cannot tolerate the side effects of the drugs they are on or, because they have habituated to such medications as sleep medications, minor tranquilizers, and analgesics—that is, the medications no longer provide any relief and, in fact, are amplifying their symptoms. These patients are frequently demoralized, chronically depressed spectators of life, and have settled into a constricted, uneventful, or self-destructive life-style in which their chronic patient role alienates them from their families and other natural support systems. These patients are the hardest to mobilize, and they require small but consistent experiences of hope at each therapy session. Hope can be revived by judicious use of procedures ranging from a covert EMG gain-adjustment during feedback training,* to cognitive reframing of an old and unproductive perception of a problem.**

A third set of patients is referred because they are either unresponsive or unwilling to continue conventional medical management and have requested referral to a behavioral medicine practitioner because of information in the mass media. Such patients often have unrealistically high expectations (Stroebel & Glueck 1973) that require recalibration during the initial evaluation process.

Another quite small number of patients is referred by previous patients who are pleased with the positive outcome of their own therapy. It is critical in such instances to determine if there has been a prior and adequate medical investigation of a patient’s problems before accepting him or her for treatment.

Most significantly for the approach presented here is a sizable group of patients who are referred because a careful medical workup identifies no clear physical findings. Their physicians proceed by what can be called “diagnosis by exclusion.” That is, they assume that because they cannot find a somatic cause, psychological and psychophysiological testing will identify psychosocial risk factors that could be the cause of the somatic symptoms. This type of referral is seldom accompanied by a letter from a physician requesting confirmation of his or her suspicion that positive psychophysiological test findings could explain the presenting physical symptoms.

Several points need to be made about diagnosis by exclusion. First, even though the physician may have concluded that no physical basis for the symptoms exists, it is entirely possible that the most appropriate or adequately sensitive medical test was not done. The physician may have been looking in the wrong physical place, or given up looking somatically too soon. Second, this approach can have a debilitating effect on patients and can be a major reason that they are “reluctant.” They are intelligent and rational enough to know that just because an M.D. has not found a physical explanation

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*A baseline frontal EMG may be established that appears relevant to the patient’s presenting symptom (tension headache or TM, for example), and it is hypothesized—and discussed—that the baseline supports the physical reality of the patient’s complaint. Then the patient is challenged to try for a few minutes to drop the baseline with EMG feedback, self-hypnosis, or hypnosis. The success of the patient’s effort can be guaranteed by a covert or “placebo” gain-adjustment, which creates hope. At least one controlled study has demonstrated that this procedure can have self-fulfilling consequences. It should be used sparingly and very judiciously.

**The symptom, an obstacle, can be cognitively reframed as a stepping stone to a higher level of psychophysiological integration that not only includes the resolution of the symptom but also extends to the attainment of a deep-seated patient desire. For example, a reframing would focus not solely on reducing headache pain as a therapy goal but would include, as a goal, the aim of fulfilling the desire, for example, of working as a volunteer with the retarded or the geriatric populations.
of an old problem. If referred to a medical specialty or referred for a medical referral to a specialist because of their somatic problem, it does not mean that a somatic problem does not exist. Finally, since diagnosis by exclusion simply assumes that psychological factors can, in fact, cause the particular symptom of a patient, it requires the patient to believe on faith, without any objective evidence, that psychological factors are causing the symptoms.

The results of multiple prior medical tests and procedures that have not given lasting symptomatic relief have already eroded the bulk of the patients’ faith in the health-care establishment. Somatizers tend to be very short on faith by the time the primary care physician or medical specialist is ready to refer them to a behavioral medicine practitioner. In all, the approach of diagnosis by exclusion is irrational and implicitly insults the patient’s intelligence.

Such patients—and behavioral medicine patients, in general—need to be confronted with a diagnosis by inclusion. That is, they need to be shown that there exist specific psychophysiological causes of their problem. It is not enough to tell a patient that because you have failed to find a somatic explanation for his or her somatic symptom, the cause must be in the patient’s head and the patient should see a “shrink.” The physician needs to go the next step and find a psychological factor whose capacity to turn a somatic symptom into a function on and off can be demonstrated to the patient. These patients need ocular proof that psychological factors can, in fact, cause somatic symptoms. My own approach toward diagnosis by inclusion is based on a set of studies that have led to what I call the High Risk Model (Wickramasekera 1979, 1984, 1987, and 1988), in which I identify seven psychophysiological factors that can be shown to cause somatic changes, an effect, I should add, that I can demonstrate in my office. Diagnosis by inclusion implicitly validates the patients’ intelligence, and then celebrates and makes a working alliance with their rationality.

On the basis of the High Risk Model, it is possible to determine if patients do, in fact, present positive psychophysiological findings that can cause somatic symptoms. If not, they should be referred back to the physician for more sensitive and complete medical investigation of pathophysiology that could have been “missed” in prior medical tests and could be medically treatable.

Finally, there are a small number of patients who are referred from major tertiary-care medical centers where they have already been medically and psychologically evaluated by sophisticated clinicians who often do a good job of educating and orienting a patient prior to referral. These patients have been told that there are new behavioral and psychophysiological techniques that are cost-effective and efficacious and that have no, or fewer, side effects than the standard medical treatments. The patient is told that these new techniques should be tried first before escalating to more radical and risky medical interventions.

In conclusion, the manner in which the referring physician prepares the patient’s mind with respect to the believability of mind-body interaction issues can powerfully influence the patient’s decision to follow through on a referral to a behavioral medicine practitioner. It can also influence the patient’s decision to actively participate in the initial assessment and therapy process.

The Initial Interview: Priorities and Procedures

Even before the patient comes in for the initial interview, it is important that he or she have some specific expectations regarding the practitioner’s competencies, skills, and reputation for dealing with his or her specific problem. The source of these expectations may be the practitioner’s published work, previous patients, or the mass media. It is in the first two or three sessions that the therapist’s social-psychological influence with the patient will be maximal. After that, credibility will start to sag (“placebo sag”) unless the practitioner’s stated observations and interventions impact the patient’s distress and symptoms at a direct experiential level. These initial sessions provide a window of opportunity. It is critical that you “get your
foot in the patient’s head” before this window of opportunity closes or the honeymoon ends.

The first priority of the initial evaluation from the therapist’s viewpoint is to determine what the patient perceives to be the primary problem that requires attention and resolution.

It is extremely important to attempt to identify what the patient believes is causing his or her problem or the factors the patient believes are associated with the onset, and the eventual solution, of the problem. Whether these patient speculations are valid or not is a separate issue. Clinically, it is important to identify the patients’ theories about the causes of their symptoms and to confront a patient with what he or she believes about the problem. This provides the first step in engagement or bonding between therapist and patient. The patient realizes that he or she is heard.

In addition, there are frequently unverbalized, underlying fantasies that the patient may have regarding a symptom, fantasies the patient is embarrassed about or considers so ridiculous that he or she is unwilling to discuss them. The therapist needs to give the patient permission to talk about such fantasies, and even to imply that he or she suspects what they are, though they may exist only in the shadows of his or her mind. This can be done by looking directly into the patient’s eyes in an inquiring and accepting way, during episodes of pregnant silence in an atmosphere of focused ambiguity. The therapist offers focused attention and respectful silence as a blank Rorschach card onto which the patient is implicitly invited to project inner fantasies about what is just below the surface of their consciousness at that moment in time.

During these episodes the patient may blurt out a “confession” of some personal mythology. For example, the patient may believe he or she is suffering from an undiagnosed catastrophic disease, or is being punished for his or her sins, or for the sins of one’s parents, or for some previous transgression of a moral or legal code. The patient may hold such beliefs as “I am no good,” a “black sheep,” or a “victim” of events, or conse-

versely, “it is my destiny to rescue and care for others,” or “I am good only when I am compulsively helping others.” These unverbalized fantasies are extremely important to elicit in the early sessions of therapy, because verbalizing them to another person can be therapeutic in and of itself. Additionally, the patient’s eventual recognition and disclosure of this unconscious personal belief increases the patient’s vulnerability to the therapist’s social influence, and will build a bond of closeness between patient and therapist.

Confronting the patient with these hitherto unverbalized fantasies is a critical step in the therapist-patient engagement. This bonding is important because the patient can now subjectively feel that he or she is not alone but has the support of a powerful and wise person, which is especially important when the exploration proceeds to even darker and more shadowy aspects of the functioning of the self—after, that is, the practitioner and patient have put out the “fire” (headache or jaw pain) and are looking for the “matches” (underlying causes). It is crucial to develop rapidly this type of patient perception, which is the authoritative aspect of the transference, regardless of how unreal the perception is. It gives the patient the support and courage for further self-exploration and makes an implicit alliance with the healthy part of the patient’s personality.

In exploring the patient’s perception of the problem, it is also important to identify the objective and subjective antecedents or conditions—interpersonal, intrapsychic, or environmental—that are associated with the onset of changes in the frequency or intensity of the presenting symptoms, and with the offset or the tapering down of the symptoms. For example, can the onset of a more serious problem or a recurring dream change the frequency or intensity of a presenting symptom? How does a change in the patient’s daily schedule affect the symptom? What happens to the symptoms on weekends and vacations?

These inquiries should be made in a direct and active way that both leads and follows the patient into the adventure of self-discovery. The therapist should be sensitive
to verbal and nonverbal feedback cues elicited by prior questions and be willing to branch out into apparently unrelated but pregnant areas. One should never stick rigidly to a predetermined format in the initial sessions unless there is a very good reason to do so.

The second priority from the therapist’s viewpoint is to get some estimate of the patient’s commitment to change, as demonstrated by a willingness to put this therapy and one’s self on the front burner and other less essential activities on the back burner, at least for the duration of the engagement. This means reserving the choicest portions of a day to be devoted to doing therapy and self-nurturing homework. This also implies being punctual for sessions and not canceling sessions except for emergencies.

Without up-front commitment of time and effort to therapy, complex and salient changes are unlikely to occur soon enough for the patient to see progress. Significant change is painful, and can be slow.

Thus, an important part of the evaluation of the patient’s candidacy for therapy includes evaluating his or her commitment to therapeutic work. The patient is explicitly told that we are evaluating his or her candidacy for therapy and that “I will seldom ask you to do anything that is easy,” or “I am, in a sense, looking for a few good people who can learn to substitute skills for pills. I wonder if you have what it takes for this journey?”

The therapeutic work-pain starts with a commitment to complete honesty and vulnerability. I will often say to the new patient, “Since I don’t read minds, you have to make yourself vulnerable in this protected setting if I am going to help you find the key to your problem.” The patient is plainly told that lives by commission, or omission, delay and destroy therapeutic work; not making a decision to talk about a salient topic is a decision. “Lack of honesty wastes my time and your money. You can tell when you are doing good therapeutic work because it will always hurt most when it counts.” Knowledge makes a bloody entry.

The third priority from the therapist’s viewpoint is to induce an aggressive attitude in the patient toward his or her symptoms and problem.

“Once I know what your dragons are,” I say, “I will be asking you to go after your dragons and not to wait for them to come looking for you.” The goal, I explain, is self-exploration, self-mastery, and eventually, the ability to practice at the “scene of the crime,” the time and place where the patient previously has been symptomatically immobilized. I explain: “People do not change, grow, and rise above their symptoms from merely doing easy things, nor do they change until they have to; and if change were easy, you would not be here today sitting in front of me.”

It is very important to the patient to remember that, at times, the practitioner will have to be hard on him or her, but that there can be a lot of love even in a psychosurgical knife. Caring has to involve firmness and discipline. It may be unpleasant for the therapist to implement this discipline, but that is precisely what the healthy portion of the patient’s personality expects and is paying one to do. Therapy, in the final analysis, is not terminating symptoms but learning flexible conceptual, affective, and motor skills that can be widely used in high-stress interpersonal situations. Reducing symptoms is only a temporary goal on the road to increasing interpersonal competencies.

Commitment to change is also behaviorally demonstrated by the patient by following through on specific self-investigative activities and homework assignments (including assigned reading, observing, and recording symptomatic responses to social changes, relaxation practice with tape, and practice at the “scene of the crime”). Such activities
It is critical for the patient to hear that the goal of psychophysiological therapy is self-mastery, coping, and self-control, not cure in a medical sense.

are essential for the patient to do adequate self-exploration and self-diagnosis and an adequate microanalysis of contingencies between environmental events, emotional and cognitive events, and behavioral responses at work or home.

Self-monitoring of target symptoms (anxiety episodes, pain reports, depressive thoughts, urges to smoke, etc.) makes the patient a keener observer of his or her own overt and covert behaviors and more analytic about emotions and beliefs. Awareness of contingencies between symptoms and emotions and environmental events reduces the probability of reflex or unconscious behavioral responding, and interposes delays that make possible conscious behavioral choices of new coping techniques.

Through all these activities the patient is explicitly told and helped to recognize that he or she is becoming a coinvestigator and an active participant in his or her own self-diagnosis, self-assessment, and rehabilitation planning. In the process of self-evaluation the patient may participate and request tasks that you might want to assign later, and when he or she makes such requests you warmly congratulate the patient for being ahead of you, on track, and on target. The therapy model is explicitly one of self-education or self-investigation and not the medical one in which the patient is the passive recipient of interventions. This model raises the patient’s self-esteem.

The Patient’s Tasks and Goals

It is most important to point out somewhere in the initial three sessions of therapy that there will be numerous symptomatic ups and downs, particularly in the early course of therapy, and that, initially, the patient may have to get worse before getting better. The ability to hold a therapeutic work course, across time, when no progress seems to occur or when, in fact, things are getting episodically worse, is explicitly stated to be the mark of courage and of a “winner.” Failures can be the pillars of success.” The patient should be shown the individual learning curve of previous patients, which is marked by numerous ups and downs in acquisition and only gradual elevation of the baseline. It is often necessary to take one step backward to take two steps forward.

Transitional points in therapy tasks are particularly vulnerable to regressions and relapses. For example, the patient with an obesity problem should be shown a graph of a previous patient losing weight. The practitioner should draw particular attention to the plateaus, when discouragement often leads to relapses. The patient needs to understand that the decisions made at such nodal points in therapy (no weight loss despite diet and exercise, pain getting episodically worse for no apparent reason, and so forth) determine the outcome of therapy in the long run. Plateaus are often pregnant with salient changes but require patience and holding a work course, in spite of apparent inertia.

Staying the course during psychic storms is also crucial. “Advanced organizers” (Ausubel 1963) such as “no gain without pain” cognitively immunize the patient against the inevitable relapses that occur in the course of therapy. If the practitioner predicts the possibility of relapses, they will not be as catastrophic when they occur and can be regarded as expected milestones on the road to recovery.

Finally, it is critical for the patient to hear that the goal of psychophysiological therapy is self-mastery, coping, and self-control, not cure in a medical sense. At some future time, the patient may want to experiment again with the patient role but, at that time, he or she will have acquired skills to keep from getting stuck in the role. The goal of psychophysiological therapy is the substitution of skills for pills. It is important to tell
the patient that, even after extended periods of symptomatic freedom, it is possible to have intense breakthrough symptoms that will test the patient’s sense of self-efficacy and his or her analytic and psychophysiological skills. When confronted with situations that they cannot change or fight, or from which they cannot flee, patients must learn to flow.

The patient should carry some central or even peripheral aspects of the clinical interview outside the consulting room into his or her natural habitat—the “take-home message” —and use them (in sleep or the waking state) to reframe the experience of his or her distress in the course of the coming week. It is also important that the new patient look forward to the next session perhaps with mild or moderate anxiety, and preferably have a list of specific topics to discuss.

In sum, the purpose of the initial interview is to convey to the patient what long, hard, and painful therapeutic work needs to be done and what help and hope is available on the other side of the work.

The Psychophysiological Model or the Trojan Horse Procedure

Within the first three sessions of patient contact (the honeymoon), before the window of hope and opportunity, temporarily opened by a new therapy context, closes in the patient’s head, it is absolutely essential to move the patient presenting physical complaints without physical findings toward a psychophysiological model and away from a biomedical model (mind-body dichotomy model). The psychophysiological model is implemented by challenging the patient’s prior beliefs about the extent to which cognitions can influence or inaccurately reflect one’s biological functions. This is accomplished through a psychophysiological role induction which uses what I call a Trojan Horse Procedure. This procedure has at least four components, which start the investigation on the outside with observable somatic symptoms and, like peeling an onion, work their way into the patient’s head (see Table 1) or core.

For the patient who presents somatic complaints without physical findings and who is skeptical about a referral to a psychologist, the initial interview should be conducted in a psychophysiological laboratory rather than in a consulting room. The psychologist should meet the patient in a white laboratory coat and confine initial questions to very objective and quantitative questions. For example, “What physical complaints do you have today? When did these symptoms start and how long do they last?” When the psychologist knows the nature, location, duration, and intensity of the patient’s physical symptoms, he or she is ready to proceed to component one of the Trojan Horse Procedure.

Psychophysiological Demonstrations

This first component is, in essence, a high credibility psychophysiological demonstration of the mind-body interaction model. It is designed for chronic and hopelessly skeptical patients “from Missouri,” who have to be shown rather than told.

My own thinking about selecting a particular demonstration is framed by my view...
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that all behavioral medicine patients can be classified as either amplifiers or transducers. Amplifiers are patients who have one or more of the seven factors that are identified in the High Risk Model (Wickramasekera 1986, 1987, 1988) and that can amplify physical findings (for example, a herniated disc) so that the pain persists even after surgical repair of the disc. Transducers are people who have one or more of the seven high-risk factors that enable them to transduce psychosocial perceptions of threat, or conflict, unconsciously into somatic symptoms (headaches, irritable bowel, and so forth). Amplifiers and transducers respond differently to different psychophysiological demonstrations. For example, 75 percent of transducers are low on hypnotic ability, and with such patients a demonstration of hypnotic analgesia has a 25 percent chance of failing. On the other hand, such a demonstration works at least moderately well with 100 percent of amplifiers.

The aim is to match the patient with an appropriate psychophysiological demonstration. Underlying this aim is the hypothesis that all mental doors can be opened provided the locksmith selects the right key. Ultimately, the purpose of the demonstration is the construction of faith that is the quintessence of any healing.

Three forms of psychophysiological demonstrations challenge the mind-body dichotomy. The first demonstration works by directly demonstrating on the patient's own physical body that cognitions can alter biological functions.

If the patient has good hypnotic ability (which can be determined by the Harvard Hypnotic Scale measure), then a reversible anesthesia, a catalepsy, a muscular inhibition, or another involuntary sensory or motor change can be induced in an area of the patient's body unrelated to his or her presenting symptom. This procedure, because it is counterexpectational, startles the patient and may capture his or her attention for several weeks. Sometimes the symptom itself may temporarily remit during this demonstration, generating hope and indicating that the circuitry for relief is still intact but may need some “rewiring.”

If the patient has only moderate- or low-hypnotic ability, one or more of several other types of psychophysiological “show-and-tell” demonstrations can be arranged to induce faith in mind-body interactions. For example, a variety of physiological functions can be monitored—including heart rate, blood pressure, electromyographic activity, skin conductance, and temperature—under resting conditions. The patient should be shown the stable baselines. Next, the patient should be unexpectedly and briefly stressed (one minute) with, perhaps, mental arithmetic or personally sensitive questions. Immediately after the cognitive stress period, the patient's attention should be drawn to his or her physiological reactivity tracked on a strip chart-recording of the reaction. In this demonstration, the patient's attention should be focused particularly on the physiological system that is more reactive (either in terms of largest elevation or variability) and the response that takes the longest time to return to the prior baseline, after the brief cognitive stressor, is terminated. A patient, for example, might show a drop of 4 or 5 degrees F from baseline while talking about some personally stressful incident or in response to a cognitive stress like mental arithmetic problems.

The patient should be encouraged to ponder these physiological tracings and their implications for how the patient responds to transient psychosocial stressors in everyday life. The patient has now seen that a particular biological system in his or her body (the patient's window of vulnerability) is particularly reactive to psychological stress. The patient has seen that certain biological systems go on red-alert too easily and stay
there long after even a trivial cognitive stressor is removed. The patient should recognize that chronic intermittent triggering of the red-alert system, by personally salient transient or enduring psychophysiological threats or conflicts (a problem child, an unhappy marriage), has something to do with why the patient is in the office today.

This little psychophysiological-stress demonstration provides a credible face-saving biological rationale for the patient's physical complaints, and demonstrates that psychosocial stress can profoundly alter biological functions. The practitioner should explain that chronic functional activation may eventually lead to structural breakdown or erosion of organ systems and clinical complaints.

A third cogent method of showing the inaccuracy or incompleteness of the patient's awareness of mind-body interaction is through a strip chart-recording of a 10-minute baseline of frontal electromyogram activity. This strip chart can be used to demonstrate how incomplete/inaccurate a patient's verbal-subjective estimate of muscle tension is, when compared to an objective quantitative measure of resting muscle tension.

For example, while a frontal EMG baseline is made, the patient can be asked for two estimates of the muscle tension in the upper portion of his or her body, on a subjectively anchored scale (the SUDS scale, or “subjective units of disturbance”) that ranges from zero (totally relaxed muscles) to 50 (extremely tense, an unbearable level of muscle tension requiring escape from laboratory setting and therapist). Typically, even the anxious patient underestimates the level of perceived muscle tension. A 10-minute frontal EMG baseline recording is then made (5 minutes eyes open, 5 minutes eyes closed) on a 50-micromicrowatt scaled strip chart. Nearly always the objective measure of EMG is much higher than the subjective estimate (Figure 1). This mismatch between perception (SUDS scale of conscious mind) and sensation (frontal EMG in microvolts) is a measure of “secrets out of mind but not out of body.”

The patient is directly and clearly confronted with the discrepancy between his

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Figure 1
Comparison of Actual EMG and Subjective Assessment of Muscle Tension

The strip is read from bottom to top. The patient, a 41-year-old woman, has estimated her muscle tension to be 25, on a scale from 0 to 50. In fact, as the EMG shows, it is almost never less than 40 and is frequently over 45.
or her verbal-subjective estimate and the objective EMG recording. This mismatch is usually so large that the patient is startled and taken aback by the extent of the insensitivity to his or her own body. The patient is told that he or she has psychologically habituated to an abnormal physiological state of muscular bracing and that, as progress occurs in psychophysiological therapy, the recognition of the level of muscle tension will become less blunted and more accurate. This increased sensitivity will enable the patient to identify early and defuse acute episodes of muscular bracing during psychosocial threat or conflict. (I have found that this verbal-subjective versus frontal EMG discrepancy is nearly always quite large in patients with chronic functional disorders.)

Such procedures usually have a startling and credibility-building effect on the patient. They often include a shift in the manner in which the patient perceives physical symptoms, a shift that is similar to opening a sunroof in the patient's head. They also provide a credible biological rationale for the physical symptoms that, in fact, may be the final common pathway for multiple psychosocial conflicts in the patient's life.

Educational Model

The second component of the role induction is the shaping of the patient's cognitions into an educational model of illness as opposed to the biomedical model in which the patient is the passive recipient of treatments. The psychophysiological demonstration is essentially a learning, or educational experience, about personal mind-body interaction. There are at least three important events that need to occur during this shift from the passive patient role of biomedicine to the active participating “student” role of health education.

The first event is that the patient should not be pressured to give up the symptoms but rather to track, measure, and monitor them daily for educational and scientific purposes. That is, the patient will collect baseline data on the frequency and intensity of his or her symptoms. This maneuver psychologically turns

the tables on the patient who, for the first time in the course of therapy, is paradoxically told not only to keep the symptoms for a while longer but also to monitor and record their frequency and intensity before they fade. Psychologically, this defuses a weapon the patient could have used to intimidate the therapist. There is also the confident, implicit suggestion that the symptoms will fade in intensity. In any event, before they fade away, it is important to identify their causes, in the event that the symptoms should return in the future.

Under the conditions of reduced pressure to stop using or experimenting with the role of sickness (Parsons 1965), some patients improve dramatically, at least temporarily. The invitation to the patient to continue to experiment for a while longer with the role of sickness occupies the patient's high ground, forcing the patient out of a well-practiced and entrenched turf. This procedure is called "spitting in the patient's soup," making it distasteful for consumption.

The second event in the process from passive patient to active "student" is that the patient is told that his or her candidacy for entrance into the therapy program is being carefully evaluated, based on the patient's performance on a battery of tests. Because of the large voluntary or behavioral component in chronic diseases or disorders (unlike acute infectious disease), the patient has to earn admission to therapy. At our clinic, the patient needs to take these tests in order to be evaluated for therapy. The patient is told that we have limited resources, skills, and time, and that we cannot help everybody. We are looking for a few good patients who are willing to work hard in therapy to improve their symptoms. We believe that only those who will "show us" not "tell us" deserve our help, because only they will improve fairly soon. The initiation rites involve taking a tedious battery of seven tests in our office that will consume about two sessions (three hours) of patient contact time.

This battery of tests is like a set of hurdles that immediately forces the patient to make multiple microdecisions to mobilize
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periphery of the patient's body, and specifically, with a focus on the symptoms. This can occur only after the patient feels some self-control over the symptoms (frequency and intensity are reduced), which can tremendously increase the patient's self-esteem. It is important to put out the fire before looking for the matches.

This symptomatic focus is not without risk because as the patient starts to collect objective and quantitative data on the symptoms, the patient could temporarily get worse— even for some reason unrelated to data collection—and the symptom data will make that relapse abundantly clear. The patient has been alerted to the possibility of such relapses by being shown, at the outset, the normal, individual learning curve, which is marked by erratic and slow acquisition of skill at symptom control.

Because the patient has to take risks and experiment with more effective coping behaviors, the course of learning real control of symptoms is not a short, positively accelerating course for which there is a "quick fix." Rather, it is an uneven course with gradual elevation interrupted by regression as physiological self-regulatory competencies develop.

During this Trojan Horse phase of therapy, while the patient collects data on the symptoms, the patient may serendipitously stumble over or discover several subtle contingencies between thoughts, attitudes, and environmental events and symptoms. These discoveries can increase the patient's curiosity about larger issues in his or her life. It is very important to reinforce and support this intellectual curiosity. These findings are discussed analytically in therapy and can be

From Student to Co-investigator

The third component in the psychophysiological role induction is to move the patient from the role of student into that of co-investigator. The patient now graduates into an analytic, objective, scientific co-investigator of his or her symptoms.

This third component of the Trojan Horse Procedure begins, as usual, on the
used by the patient to expand a sense of self-exploration and self-regulation, within the limits of the symptoms. This early sense of even sporadic and modest self-control of previously immobilizing symptoms increases the patient’s self-esteem, further motivating the patient to continue the painful process of exploration of self, as he/she interfaces with the interpersonal and physical environment.

Out of the Closet:
The Psychotherapy Candidate

The fourth and final component in the psychophysiological role induction is to directly and openly investigate the psychosocial antecedents and consequences of the patient’s symptoms. Now that the patient is no longer an “impersonal,” he or she is out of the closet and is a psychotherapy candidate. The patient can now be approached, just as in traditional intensive psychotherapy, as a patient presenting psychological symptoms (anxiety, guilt, depression, etc.). The difference is that there is often concurrent physiological monitoring (heart rate, EMG, blood pressure, skin conductance, peripheral skin temperature, etc.) to explore, identify, or confirm suspected sensitive topics. This is truth, not lie detection, and is the royal road to the unconscious (Wickramasekera 1990, 1991). The physiological information is shared concurrently with the patient, so that the patient becomes a coinvestigator in the exploration of the unconscious headwaters of the disorders and symptoms.

At this fourth step, the patient’s symptoms have typically shifted from predominantly somatic (pain, dizziness, etc.) to predominantly psychological complaints (phobias, anxiety, depression, etc.). The polygraph is used in these sessions as a truth detector because the patient’s body may be closer to the patient’s unconscious mind. Often the most significant personal beliefs or mythologies are unconscious or “unattended” (Bowers 1984) and need to be identified, examined, and then reframed or falsified.

The patient shares with the therapist the sense of excitement of a coinvestigator using all available tools to narrow down and corner the prey (dysfunctional beliefs or perceptions). The patient’s body has become a good friend and ally, which deserves more respectful attention because it is a mirror that is less easily distorted by such ego defenses as denial, projection, or repression. The attitudinal shift often leads to important and durable life-style choices and changes (decisions to stop smoking, to lose weight, to do regular physical exercise, etc.) intended to protect and enhance one’s body. These are a reflection of the growing recognition by the patient that “this is the only body I will ever have and it deserves care and respect.”

If the unconscious perceptions, fantasies, and beliefs that cause and sustain physical symptoms have not been identified by psychophysiological monitoring during psychotherapy, then a variety of procedures that inhibit or bypass ego defenses and enable the patient to access and process present, past, or future information in a fresh way, may be used. For example, techniques that range from live role-playing (the Gestalt empty-chair technique) to in vitro or in vivo desensitization can be used to access new perspectives on old problems. These techniques enable the patient to look at chronic problematic areas from previously unattended viewpoints that are potentially within the sphere of consciousness.

In using these techniques, it is important to emphasize their value in diminishing unhealthy physiological reactions (like sympathetic hyperactivity) and to use concurrent physiological monitoring to give the patient highly credible information that the extinction of fear and avoidance is occurring.

It is equally important to attend to any fresh information or new ways in which old problems can be conceptually represented in consciousness with new labels or frames. This reframing can have new physiological and behavioral consequences for the ways in which old problems are viewed and approached. This is called disrupting cognitive stereotyping.

Hetero- or self-hypnosis is another technique of accessing a fresh perspective on
old problems. A procedure like low-arousal physiological training (such as relaxation) or self-hypnosis can often enable a patient to view an existing life problem from a fresh perspective. There is some evidence that the mind is more creative when in the low-arousal or self-hypnotic state (Bowers & Bowers 1979; Fromm et al. 1981). A patient in the low-arousal state may be more responsive to new information and fresh ways of looking at old problems. It is possible to use these conditions to enhance suggestions that the patient will have night dreams that will clarify or resolve the meaning of waking conflicts.

The enhanced suggestibility of the low-arousal state and the growing positive transference situation can be used further to challenge the patient's dysfunctional attributions ("My pain is due to something I ate; "It is important to look for scapegoats.") and irrational beliefs, and to encourage the patient to act experimentally (take a risk) on new assumptions or hypotheses about human relationships and destiny. It is crucial at this final step, explicitly to encourage risk taking that may involve confronting the prospect of failure, pain, and defeat. New and more effective coping strategies can then be developed even in the face of anticipated fear and pain, and new support systems (friends, social groups, church, athletic clubs, professional groups, etc.) can be found.

In the final analysis, it is the patient's growing personal competencies that will provide the best defense against further symptomatic relapses, and not a mere freedom from symptoms. By teaching analytic problem solving, interpersonal risk taking, and assertiveness skills, and by increasing role flexibility, we immunize the patients against symptomatic relapses and prepare them to cope with future sensitization.

In this last stage of therapy, the psychophysiological therapist is earmarked as a new kind of psychotherapist, who with the patient's permission encourages the patient to open the city gates to new sources of information (dreams, daydreams, fantasies, role playing, etc.) that otherwise would have been rejected as alien invaders at the city walls. In the process, the patient, rather than escaping from psychological pain through defenses like somatization, nomadism, or acting out, accepts the responsibility of dealing with psychological conflicts at the appropriate level by using appropriate psychological mechanisms, including insight, abreaction, desensitization, and reframing. At this point of psychological maturating the incidence of somatic presentation reduces and the incidence of psychological presentations (anxiety, depression, fear, loneliness, etc.) increase in therapy. The patient is no longer a closer psychotherapy case or a medical impostor and is less likely to be able successfully to use somatization as a method of transducing psychological conflicts into physical presentations.

Data on the Effects of the Trojan Horse Procedure

The following data are from two five-month periods in which the Trojan Horse role induction was used to orient exclusively somatizing patients to the services of the Behavioral Medicine Clinic and Psychophysiology Laboratory at the Eastern Virginia Medical School (see Figure 2). Period A represents a phase when the role induction procedure was used nonsystematically by the present therapist in the early years of the clinic and laboratory. Period B is based on a more recent patient sample when the present therapist was systematically using the role induction procedure. The number and type of patients (age, sex, diagnosis, chronicity, presenting problems, and so forth) was comparable in Periods A and B. The present author did the role induction in both periods.

During Period A (N=20), 60 percent of the referrals were retained after the psychophysiological role induction and 40 percent of the referrals dropped out. This 40-percent rate includes patients who dropped out after the initial interview, after testing, or who did not come back for therapy after the feedback session. (The feedback session presents the results of the clinical interview and all the
psychological and psychophysiological tests, and the patient is essentially told the results of his or her application for candidacy for psychophysiological therapy.)

Based on a survey of 600 community mental health centers, Phillips (1985) concluded that, of those patients who present themselves for psychotherapy, only 50 percent return after the initial interview. It is well known that the dropout rate is very much higher for the patient who presents somatic complaints without physical findings.

During Period B the role induction was used systematically with all patients screened. Eighty-three percent of the patients returned for therapy after the feedback session. The low dropout rate of 17 percent is particularly impressive because it included patients who were referred elsewhere. Our current (1991) dropout rate after the first session is 10 percent or lower.

REFERENCES


