Somatizers, the Health Care System, and Collapsing the Psychological Distance That the Somatizer Has to Travel for Help

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The somatizing patient is a major challenge for differential diagnosis, referral, and therapy. An investigative–diagnostic model is presented composed of four sector combinations of pathophysiology and psychopathology. I present a logical analysis of the apparent tacit conspiracy of silence among the somatizing patient, the physician, and the health insurance industry with regard to the psychosocial factors contributing to somatization. There is a need to find psychophysiological alternatives to repeated biomedical investigations that are clinically unproductive and iatrogenic. Two alternative psychophysiological pathways (the High-Risk Model and the Trojan Horse Procedure) may reduce in the somatizer’s mind the vast psychological distance (often several light-years) from the physician’s to the psychologist’s office.

"Sometimes it is more important to know what kind of patient has a disease than what kind of disease the patient has."—Sir William Osler (Straus, 1968, p. 3)

Somatizers are people who transduce psychosocial conflicts into somatic complaints and disorders such as chronic muscular and vascular headaches, irritable bowel, and chronic low back pain. These symptoms are among the most common physical complaints seen by primary care physicians in the United States. These patients present these chronic and recurrent physical complaints in the absence of serious or identifiable pathophysiology (Barsky & Klerman, 1983; Houp, Orleans, George, Keith, & Brody, 1980; Lowy, 1975). Seldom do these patients show evidence of obvious or serious psychopathology (Jenkins, 1985).

It has been estimated that more than 50% of patients seen by primary care physicians in the United States today are somatizers (Barsky & Klerman, 1983; Brown, Robertson, Kosa, & Alpert, 1971; Garfield, et al., 1976; Jenkins, 1985). There are several indicators that the profile of illness presented to the nation’s primary care physicians in the last 50 years has changed dramatically from acute infectious bacterial diseases of chance (e.g., cholera, smallpox, and tuberculosis) to chronic psychophysiological stress-related disorders of choice (e.g., cardiovascular disease and musculoskeletal disorders) in which somatization can be a major component. For the new chronic disorders, behaviors and life-style choices are major risk factors.

Clearly, complex psychosocial stressors related to family, marriage, and work, in addition to intrapsychic conflicts, contribute to the rate of somatization today. There is evidence that this large subset of somatizing patients significantly overuses medical services (Cummings, 1977; Mumford, Schlesinger, Glass, Patrick, & Cverdon, 1984), contributing through repeated hospitalizations, diagnostic tests, and medications to the rapidly escalating cost of health care. Health care is today almost 11% of the gross national product (W. S. Cohen, 1985). These patients’ somatic symptoms are pervasive and chronic. Primary care physicians typically palliate these patients’ symptoms with analgesics, tranquilizers, antibiotics, and sleeping pills and seldom treat the underlying psychosocial etiologic component of their somatic complaints. These patients often become a continuing, inappropriate, and massive drain on the expensive and precious medical resources of this country. Chronic medical palliation (Orleans, George, Houp, & Brodie, 1985) can and often does develop new problems of chemical and polysurgical addiction (Melzack, 1973), drug tolerance, and many negative physical and psychological side effects (Aronoff, 1985; Cummings, 1979).

In this article I present a model for differential diagnoses of various combinations of physical and psychophysiological test findings. I point out that there appears to be a tacit conspiracy of silence among physicians, patients, and health insurance companies with regard to the psychosocial components in somatic symptom presentations. It is unlikely that this tacit conspiracy of silence regarding the psychosocial factors in somatic presentations will end until there are effective psychosocial alternatives to repeated biomedical investigations of the somatizing patient. The High-Risk Model (Wickramasekera, 1979, 1983, 1984, 1986a, 1987a, 1987b), the Trojan Horse Procedure (Wickramasekera, 1979, 1983, 1986b, 1988), and psychophysiological therapy (Wickramasekera, 1988) are presented as promising alternatives to further clinically unproductive and iatrogenic biomedical investigation of the somatizing patient.

Today we distinguish psychophysiological or functional so-
Physiological Findings

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Psychophysiological Findings

- Psychophysical findings that account for physical symptoms independently of physical findings. The identification of such high-risk psychophysiological variables would have profound implications for diagnostic practice, as well as for therapy and for primary prevention (Friedman & Booth-Kewley, 1987). For example, the presence of positive psychological findings in a patient can help the clinician to inhibit his or her tendency to submit the patient to extensive physical investigations that could increase the probability of identifying and then treating a false positive physical etiology and producing an iatrogenic condition. An example of this would be unnecessary back surgery for benign and self-limiting back pain (Foydye, 1980).

Basing the diagnosis of psychophysiological disorders mainly on the exclusion of physical findings is not a rational procedure because it is possible that the appropriate physical investigation was not done (Hall, 1980). In fact, this approach implies that patients with physical complaints whose medical tests fail to yield positive and independent psychophysiological findings should receive the most complete and careful physical investigations.

Some physical complaints (e.g., headaches and backaches) can be accounted for either by positive physical findings (e.g., a brain tumor or a herniated disc) or, alternatively, by positive psychophysiological findings such as functionally based high levels of muscle tension (Flox, Turk, & Birbaumer, 1985) or neuroticism (Eysenck, 1983), or both. Patients who present physical complaints (Wickramasekera, 1986a, 1986b) can be grouped into four cells (see Figure 1) on the basis of the demonstrated presence or absence of identifiable physical findings from physical examination and laboratory tests or identifiable psychophysiological findings (from psychological and psychophysiological tests).

Cell 1 is an instance of both positive physical findings and positive psychophysiological findings. A patient in this cell can present with chronic headaches and on investigation is found both to have a brain tumor and to be anxious and depressed. The anxiety and depression could be secondary to and amplifying (Melzack, 1973) the sensory pain component that results from the brain tumor. Empirical studies have shown that psychosocial factors (Melzack, 1973) can amplify sensory signals from pathophysiology, which accounts for approximately 50% of the variability, for example, of postsurgical measures of acute pain (Taenzer, Melzack, & Jeans, 1986). However, in certain people who are prone to somatize, the anxiety, the depression, and the pain may persist even after the brain tumor is removed.

An instance of a patient in Cell 2 is one who presents chronic low back pain in the absence of a herniated disc or other appropriate physical findings (Fior & Turk, 1984) but who is depressed and anxious and sleeps poorly at night. These patients' responses to therapy frustrate the best diagnostic, surgical, and chemical efforts of physicians. Physicians find patients in Cell 2 the most difficult to manage therapeutically.

A patient in Cell 3 can present acute low back pain that is secondary to a herniated disc with nerve root involvement and without enough time for psychological elaboration and amplification of the back pain. Surgical repair is followed by rapid resolution of the physical complaint (Hirsch & Nachemson, 1963). Current medical education prepares physicians best to treat only this type of patient.

A patient in Cell 4 may present headache pain in the absence of positive physical or psychophysiological findings. These negative findings (Hall, 1980) may be attributed to insensitive or inappropriate physical and/or psychophysiological tests and examinations.

Why do somatizing patients in general remain doctor shopping in the medical/health care system, when in fact they are treated ineffectively and expensively and often receive iatrogenic injury from tests, therapies, and hospitalizations (Arnow, 1985; Benson, 1979)? It is because there is often a tacit conspiracy of silence among the patient, the physician, and the health insurance industry with regard to the psychosocial factors that can cause or amplify their somatic disorders and diseases.

The Patient

There are several plausible reasons for the tacit conspiracy of silence on the patient's part. The patient may prefer to think he or she has a somatic illness, or to have a medical diagnosis rather than a psychiatric or psychological diagnosis, for several reasons. A medical diagnosis avoids the stigma of mental illness and the consequent negative social and vocational consequences. A medical diagnosis often reduces the cost (the deductible) to the patient of tests and treatments. Medical diagnoses, unlike psychiatric diagnoses, have more and longer health insurance benefits periods and are more readily and richly reimbursable. Hence the presentation of psychosocial conflicts as physical symptoms is reinforced by potent personal, social, vocational, and financial consequences. The somatic packaging of psychosocial conflicts increases their reimbursability and social acceptance.

The Physician

There are several complex and plausible reasons for the tacit conspiracy of silence on the part of the primary care physician. First, because these patients represent approximately 50% of a
primary care physician’s practice (Barsky & Klerman, 1983), the physician cannot reasonably be expected to refer out 50% of his or her patients and reduce his or her gross income by approximately 50%.

Second, in spite of repeated negative medical tests and potent therapies, the patient still continues to have somatic complaints such as headache, chest pain, gastrointestinal distress, backache, and so on. On the basis of a careful history, a physical exam, and appropriate medical tests that have failed to reveal identifiable or serious pathophysiology, medical reassurance fails to durably reduce the intensity and frequency of the somatizing patient’s physical complaints for long. In this frustrating situation, the conscientious physician may question his or her own medical competence and feel that he or she has missed some moderate or serious pathophysiology because the patient’s physical symptoms persist. This concern about missing something may be reinforced by the physician’s fear of the increasing numbers of malpractice lawsuits that could ruin the physician. The physician’s fear of missing something and of malpractice lawsuits, in addition to the patient’s insistence on a medical definition and a solution to the somatic complaints, are jointly potent incentives to order a new series of tests, more specialist consultations, more hospitalizations, and new medical treatments. It is also known that approximately 10% of patients with psychiatric or psychological problems (Cell 1) have diagnosable pathophysiology (Hall, 1980).

Third, the average primary care physician’s training and confidence in his or her psychosocial diagnostic skills is not extensive (Houpt et al., 1980; Jencks, 1985; Orleans et al., 1985). In fact, psychiatric training is often the smallest, weakest, and least popular component of a physician’s medical education (Light, 1980; Nielsen & Eaton, 1981). As a previous editor of the New England Journal of Medicine has said, a physician’s education and practice should stress the diagnosis and therapy of acute, serious, life-threatening conditions (Ingelfinger, 1978). Psychosocial factors are regarded as trivial and transient in the biomedical model (Engel, 1977). Psychosocial and behavioral factors contribute mainly to chronic disease, and these factors are in fact regarded as epiphenomena in the biomedical model of acute disease in which physicians are primarily educated (Engel, 1977). Because of conceptual bias, lack of interest, and poor psychosocial investigative skills (Jencks, 1985; Orleans, et al., 1985), the primary care physician is very likely to ignore or miss important psychosocial risk factors that can cause or amplify chronic somatic complaints.

A fourth reason is the current lack of empirically validated, potent, objective–quantitative psychosocial risk factors that can independently account for somatic complaints in the absence of pathophysiology. In fact, if such documented potent psychosocial risk factors existed, they would substantially reduce the conscientious physician’s legal vulnerability when he or she refers a somatizing patient to a clinical psychologist. Such psychosocial risk factors could also significantly increase the physician’s personal confidence that the puzzling patient is embarked on a rational course of psychosocial investigation and specific therapy. I have, in fact, elsewhere (Wickramasekera, 1979, 1983, 1984, 1986a, 1987a, 1987b, 1988) proposed such a comprehensive set of psychosocial risk factors that are operationally defined and permit empirical validation, identification, and testing of patients who are likely to be or are suspected of somatizing. These psychosocial factors are called the High-Risk Model (Wickramasekera, 1979, 1983, 1984, 1986a, 1987a, 1987b, 1988) and are discussed later.

The Health Insurance Company

Why is the health insurance company likely to concur with this tacit conspiracy of silence regarding the psychosocial factors in somatization? There are several reasons why the health insurance company is unlikely to raise questions concerning psychosocial factors in a somatizing patient’s condition. First, medical doctors, unlike psychologists, are well represented on the policy-making boards of health insurance companies. It is unlikely that questions concerning the psychosocial component of the somatizing patient’s problem will be raised by physicians because of the constraints of their limited psychiatric education and because such questions could only jeopardize 50% of their income from a frustrating but reliably lucrative patient source. Second, in recent years there has been a proliferation of heterogeneous mental health providers, and they are all clamoring for insurance reimbursement. This proliferation causes the health insurance companies confusion about the qualifications of legitimate providers and economic distress over the increasing number of providers to be “fed” from the shrinking mental health dollar.

Hence, there are clearly powerful financial, social, educational, legal (malpractice), and personal–psychological reasons for the patient, the physician, and the health insurance industry to maintain a tacit conspiracy of silence regarding the psychosocial factors that contribute to somatization.

The Need to Explore Alternatives to Further Biomedical Investigations

Because of the ineffectiveness, high costs, and health risks associated with some repeated medical investigations (Frazier & Hiatt, 1978; Relman, 1980; Tancredi & Baroness, 1978) and therapies of the somatizer (Barsky & Klerman, 1983), there is a real need for a credible and face-saving rationale for the frustrated and angry physician and the disappointed patient to call a halt to more unproductive medical investigations. Such a rationale will at least have to include the following components. First, there is a need to establish that some serious undiagnosed pathophysiology is very unlikely in a specific case. A careful history, a physical examination, appropriate medical tests, and consultations with specialists can establish this conviction. Even if there are positive or borderline physical findings, the physician knows that there are many instances in medicine in which positive physical findings alone cannot account for clinical symptoms. For example, degenerative diseases of the spine are considered to be a primary cause of chronic back pain (Flor & Turk, 1984). Specific postulated degenerative mechanisms include disc hernia, spondylodiscitis, osteoarthritis, transitional vertebrae, and so on. Schmorl and Junghanns (1932), in their classic autopsy studies of 4,353 spines, found that by age 50, half of the population have degenerative changes in the spine; 70% of the population show degenerative changes by age 60, and 90% by age 70. X-ray studies of the general population confirm these
figures (Hult, 1954). Fifty percent of the population at age 50 do not complain of chronic low back pain! In fact, Magora and Schwartz (1980) found that single disc degeneration occurs more frequently in people who have never complained of back pain than in those who have complained of it. Nor does empirical evidence support other postulated pain mechanisms (e.g., inflammatory, structural, traumatic, and muscular) as conditions that are either essential or sufficient for the complaint of chronic low back pain (Flor & Turk, 1984). These data suggest that pathophysiology may be neither essential nor sufficient to present the complaint of chronic back pain.

Second, because the patient’s somatic symptoms persist, there is a need to empirically document the fact that an alternative set of psychosocial risk factors can account for this patient’s somatic symptoms in the absence of any pathophysiology. Also, that alteration of these psychosocial risk factors is reliably associated with the remission of somatic symptoms. Positive psychosocial test findings can provide the physician with credible independent confirmation of his or her original clinical judgment (based on history, physical, and negative laboratory tests) that not only has he or she not missed serious pathophysiology but that there is in fact psychosocial test evidence that confirms the physician’s clinical intuition that psychosocial factors are in fact contributing to the patient’s somatic complaints. Osler’s statement, “Sometimes it is more important to know what kind of patient has a disease, than what kind of disease the patient has” (Straus, 1968, p. 3), is very relevant to this point. The High-Risk Model (Wickramasekera, 1979, 1983, 1984, 1986a, 1986b, 1987a, 1987b) that I have proposed operationalizes Osler’s intuition into a model that is logical and has some empirical support, but it needs more independent empirical testing and validation.

The High-Risk Model

The High-Risk Model has three components: predisposers, triggers, and buffers. The three predisposing personality variables are (a) very high or very low hypnotic ability, (b) catastrophizing cognitive habits (Ellis, 1962), and (c) negative affectivity (Costa & McCrae, 1985; Watson & Clark, 1984; Watson & Tellegen, 1985) or neuroticism (Eysenck & Eysenck, 1968). The two triggering situational variables are major life change (Holmes & Rahe, 1967) and an accumulation of minor hassles (Kanner, Coyne, Schaefer, & Lazarus, 1981). The two buffering variables are the availability and use of (a) support systems (S. Cohen & Wills, 1985; Sarason, Levine, Basham, & Sarason, 1983) and (b) coping skills (Argyle, 1981; Rosenbaum, 1980). The buffering variables reduce the probability that an increase in the triggering variables will be associated with the onset of somatic or psychological symptoms. The predisposing variables increase the probability that the triggering variables can be associated with the onset of somatic or psychological symptoms. A combination of these predisposing, triggering, and buffering variables is hypothesized to account for the bulk of the variance in predictions of the onset, the offset, and the stability of clinical symptoms (see Figure 2).

Positive test findings on this or another high-risk model can provide useful information and a rational explanation of the patient’s persisting somatic complaints that are independent of identifiable pathophysiology to a frustrated physician who is stuck with a puzzling, angry, and demanding somatizing patient. The conscientious physician, who has done a complete but unproductive medical investigation for pathophysiology, can feel relieved and medically and legally justified after such medical and psychosocial High-Risk Model testing when the physician refers the patient for psychophysiological therapy (Wickramasekera, 1988) for somatic complaints. Such joint investigations for pathophysiology and psychosocial risk factors could reassure the conscientious physician that he or she is making a rational referral and that the patient is launched on a rational and conservative course of therapy with some prospect of palliation of somatic symptoms, if not specific therapy, for the specific etiology (e.g., psychosocial conflicts) of the patient’s somatic complaints. A conservative therapy, that unlike chronic palliative use of tranquilizers and pain medications or irreversible surgical mutilations, will not cause new negative physical and psychological problems.

The Somatizer and the Psychological Referral

The physician knows that this kind of patient, the somatizer, is unlikely to accept and complete a conventional psychological or psychiatric referral and evaluation. The typical psychological or psychiatric evaluation has zero face validity for chronic low back pain or for a patient with headache pain that is associated with sustained contraction of head or neck muscles, extra- and intracranial vasodilatation, nausea, and vomiting. Hence, such a referral will provoke skepticism at best and perhaps even anger. The somatizing patient remains committed to a medical definition and resolution of his or her somatic complaints, and any referral to a “shrink” is seen as an insult or challenge to the authenticity of his or her obvious somatic symptoms. In spite of the physician’s suspicions to the contrary, the patient may be unaware that he or she has any psychosocial conflicts (DeGood,
unaware that his or her psychosocial conflicts can trigger muscle spasms and vascular contractions, and/or unaware that physiologically he or she is chronically in a "fight or flight" or stress mode (Wickramasekera, 1976, 1988). In fact, for example, nearly all mild to moderate hypertension has no conscious verbal subjective correlates, such as "my blood pressure feels high," that are identifiable by a patient (Pennebaker, 1982).

It is precisely for these reasons that even unsystematic and adjunctive therapies such as biofeedback and stress management, in which one directly and obviously uses and monitors physiological functions, have higher face validity for the somatizing patients than does a conventional psychological interview. Psychological referrals are unacceptable to the somatizing patient who (a) keeps mind and body in separate cognitive compartments, (b) does not believe that his or her mental-emotional changes can alter biological functions, and (c) may not subjectively feel physiologically or musculey braced or stressed. Hence to engage such a patient productively and efficiently in any therapy, there must occur certain minimal changes in his or her perception of the clinical situation. First, the patient needs to see and experience personally and repeatedly in objective and quantitative terms, in perhaps a psychophysiological laboratory situation, that the mind can alter biological functions. Second, he or she may also need to be shown and to recognize that his or her body is chronically on red alert at work or at home, or both. Subjectively, the patient is often totally unaware, for example, that parts of his or her body are chronically vasoconstricted (e.g., cold or wet hands and feet) or musculey braced in specific psychosocial situations at work or at home, or both. Third, he or she may need to recognize that he or she is subjectively unaware or has psychosocially habituated (Wickramasekera, 1976, 1988) or adapted to this abnormal chronic red-alert status, which may be contributing to his or her somatic complaints.

Psychophysiological Therapy: The Referral and the Trojan Horse Procedure

Psychophysiological therapy can be defined as the use of objective and quantitative physiological and psychological monitoring and measuring devices to potentiate awareness of complex physical and emotional learning and discrimination about psychotherapeutic mind-body relationships (Wickramasekera, 1988). This is done through mechanisms that identify, amplify, and track the conscious and unconscious physiological antecedents, concomitants, and consequences of complex cognitive and emotional events (Wickramasekera, 1976, 1979, 1988).

If a trial of psychophysiological therapy is indicated, the central problem confronting the primary care physician is to find a reliable and plausible bridge to carry the somatizing patient out of the physician's office and into the office of the psychophysiological therapist. The somatizer typically perceives the psychophysiological distance between the primary care physician's office and a psychologist's office as several light-years. If the somatizer enters the psychologist's office, the immediate problem is to find a method to engage such a somatizing patient in psychotherapy in a way that has high face validity for the patients' presenting somatic symptoms.

I have proposed (Wickramasekera, 1979, 1983, 1986b, 1988) precisely such a bridge and method: the Trojan Horse Procedure, which is the biological packaging of a psychological intervention that reduces both the psychological and the physical distance between the primary care physician's office and the psychologist's office. The Trojan Horse Procedure provides a psychophysiological bridge from the biomedical model, in which the patient is a passive recipient of services, to the biopsychosocial model (Engel, 1977), in which the patient is an active participant. The latter model is more nearly an educational one in which the doctor is really a teacher, as the word doctor originally implied, and the patient is a student.

The Trojan Horse Procedure reduces the physical distance between the physician's office and the clinical health psychologist's office by relocating the psychologist's office inside the physician's office or right next door. From this location, the clinical health psychologist can function as a peer and expert consultant to the MD on issues of mind-body interaction. The psychologist's role is that of an expert who does not duplicate the physician's training but has a different and useful set of psychosocial investigative skills. The psychological distance is reduced through a set of psychophysiological role-induction techniques that are described elsewhere (Wickramasekera, 1979, 1983, 1986b, 1987b, 1988). These role-induction techniques involve three types of psychophysiological demonstrations or show-and-tell procedures. The Trojan Horse Procedure provides a cognitive objective and quantitative evidence that (a) the mind can alter biological functions, (b) the patient's body is chronically on red alert, and (c) the patient has psychosocially habituated to a chronic abnormal biological state of which he or she is unaware.

The goal of the Trojan Horse Procedure is to circumvent and disengage the psychological defenses of denial and skepticism in regard to mind-body interaction. It does this by objectively, quantitatively, and experientially demonstrating on the patient's own body that mind and body are closely connected. For example, if the Harvard Scale (a component of the High-Risk Model) reveals that the patient has superior hypnotic ability (scores between 12 and 10), one can confidently use suggestion, only with the patient's consent, to demonstrate a catalepsy in regions of the patient's body far removed from the area of the presenting symptom or symptoms. For patients of moderate or low hypnotic ability (approximately 90% of the general population), biofeedback instruments can be used to demonstrate the dramatic effects of performance stress generated by simple mental arithmetic on blood pressure, heart rate, muscle tension (through an electromyograph, or EMG), skin conductance, and so on.

A personal experience is often worth many explanations for the skeptical patient. Many of these patients believe in nothing that they are told and less than half of what they can be shown; they may be assumed to share the motto of Missouri, the "show me" state. The Trojan Horse Procedure can be defined as a psychophysiological role induction that is facilitated by physiological (EMG, electrocardiograph, galvanic skin response, etc.) and psychological (Harvard Scale, Barber Hypnotic Scales, Eysenck Scale, etc.) monitoring and measurement instruments. The Trojan Horse Procedure is in essence a psychophysiological role induction that has at least four features detailed elsewhere (Wickramasekera, 1979, 1987b, 1988). It can provide for the
patient (from the results of the hypnotic and/or the psychophysiological stress test) a face-saving and plausible rationale for the somatic symptoms (e.g., a hypnotic demonstration of cognitive amplification or creation of somatic symptoms, or muscular braking as indicated by high and sustained baseline EMG levels and/or delayed recovery from mental arithmetic stress).

The Trojan Horse Procedure provides an empathic, but objective, quantitative approach and a psychophysiological laboratory demonstration in which, initially, the psychologist may ask somatic questions that are even more specific than those asked by the primary care physician. This objective, quantitative, and biological approach reduces the discontinuity between the physician and the psychologist and seems to quickly collapse the psychological distance between the physician's and the psychologist's procedures (Wickramasekara, 1979, 1983, 1986b, 1987b, 1988). This up-front attention to and acceptance of these patients' somatic symptoms disarms their motivation to resist the psychophysiological investigation. Eventually the somatizing patient can be lead by the psychophysiological therapist out of the somatic closet onto the psychotherapy couch.

Conclusion

In summary, until primary care physicians are aware of potent and validated clinically efficacious models of psychosocial risk factors for somatization, powerful legal and economic incentives ensure that they will continue to limit their investigations of the somatizer to the biomedical model (Engel, 1977). The empathic but objective and behaviorally–biologically focused Trojan Horse Procedure conducted in the psychophysiological laboratory can begin to collapse psychological space for the somatizer. The Trojan Horse Procedure (or some other psychophysiological role induction procedure) and a model of high-risk psychosocial factors may jointly reduce the vast psychological distance that the somatizing patient has to travel today from a commitment to a biomedical model to a commitment to a psychophysiological model of the etiology and therapy of his or her complaints. Until the somatizer's perception of the psychologist is altered, this patient will be unable to use the psychologist's skills. These patients have to be met at least half-way by the psychologist, and he or she can approach them without threatening them if he or she uses the High-Risk Model and the Trojan Horse Procedure.

The psychophysiological therapist needs to be very familiar with medical knowledge on the etiology, diagnosis, tests, and therapies of the limited number of psychophysiological disorders that he or she treats.

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