Figure 13a. The patient is shown the discrepancy between his SUDS scale and the objective EMG measure.

to his or her own body. In high hypnotizables one must dilute this demonstration and use it cautiously lest it trigger an exacerbation of the pain by suggesting that the patient should be having more pain than the patient is currently reporting. 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. Hypertension is another example of a psychologically silent, but physiologically important, change that has health consequences. I have found that this verbal-subjective versus EMG (frontal) discrepancy is nearly always quite large in patients with chronic functional disorders. (See Figures 13a, 13b.)

The procedures cited usually have a startling and credibility-building effect on the patient. It often induces a shift in the manner in which the patient perceives physical symptoms that is similar to opening an entirely new sunroof in the patient's head. It also provides a credible face-saving biological rationale for the physical symptoms that may, in fact, be the final common pathway for multiple psychosocial conflicts in the patient's life.

Wicicaramasakura (1988)
Figure 13b. Pretherapy low-hypnotic-ability (female patient, age 41 years).

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 a biomedical model in which the patient is the passive recipient of treat-