Collaborative Treatment for the Psychosomatic Couple
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This article reflects on the conceptualization and treatment strategies associated with a systems perspective of the somatic couple. It is suggested that resistance to change, nurturance of the somatic patient by his or her partner, and rigid role taking serve to promote relationship stability and individual pseudopower at the cost of patient health. The authors suggest that psychotherapists can aid primary care physicians in more effective treatment for somatizing patients by educating physicians about the role of the couple relationship in the maintenance of somatic disorder, how the somatizing patient can triangulate health care into an unstable dyadic relationship, and the usefulness of a multidisciplinary, contextual approach to the treatment of somatization. A case example is offered to demonstrate these concepts.

Keywords: collaborative treatment; psychosomatic families; somatization; systems approach; triangulation

One of the frustrations experienced by primary care doctors is managing somatizing patients who significantly increase caseloads (deGruy, 1996). Referral of the somatic patient for psychotherapy is often blocked by the patient seeking ongoing symptom relief from a doctor or doctors who, in turn, feel compelled to attempt to provide that relief. It seems that patient care leads to a greater dependency on patient care for this population (Willi, 1975/1982). Somatization may be simply defined as psychological distress making a presentation in physical symptoms (Willi, 1975/1982), and it is the premise of this article that psychotherapists can aid primary care physicians in more effective treatment for somatizing patients by (a) educating the physician in understanding the significance of the marital or couple relationship in the establishment and maintenance of somatic disorder, (b) educating the physician in how the somatizing patient can triangle health care providers into an unstable dyadic relationship in order to distract and attempt to bring balance to the unstable dyad, and (c) facilitating through education and networking, a multidisciplinary systems approach to the treatment of somatization. In line with these above goals, we will suggest a systems theory perspective of somatization that describes an unconscious collusion between physicians and their patients that actually maintains symptoms. We will then suggest a multidisciplinary, biopsychosocial treatment protocol that will enable patients to accept referral with greater equanimity and deal with dyadic issues that often reside at the core of the disorder.

The American Psychiatric Association's (2000) Diagnostic Statistics Manual (4th ed., text revision), or DSM-IV-TR, defines somatization disorder more fully as a pattern of physical complaints that result in treatment being sought or significant impairment in social, occupational, or other important areas of functioning that cannot be fully explained by known general medical conditions or are in excess of what would be expected from the patient's history and physical examination of laboratory findings. Such a presentation of psychological distress that does not appear to have a physiological basis creates a source of frustration for primary care providers and constitutes a significant impact on limited medical care resources (DSM-IV-TR, 2000; Kaplan, Lipkin, & Gordon, 1988; Smith, Monson, & Ray 1986). In addition, patients with somatic symptoms exhibit a lower quality of life and higher levels of emotional distress than nonsomatizers (Ladwig, Marten-Mittag, Erazo, & Gundel, 2001).

Somatization has extensive implications for the somatizing patient, his or her health care provider and the health care system in general. Research indicates that 38% to 60% of patients in the primary care medical setting present with problems that have no serious medical basis (American Association of Family Practice, 1995; Miranda, Hohmann, &
Attkison, 1994; Narrow, Reiger, & Rae, 1993; Norquist & Regier, 1996). Somatizing patients utilize 50% more primary care medical services than other patients on physician case-loads (DeGruy, Columbia, & Dickinson, 1987). Somatizing also accounts for 14 times the U.S. per capita physician charges and 6 times the per capita of overall health care expenditures. The problem of somatization is widespread, as patients presenting with somatic symptoms are just as likely to present in urban primary care clinics as in more affluent clinics (Feder et al., 2001).

SYSTEMS PERSPECTIVE

Systems theorists have suggested that family functioning plays an important role in the development and maintenance of somatic symptoms and that such symptoms are associated with unresolved family conflict. Systems theory proposes that somatic symptoms serve to maintain the dynamic balance of families, allowing individuals to express emotional needs that would normally disrupt the system in an acceptable manner (Bowen, 1978; Haggerty, 1983; Minuchin, 1974; Minuchin, Rossman, & Baker, 1978; Roy, 1982; Turk & Kerns, 1985; Waring, 1986). Minuchin (1974) developed the concept of the somatic family observing that families of somatic children appear to be more rigid, enmeshed, and avoidant of negative communication. Minuchin proposed that somatic symptoms in children are ways of expressing emotional distress within families in which one cannot deviate, rebel, or communicate openly. Somatic symptoms express distress in a manner that does not violate the rules of such families.

Based on the somatic family formulation, Waring (1983) suggested the concept of the psychosomatic marriage. Consistent with Minuchin, Waring proposed that somatic symptoms are a means of expressing emotional distress within marital relationships characterized by enmeshment, rigidity, and avoidant communication. In such marriages, changes in roles, distance, and negative emotion are not tolerated, and somatic symptoms function to express distress, although not disrupting the basic structure of the marriage.

Although the family psychology literature has continued to write about the concepts of somatic families and psychosomatic marriage, there is little empirical research on the subject (Onnis et al., 2001; Von Schlippe, Theiling, Lob-Corzilius, & Szczepanski, 2001). Sayre’s (2002) study is one of the first to empirically test the concept of the psychosomatic marriage, with somatization recognized, in part, as a systemic strategy for maintenance of homeostasis in the relationship. The somatizer’s poor interpersonal communication facilitates indirect symbolic communication of emotional aspects of the relationship, which both partners find safer or less threatening than direct verbal communication. Black and white logic keeps the system resistant to change, constantly moving in the direction of increasingly rigid role taking in the pursuit of stability, whereas a rigidly enmeshed system keeps the dyad from dealing directly with underlying relational conflicts (Miehls, 1996; Retzer, 1991).

The presentation of somatization works in the service of maintaining pseudopowerful, rigidly defined roles in the dyadic relationship. The nurturing role of the nonsomatizer offers him or her an unrealistic sense of power as caregiver in the relationship but of course does so at the cost of the health of the partner. A relational dance around symptoms creates an equally unrealistic position of power for the patient, whereas focus on physical symptoms by the dyad distracts from underlying relational conflict and dysfunctional attachment styles, which ultimately reinforces a sense of underlying dyadic impotence as well as individual despair (Taylor, Mann, White, & Goldberg, 2000).

ROLE OF HEALTH CARE PROVIDERS IN THE MAINTENANCE OF SOMATIZATION

Somatization is a significant source of frustration for primary care providers (Kaplan et al., 1988), in part because patients are highly resistant to referral for psychotherapy and in part because patients often exhibit a lack of introspection into the true causes of illness manifestations. The physician may welcome the psychosomatic patient at first because the patient is knowledgeable regarding his or her physical symptoms and rejects the existence of psychological symptoms. The physician may not delve into psychological symptoms or causes for psychosomatic symptoms because he or she has a full and busy caseload and/or feels obligated not to pry into the patient’s psychological history. Consequently, a collusion where the “unconscious interplay of two or more partners which is concealed from both of them” ensues between the psychosomatic patient and his or her physician(s) (Willi, 1975/1982, p. 55). Typically, the collusion breaks as the client finds that his or her symptoms persist, and the clinician becomes irritated with both the lack of cause for the symptoms and the ongoing complaints of the patient. This is the point where the physician may refer the client to another doctor and the cycle of collusion begins all over again (Willi, 1975/1982).
The somatizer’s lack of introspection, worry about psychological issues, and resistance to psychological treatment is more easily understood when seen as an operation of relational homeostasis (Bridges, Goldberg, Evans, & Sharpe, 1991; Kirmayer & Robbins, 1996). Triangulation with the health care system maintains homeostasis because traditional medical treatment reinforces the sense of underlying impotence on the part of the couple dyad. The physician either denies or discounts the reality of symptoms reported by the patient and often cannot or will not provide biopsychosocial explanations that account for the symptoms. The physician inadvertently joins the dysfunctional system in overconcern about and treatment of benign and or stress-related somatic symptoms (J. Skidmore, personal communication, February 25, 2002).

Health care system triangulation may be best understood when health care delivery is defined by first and second order change. The medical field operates from a positivistic position conceptualized as first order change. First order change is defined as “change within the normal definitions, understandings, premises, rules and practices of a given system, i.e. change in frequency, intensity, location, duration and so on of a given practice or action” (Fraser & Solovey, 2006, p. 194). The medical practitioner is compelled to enact treatments that are symptom oriented and may not get at the core issue(s) when the issues are psychological in nature. Second order change, however, focuses on the following:

A change of the premises, definitions, assumptions, practices and traditions of a given system of relationships—it most often represents a counterintuitive stepping out—or a reversal—of the commonly held ideas on the nature of a situation and its logical or reasonable solutions. (Fraser & Solovey, 2006, p. 195)

Second order change conceptualization and intervention are routinely embraced by family psychology that emphasizes symptoms-in-context in a biopsychosocial model of change. A biopsychosocial model recognizes the role that biological, psychological and social factors play in intrapersonal and interpersonal health (Engel, 1977). The goal for the family psychotherapist is to facilitate a multidisciplinary approach and reorient the medical practitioner and psychosomatic patient to the importance of context, exploring core issues that may find their etiology in deficits of relationship intimacy (in the broadest sense) between the psychosomatic patient and his or her partner. Thus, through a process-oriented approach, the tackling of both symptoms and symptom causes will more fully facilitate second order change.

Moving the focus of treatment from physiological pathology to relationship intimacy will require a strategic alliance between the psychotherapist and the primary care physician in drawing the psychosomatic patient’s partner into the health care process. The implications for this are particularly useful in that the psychosomatic patient often resists the suggestion that personal psychological issues play a part in symptom expression, so that, by including the partner, a shift in focus from identified patient therapy to couples’ therapy occurs and may be more palatable to the patient. Pathology is externalized and conceptualized in terms of enhancement of intimacy rather than treatment of individual pathology.

**IMPLICATIONS FOR TREATMENT**

The theoretical framework arising from the work of Minuchin (1974) and Waring (1986), and the research of Sayre (2002), appeals to a contextual or systemic understanding of somatization. That is, somatization is as much a product of environmental or interpersonal pressures as it is of biomedical or intrapersonal determinants. Such a contextual understanding has implications for the couple’s course of treatment. The following case serves to illustrate the dynamics around the psychosomatic relationship. We will note the contextual nature of the diagnosis around marital and health care issues.

Mr. and Mrs. X are an African American couple who have been married for 22 years. They have three children, two of whom are still living. Their oldest child, a daughter, was killed in an automobile accident 4 years ago. Mr. X, age 46, works as a high school teacher and Mrs. X, age 44, is a trained paralegal. When asked, they report that they have not ever really talked about their daughter’s death. In the past year the issue of placing a headstone at the gravesite has been raised, and although the couple acknowledges their agitation in a cursory fashion, they do not discuss their feelings. The couple is religious and believes that to acknowledge grief is a sign of lack of faith in God. Mr. X, as a deacon in his church, has been adamant that they trust their daughter to God and focus on the children still with them.

In the past year, Mrs. X approached her primary care physician regarding lower back pain. She defined the pain as an excruciating prickly sensation, radiating from the region of her coccyx down into her buttock, moving into her thigh. During this time, Mrs. X had to take a leave of absence from her job due to pain, and Mr. X picked up secondary income doing youth ministry at the church. History reveals that Mrs. X’s father, aged 63, has had symptoms of lower back pain for the previous 10 years.

The physician thought that she might be suffering from sciatica; an ultrasound was performed, and the diagnosis was inconclusive. Her physician suggested Mrs. X see a psychologist to discuss emotional issues around her daughter’s death, but she resisted the idea, stating that the family is dealing with that issue in a spiritual way. Over the course of the year, Mrs. X saw a plethora of specialists who variously diagnosed a bone spur, disc tissue damage, and sciatica, but none actually found signs to accompany Mrs. X’s symptoms. Doctors prescribed regimens of spinal injections, narcotics, tranquilizers, tricyclics, and pain management therapy.

The above case example illustrates several issues pertaining to the treatment of somatic patients and psychosomatic marriage. First, relational issues may be considered as a
potential differential diagnosis or co-occurring diagnosis with somatization. A contextual or systems perspective will recognize the recursive impact of the dyadic relationship on the physiological life of the somatizer, and the impact of somatopsychic life on the dyad. For instance, the symptoms Mrs. X manifests are more easily understood as a coping mechanism and method of expression when viewed within the overall context of her life events. The family has adopted a relatively rigid schema for handling psychic pain, a spiritual stiff upper lip so to speak. The physical pain that Mrs. X experiences is allowable, whereas emotional expression is not. Furthermore, physical pain as a coping style seems to be a family legacy, given the similar symptomatology of Mrs. X’s father.

Second, thinking about somatization in terms of both medical symptoms and relationship factors affects treatment strategy. A traditional symptom focused approach results in a temporary masking or amelioration of symptoms, but the root cause will remain unchanged. Symptoms are likely to remain in similar or changed form but remain in the service of homeostasis. Like the monster Mothra in the old Japanese horror movies that gained strength from the bullets and bombs meant to destroy it, pain simply becomes more entrenched as medicine throws every measured treatment its way. The simple lesson is to follow one’s informed intuition and find a way around patient resistance to secure therapies that will result in reduction in physical, psychic, and relational pain.

Finally, a contextual approach argues for process-oriented collaboration. Process-oriented collaboration promotes the “simultaneous targeting of interventions at the different levels of all the systems involved with the patient, physicians, other professionals, and family” (Pace, Chaney, Mullins, & Olson, 1995, p. 133). Targeting multiple problems at multiple levels of complexity will require collaborative efforts for treatment such as multidisciplinary teams that include medical, psychological, and/or family therapy professionals. Psychologists and psychotherapists should be viewed as health care specialists working with the gatekeeper primary care physician. It is documented that the use of psychological services in primary care reduces utilization of primary care services, and thus psychological services should be routinely considered in the treatment of somatic disorders (Mumford, 1984).

**TREATMENT STRATEGIES**

**Collaborative Treatment Models**

There are two basic models for the integration of psychological and biological aspects of treatment for somatization. The first is a medical setting model in which psychologists are trained to work in the medical setting (van der Feltz-Cornelis, van Oppen, Ader, & van Dyck, 2006) or physicians are trained in psychotherapeutic skills (Fritzsche, Larisch, Cierpka, & Wirsching, 2004; Wickramasekera, 1989). For example, Van der Feltz-Cornelis et al. (2006) suggested a model in which psychiatrists consult with general practitioners regarding clients who have had persistent and unexplained medical symptoms and the general practitioners are educated in cognitive behavioral techniques and other psychotherapeutic skills. Meanwhile Fritzsche et al. (2004) discussed how physicians in Germany may receive up to three different levels of education in treating the psychological aspects of somatization, with the highest level entailing an additional 5 years of education.

The medical setting model also offers options for medical practitioners, nurses, mental health professionals, and other professionals working in the medical community to acquire specialized training in medical family therapy (MedFT). According to Linville, Hertlein, and Lyness (2007) MedFT is a biopsychosocial–spiritual and systems perspective on health care that promotes mental health and medical field collaboration and highlights the influence of contextual or familial relationships on a patient’s health, both of which are important for the treatment of psychosomatic couples.

There are a variety of training and educational opportunities in MedFT ranging from continuing education programs to post-masters certificates (such as the excellent program offered at Seattle Pacific University). The University of Nebraska Medical Center offers masters and doctoral level internships in MedFT and in collaboration with the department of child, youth, and family, the medical center at the University of Nebraska-Lincoln offers a postdegree certificate program in which any professional working in a medical setting, including mental health professionals and students, can be trained in MedFT (University of Nebraska Medical Center, 2008, paras 1 and 4). Finally, professionals can also participate in a 3- or 4-day MedFT training program at the University of Rochester Medical Center, where they are educated in working with patients and families dealing with illness specifically within their particular profession (University of Rochester Medical Center, 2007, paras 1 and 2).

The second model for integrating psychological and biological aspects of treatment is a collaborative treatment model. Simon and Folen (2001) suggested a model where chronic pain patients undergo 3 hrs. of assessment in which three specialties (psychologists, physicians and anesthesiologists) weigh in on the patient’s treatment. The specialists then meet together to discuss their findings, determine who will be the primary treatment provider for the patient, and then that primary treatment provider organizes a multidisciplinary treatment plan that entails all three specialties. Meanwhile, Wickramasekera (1989) recommended a collaborative treatment model in which physicians are trained in a psychosocial and physiological diagnostic system to detect somatization while maintaining offices next door to psychologists’ offices so that the process of referral is more seamless for both the physician and the patient. Finally, McDaniel (1995) proposed a collaborative treatment model for the psychosomatic couple in which the physician attends psychotherapeutic sessions with the patient, his or her significant other and/or family and helps explain physiological symptoms and processes pertinent patient concerns.
These models, in their various permutations, are attempts at biological or psychological formulation and treatment and are therefore highly useful. What we propose is not so much a new model, but a paradigm shift to a full biopsychosocial approach, which represents second order change, taking into account the patient’s social context. Essentially, this means that whether the model be a variant of cross training or collaboration, attention is paid to the relationship matrix of the patient, and treatment fully involves the patient’s significant other. McDaniel’s collaborative treatment model comes closest to exemplifying this approach by including the patient’s significant other as an adjunct to the patient’s therapy, although not a full player in the therapeutic process. For example, McDaniel stated, “A motivated spouse may be a resource in bringing the patient to therapy, supporting the patient, and helping to discern any family patterns that may reinforce the somatizing behavior” (1995, p. 121). What we suggest is that the significant other be included with the somatizer as the client system for treatment.

Collaborative Steps

Treatment for somatization should have a biopsychosocial orientation targeting all levels of the system. Relational as well as medical skills are needed for effective, comprehensive treatment. Individual referral for mental health treatment is often met with resistance by the somatic patient; however, referral for couple’s therapy can offer a nonpathologizing entrée to psychological services, although verification of this idea will require further research. The primary care physician in the case cited above might have effectively counteracted Mrs. X’s resistance by referring the patient and her husband for therapy, thereby reducing the stigma of individual therapy for the patient and enlisting the participation of the other half of the pain constellation, or couple.

There are three steps that psychotherapists can take to aid primary care physicians in the treatment of couples dealing with somatization. First, psychotherapists can establish relationships with medical professionals. Psychotherapists may come into contact with medical professionals through referrals and case consultation, and it is beneficial to strengthen these relationships to encourage medical professionals to refer appropriate patients for therapy and to provide cohesive treatment for clients. On obtaining a referral from a physician, a psychotherapist should obtain a release of information from the client system to speak with the referral source and request input from the referring physician. The psychotherapist should also, with the clients’ permission, provide the physician with periodic updates about the course of therapy and continue to ask for collaborative input (Thoburn, Hoffman-Robinson, Shelly, & Hagen, in press). This type of communication demonstrates to the referring physician that the psychotherapist is committed to collaborative treatment and indicates that the physician’s input is valued and respected.

In addition to encouraging a collaborative treatment approach, it is helpful to offer to perform a service for the physician. For example, a psychotherapist could offer a workshop for doctors and patients on stress reduction or pain management or offer to consult with doctors on how to avoid triangulation into family dynamics. Services such as these could prove to be valuable to physicians as they may (a) help inform the physicians about psychological issues patients typically face, (b) introduce a psychotherapy source directly to the somatizing patient, and (c) potentially strengthen the collaborative relationship between psychology and medicine (Thoburn et al., in press).

The second step psychotherapists can take is to aid the primary care physician in the referral process by giving him or her a rationale for treatment that is palatable to the couple. For example, the psychotherapist may suggest the doctor speak with the couple about how strengthening social support is useful when dealing with pain symptoms (Treharne, Lyons, Booth, & Kitas, 2007). It may even be useful to give the doctor an example of a conversation between him or her and the patient. The psychotherapist could provide the doctor with the following example.

Doctor: Ms. X, I wanted to speak with you today about ways to help you deal with the pain you are experiencing. One thing that other patients and research studies have found to be useful in managing pain is strengthening social support. This can often be accomplished through couple’s therapy.

Mrs. X: But my husband and I are not having any relationship problems.

Doctor: Well, couple’s therapy can be useful for couples not experiencing serious difficulties. It can be used to help couples build upon the strengths that they already have. I can refer you to a psychotherapist who I have worked with before who has knowledge about how to help couples dealing with medical issues.

It may be useful to explain to the physician that referring the patient to couple’s therapy can help remove the label of identified patient from the individual and focus the attention to the couple system. The individual patient may feel less pathologized when therapy is reframed as a way to build social support.

The third collaborative step psychotherapists can take is to help prevent both the doctor and the couple from colluding with the couple system (Willi, 1975/1982). Educating the doctor about couple dynamics can help extricate the doctor from triangulation. If the psychotherapist has nurtured a professional relationship with the primary care physician, then education will simply be an extension of that relationship, through in-service workshops and individual consultation.

Following the referral, the psychotherapist can help shift the couple from a position of unconscious collusion with physical symptoms and the medical establishment to a position of social support. To do this, the psychotherapist should seek to see the patient in context, and gain an understanding of where the pathology really lies, which may be in the relationship, not the individual. Thus, the goals for couple’s
therapy include reality testing, increased intimacy through communication skills training, facilitating the sharing of deeply held emotions about previously taboo issues, and increasing greater flexibility in partner roles.

Couple’s Therapy

It is important to first note that when a couple is referred to therapy by a doctor rather than coming to therapy on their own, they may be resistant to the therapeutic process (Hanna & Brown, 2004). The couple may fear stigma, doubt therapy’s efficacy, or deny personal responsibility for problems. The psychotherapist may need to use motivational techniques in the initial sessions to ensure participation from both parties. In addition, the psychotherapist can make sure that the sessions offer hope and concrete steps that the couple can take toward accomplishing their goals (Thoburn et al., in press).

The psychotherapist should have an understanding of the theoretical underpinnings of the treatment approach he or she will provide to the psychosomatic couple. For instance, Bowen family systems therapy, with its emphasis on emotional relationship systems, provides a theoretical grounding in the treatment of the psychosomatic couple. From a family systems viewpoint, psychosomatic symptoms may be seen as a result of the couple having difficulty balancing two counterbalancing forces: togetherness and individuality (Goldenberg & Goldenberg). These two opposing forces result from stress that exceeds a person’s ability to cope and are mediated by anxiety expressed through psychosomatic symptoms. This fits well with Waring’s (1983) finding that psychosomatic couples have relationships characterized by enmeshment, rigidity, and avoidant communication, as all three of these marital patterns can be seen as dysfunctional attempts to manage needs for togetherness and independence. A lack of balance between these needs will lead to fusion or undifferentiation, which involves reacting to others, losing touch with one’s own goals, triangulation of others into the relationship and becoming caught in others’ agendas (Gilbert, 1995).

Given this family systems understanding of the psychosomatic couple, the primary goal for couples therapy should be to disrupt these negative and or helpless patterns in the couple dyad by linking interactional and contextual patterns and issues with problems or symptoms and decrease triangulation (Retzer, 1991). The therapist can decrease the level of anxiety in the couple system by placing the problem in a multigenerational context through the use of a genogram. By gaining an understanding of their family dynamics, the couple can understand and modify old habits and be freed from childish reactivity (Nichols, 1987). The therapist can also make use of the concept of triangles. In family systems therapy, a triangle occurs when there are high levels of anxiety between two family members. The couple will pull in a third party to defuse the anxiety, such as a medical provider (Goldenberg & Goldenberg, 2000). The therapist works to create a new therapeutic triangle with herself or himself and the couple. A stable triangle where the therapist is not emotionally charged can help dissipate tension. The therapist acts as a coach and emphasizes calm rationality when feelings are running high. The therapist asks the couple questions to get them to think first and feel subsequently and may direct the spouses to speak to the therapist rather than to each other. The therapist may also change the topic to minimize conflict between the couple. The diffusion of conflict and the emphasis on separating feeling from thinking inherent in this technique serves to meet the family systems therapy goals of decreasing anxiety and increasing self-determination.

A secondary goal should be the facilitation of relational empowerment, including an increase in differentiation between dyad partners, an increase in relationship role flexibility, and processing emotions linked to insecure attachment (Sayre, 2002). The family therapist acts as an “active expert who calmly assists family members, through low-key direct questions, in defining and clarifying their emotional responsibility to one another” (Goldenberg & Goldenberg, 2000, p. 185). Couples are encouraged to listen to one another, control emotional reactivity, and take responsibility for their part in the relationship (Goldenberg & Goldenberg). Family therapy gives couples a neutral setting in which to explore roles, distance, and negative emotion, so that somatic symptoms are no longer needed to express distress.

Mr. and Mrs. X must be helped to see the link between Mrs. X’s symptoms and the events of their life together. Somatic pain can be a metaphor for emotional pain that has not been expressed. The issue of the headstone has brought to the surface the need for the Xs to grieve the loss of their daughter more fully. They will need to re-examine core beliefs about God and family and coping styles that have operated in the service of denial based relationship stability.

Mrs. X has seemingly become very powerful as the life of the family has become organized around her pain and pain management. Mr. X has become seemingly powerful as well, consolidating the power of being the breadwinner into his hands, and manifesting the benevolent power of the “well one” in the relationship, giving the illusion that he is stronger than she is. Each person has the misplaced notion that need is greater than want. In other words, given a choice, the partner would not want them, so they manipulate each other. “He has no choice but to stay with me, I’m too sick to live on my own,” and “She can’t get along without me,” are neurotic stances that keep the pain constellation intact. Therapy should work to help the couple relate to each other in ways that do not require the use of power.

CONCLUSION

Preliminary research pointing to the idea that somatization may, in part, be explained by couple collusion is provocative and worth further investigation. Specifically, research will want to investigate couple communication, intimacy, and somatization as well as the part medical interventions might play in maintaining symptomatology and the overall strength of couple homeostasis. Research will also want to further
examine a multimodal and multidisciplinary team approach to treatment outcome compared to a more circumscribed biomedical approach. Specifically, does referral for couple’s therapy reduce patient utilization of primary care services? Research will also want to evaluate differences in referral compliance between those somatizers referred to psychotherapy individually and those referred for couple’s therapy. Research might also mine fertile ground investigating the part that the somatizing patient plays in the primary care system, that is, how might changing treatment protocol to a multimodal approach and relieving the primary care doctor of a source of patient care frustration might possibly affect primary care homeostasis? Waters and Lawrence (1993) noted, “Too often we map our clients’ prison, but not their escape” (p. 53). Psychologists and primary care physicians who collaborate on somatic patient care will shift the psychosomatic prison, providing an escape route through heightened interpersonal intimacy and offering a significant service to those who suffer, to their loved ones and to the health care system as a whole.

REFERENCES


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