

CHAPTER ONE

Speaking through the Body

Man has no Body distinct from his Soul.
—William Blake, *The Marriage
of Heaven and Hell*

In *Caring for Patients* Dr. Allen Barbour reports on a number of challenging cases that led him to a more successful method of treating them. Barbour headed the Diagnostic Clinic, part of the General Medical Clinic at Stanford University Medical Center, a tertiary care facility to which patients are referred when physicians elsewhere have not been able to diagnose and handle their complaints. Many of Barbour's patients had received medical attention for several years, had undergone all sorts of advanced tests and examinations, yet either showed no improvement or actually kept getting worse.

A typical case is that of Joseph H., a sixty-seven-year old widower, who complained of feeling "lightheaded, dizzy" for the eighteen months prior to admission. The patient had no other specific symptoms and an unremarkable medical history. He had shown no recognizable disease either at the routine physical examination and laboratory tests or at the elaborate workup, which included a comprehensive (and expensive) series of technological procedures to detect disease. Six or more potential syndromes, some quite rare, had been considered in the process of differential diagnosis. None fitted, nor had Joseph's dizziness yielded to therapeutic trials of various drugs such as antihistamines, anticoagulants, vasodilators, and antidepressants. By the time he was sent to Stanford, both he and his doctors were discouraged. However, to Barbour's own surprise, when he saw Joseph, "the source of his illness was clear from his initial response" (11). He quotes the patient's words, which revealed the crux of the problem: "Doctor, I feel dizzy nearly all the time since my wife died. I don't know what to do with myself. I'm confused. I watch TV, but I'm not interested. I

go outside, but there's no place to go" (11). Recently moved to California, with no children, close friends, or special interests, he expressed his confusion as, and in, "dizziness." Joseph is a fine example of speaking through the body. Barbour comments: "He was a lonely man who had not yet assimilated his grief or learned to develop a new life. His personal situation *was* the clinical problem, and the key to its solution" (11). The remedy for Joseph's dizziness lay not in a medication but in being persuaded by a social worker to join a club where he could share activities.

Barbour chronicles many similar instances where he was able to remove or alleviate puzzling symptoms that had previously defied diagnosis. Jean G., a fifty-five-year old homemaker with three grown-up children who visited often, appeared to have no problems to account for the debilitating headaches that had become increasingly severe in the past three years. They were so intense that she was taking unusually high daily doses of codeine and visiting the emergency room about twice a month for injections of Demerol. Her marriage was loving and communicative; the couple had a nice home and no economic worries or concerns about their sexual relationship. Barbour decided "to view Jean in terms of her social situation. . . . I asked, 'What do you do?' 'Housework.' Then what? Long silence. So I asked, 'What else?' 'More housework'" (74). Barbour realized that, with her children married and successfully launched in their careers, "Jean had run out of purpose" (74); her life was barren for lack of meaningful social, athletic, intellectual, artistic, or recreational interests of significance to her. Encouraged to develop a minor hobby into an active business, making and selling greetings cards, Jean was able to dispense with the heavy drugs and to manage her occasional headaches with over-the-counter analgesics.

With Joseph and Jean, Barbour's nonmedical intervention resulted in changes in their lives that made a positive difference and so paved the way for improvement in their health. Even when no immediate, decisive modification ensues, a patient may be helped through understanding the underlying roots of the current symptomatology. This is what happened with Ruth B., a twenty-one-year old married dental assistant with one child who had had persistent pelvic pain in the right lower quadrant of her abdomen, plus occasional vomiting and constipation, irregular periods, and headaches. Over nineteen months she had been seen by sixteen physicians on twenty outpatient visits, four of them to the emergency room; she had been hospitalized three times, and, after X rays and other studies produced normal results, she had undergone an exploratory laparotomy with an appendectomy. Her doctors had recorded twenty possible diagnoses and tried four drug treatments. Her pelvic pains were ascribed to "obscure cause" (16) and compartmentalized, that is, never connected to her

headaches. It was finally a student physician, “kindly, accepting, open-minded” (16), who had the insight that Ruth was suffering “from an emotional illness expressed as pelvic pain” (16). Without difficulty he elicited her story of material and sexual anxieties, which she readily opened up.

Another patient, Orvieta T., was, like Ruth, helped by being enabled to grasp the source of her symptomatology, despite the fact that there seemed to be no prospect of her breaking out of the vicious circle in which she was trapped. A sixty-two-year old married woman, Orvieta had, besides well-controlled asthma, persistent abdominal pains, headaches, backaches, and joint and muscle pains. She brought to the Diagnostic Clinic several pounds of X rays and results of assorted tests carried out over the previous three years, and although she was taking eight drugs (one for each symptom!), she had been getting steadily worse. Just by talking to her Barbour learned that she ran a boarding-house with six boarders to support herself, her alcoholic husband, and a thirty-year-old delinquent, unemployed son. She worked from 5 A.M. to midnight; her only satisfaction derived from her big vegetable garden and the flowers in front of the house. Barbour concludes: “[O]bviously she was exhausted—physically, emotionally, spiritually” (39). Once the process became apparent to doctor and patient, Orvieta was “able to laugh a little about the absurdity of what she expected of herself” (39), and to Barbour’s amazement the outcome was a virtual disappearance of her symptoms and a reduction of her drugs to two.

These patients have one thing in common: from the strictly medical point of view they have no identifiable disease. To the dismay of their physicians, their often multiple symptoms and their test results defy diagnosis into a recognizable syndrome. The consequent impasse has been vividly evoked by George Engel, an internist with a psychological bent who practiced in Rochester, New York: “[P]hysicians feel bewildered, inept, frustrated, and angry when sophisticated instrumentation fails to yield answers,” while patients for their part feel “used, abused, and dehumanized and become resentful of physicians.”¹ Nor is the classification of hypochondriasis apposite, for “the essential feature of hypochondriasis is preoccupation with fears of having, or the idea that one has, a serious disease based on misinterpretation of one or more bodily signs or symptoms.”² It is not fear of disease that dogs Barbour’s patients but diverse relentless pains and disabilities as real to them as they are refractory to treatment by drugs or surgery. So, in the words that Barbour hears from doctors who are themselves “ill at ease with a patient who has no disease,” “[H]ow can a patient complain of a sickness when there is ‘nothing wrong?’” (37).

The cases Barbour cites suggest the erroneousness of the claim that there is “nothing wrong,” in a wider sense despite the absence of demonstrable disease. Barbour’s plea for a more broadly based model of caring

for patients grows out of his experience that many illnesses are “caused predominantly by personal situations” (1). He argues that “the sick person, not a disease, is the reality” (36). Barbour is careful to emphasize the distinction between disease as a pathological reality, evident in abnormal test findings, and illnesses as expressions of human predicaments that must be explored in their context in order to uncover “the life situation that molded the illness in its present form” (36). Therefore, once actual disease has been ruled out, the focus must be on “patients as persons in family and social systems” (3), for, as Barbour’s series of cases reveals, interactions between individuals and the social systems in which they are embedded, may well turn out to underlie their illnesses, especially if tension, hostility, resentment, or even just bewilderment are involved.³

Joseph, Jean, Ruth, and Orvieta, together with many others, male and female, whose stories Barbour tells, have psychosomatic disorders. These illnesses are “‘idioms of distress’ that are employed to express concerns about a broad range of personal and social problems.”⁴ This basic definition recurs in medical textbooks in varying terms, all of which underscore the role of the physical symptoms as carriers of psychological meaning. For example, Zbigniew Lipowski, a leading researcher in the field, envisages “‘psychosomatic’ symptoms” as representing “the *preferred* mode of experiencing, expressing, and/or reporting psychological distress.”⁵ Similarly, the *Synopsis of Psychiatry* designates this kind of symptomatology as “a type of social communication” that may serve “to avoid obligations” such as a disagreeable job, “to express emotions” such as anger, or “to symbolize a feeling or belief” through, for instance, “pain in one’s gut.”⁶ The word “symbolize” here indicates the central metaphoric dimension of the illness as a substitute, culturally sanctioned production of feelings that the patient may regard as socially prohibited. This displacement of emotion into the body is forefronted in the textbook *Abnormal Psychology*, which explains “psychosomatic” as a manifestation where “the body expresses psychological conflict and stress in unusual, and sometimes bizarre, fashion.”⁷ The most graphic formulation comes from Susan Sontag, who designates illness as “what speaks through the body, a language for dramatizing the mental as a form of self-expression.”⁸

Such dramatization of the mental through the body is known in psychiatry as conversion. It is, in effect, a form of translation, as states of mind are projected into the body, which is made to act as a scapegoat. When emotions are “converted” into symptoms, they are simultaneously masked *and* manifested in a nonverbal style of communication. The recuperation of the covert psychological meaning, the retrieval into verbal utterance (and thus into consciousness) is the essence of Barbour’s work with his patients. This naming of the feelings or situations animating the conver-

sion makes it amenable to more rational analysis and thereby extricates it from the body, which is relieved of the task of indirect communication imposed on it in the conversion process.

This principle of a transfer from mind to body underlies the diagnostic criteria for conversion disorder laid down in *DSM-IV*:

- A. One or more symptoms or deficits affecting voluntary motor or sensory function which suggest a neurological or other general medical condition.
- B. Psychological factors are judged to be associated with the symptom or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors.
- C. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).
- D. The symptom or deficit cannot, after appropriate investigation, be fully explained by a general medical condition, or by the direct effects of a substance, or as a culturally sanctioned behavior or experience.
- E. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation. (457)

Since conversion disorders can simulate medical conditions of any kind, *DSM-IV* requires specification of the type of symptom or deficit. However, as the extensive testing of Barbour's patients discloses, the symptomatology does not correspond to known syndromes, nor do the laboratory findings indicate abnormalities. "In fact," *DSM-IV* points out, "it is the absence of expected findings that suggests and supports the diagnosis of Conversion Disorder" (455). The implausibility of the symptoms and especially of the symptom combinations in discrete parts of the body may also alert the physician to the possibility of such a disorder. Under these circumstances, psychological factors have to be probed. It is their role as stressors in initiating and exacerbating the physical symptoms that is crucial for the appearance of psychosomatic disorders as language in the body.



In practice the distinction between disease and illness may not be nearly as categoric as Barbour's clear-cut examples imply. Disease is described as "organic" because it stems from changes in the *structure* of bodily tissues that can be visualized through X rays, MRIs, or CAT scans or that become

manifest as abnormalities in bodily fluids. The term complementary to “organic” is “functional,” which denotes the absence of such pathological changes and consequently attributes the complaint to a disturbance in *function*. These two words have tended to be used as a means of discriminating between somatic and psychosomatic symptoms. As recently as 1997 Steven L. Dubovsky stated in *Mind-Body Deceptions*: “Symptoms that cannot be traced to identifiable somatic problems are called functional complaints because they are a function of a psychological process and not a product of a structural change in the tissues of the body” (91). Such a distinction reaches back to an earlier tradition. Franz Alexander, a Freudian who wrote on psychosomatic disorders from the 1930s to the 1950s, for a while favored the dissociation of “organic” and “functional.” The differentiation is indeed legitimate: a headache may be due to annoyance or to a brain tumor; in the latter case, it is likely to be persistent, progressively severe, and detectable by modern technology; on the other hand, if it is a precipitate of annoyance, it will probably dissipate spontaneously and fairly quickly. But Alexander himself in his major book, *Psychosomatic Medicine* (1950), acknowledged that “nature does not know such strict distinctions as ‘functional’ versus ‘organic’” (43).

So the former division into organic and nonorganic disturbances “is gradually disappearing.”⁹ That concession was made in 1988 by Benjamin Wolman, author of *Psychosomatic Disorders*. Eleven years later the same view was voiced with far greater bluntness, when John C. Marshall, a neuropsychologist at the Radcliffe Infirmary, Oxford, asserted point-blank that “no one believes in the mind-body dualism any more, and hence the old distinction between functional and organic conditions can no longer be drawn.”¹⁰ Even *DSM-IV*, which, as a diagnostic manual aims to achieve utmost delineations, issues the warning that “[i]t is important to note, however, that conversion symptoms can occur in individuals with neurological conditions” (455). The estimate given is that “as many as one third of individuals with conversion symptoms have a current or prior neurological condition” (453). A still higher figure, one half, is cited in *Abnormal Psychology* (239–40) for patients treated for a psychosomatic disorder who receive a subsequent medical diagnosis. Similarly, the *Synopsis of Psychiatry* found systemic disease of the brain prior or concomitantly in 18 to 64 percent of hospitalized patients with conversion disorders, and nonpsychiatric disorders are eventually diagnosed in 25 to 50 percent of them (623). These numbers suggest, first, that even the most up-to-date diagnostic methods are far from infallible, and second, that there is a tendency to assume that symptoms in certain segments of the population are more likely to be psychosomatic. It is no coincidence that Barbour’s patients comprise conspicuously more women than men.¹¹

Recognition of this overlap between organic and functional, between disease and illness complicates the diagnosis of psychosomatic disorders. "Functional or 'psychosomatic' symptoms may occur in the presence or absence of demonstrable organic disease," Lipowski notes.¹² Barbour plays down this overlap for the sake of the incisiveness of his argument, although he is well aware of the interplay not only between mind and body but also between disease and illness: "[T]he disease itself can be accentuated by ongoing emotional disturbance in some patients" (50). Certain diseases, notably asthma, hypertension, and heart conditions are particularly liable to be affected by emotional disturbances.

As a corollary to the waning of the old opposition between organic and functional, the role of psychological factors in the processes of drift from dysfunction to structural disease has attracted increasing attention. Alexander already observed that "local anatomical changes themselves may result from more general disturbances which develop in consequence of faulty function, excessive stress, or even emotional factors."¹³ Functional disorders of long duration may gradually lead to serious organic disorders associated with morphological changes. The mechanisms conducive to such changes have been spelled out in varied but broadly consensual terms in recent medical writing; for example, "[W]hen an intense stress provoking stimulus ('stressor') acts on an organism, the organism responds by a series of biochemical and physiological changes in the glands of inner secretion, called the 'alarm reaction.' The alarm reaction is followed by increased hormonal secretion of the pituitary gland, which activates the cortex of the adrenal gland."¹⁴ Or, as another writer explains, a vulnerable organ subjected to ongoing stress may be permanently changed: "Once the heart adjusts to beating at an excessive rate, or the blood vessels remain in spasm long enough, the affected system may reset itself to a pathological level of functioning that is independent of the emotional state that originally mobilized it."¹⁵ So disturbed function can actually lead to disturbed structure. The emotional conflicts that cause continued fluctuations in blood pressure can, in the long run, result in chronically elevated blood pressure and irreversible forms of kidney damage. Or a sustained paralysis of a limb, found to be without pathological foundation and therefore deemed psychosomatic, will through sheer inactivity trigger degenerative changes in muscles and joints.

One consequence of this abandonment of the radical separation of organic and functional is the tendency to claim the involvement of psychological factors in all sickness. Advocates of this position declare "that social and psychological factors play some role in the predisposition to, initiation of, response to, and maintenance of every disease."¹⁶ Such beliefs are based partly on research in immunology, specifically into the forces

that strengthen or lower an individual's immune system. That those who have sustained a loss or who are suffering from depression are more liable to infections and other kinds of ill-health has long been known. Before advances in immunology, attempts were made to establish direct connections between psychological and physical processes and to link certain diseases to particular emotions. Tuberculosis was thought to stem from an excess of passion and cancer conversely from the repression of passion. Herself a cancer survivor, Sontag protests vehemently against these simplifications of the mind-body relationship: "[T]he hypothesis that distress can affect immunological response (and, in some circumstances, lower immunity to disease) is hardly the same as—or constitutes evidence for—the view that emotions cause diseases, much less that specific emotions can produce specific diseases."¹⁷ Sontag's lay views are supported by Lipowski's considered medical assessment: "It is meaningless to say that emotions cause disease; they cause nothing. It is equally incorrect to propose that any other psychological variable causes disease; it can only influence susceptibility to disease through the mediation of neuroendocrine processes controlled by the brain."¹⁸ The key word here is "susceptibility," which fashions a judicious bridge between "emotions" and "neuroendocrine processes."

The confluence of the functional and the organic is of enormous importance for the approach to psychosomatic disorders, although it greatly magnifies the difficulties of both medical diagnosis and cognitive understanding. For the slippage places psychosomatic disorders in the borderlands between pronounced physical pathologies and psychological problems. So their intrinsic elusiveness is vastly heightened. To compound the problem further, psychosomatic medicine lacks a site anchored in any one area of the body in the way that cardiology, gastroenterology, nephrology, or dermatology do. Since psychosomatic disorders can surface in any part of the body, they hover homelessly in shadowlands; not localized, they are potentially everywhere, yet also nowhere. Shifting and at times polysymptomatic, they exhibit a peculiar vagrancy that is at once their hallmark and a primary source of the puzzlement they occasion.

Because of this instability, malattributions and misdiagnoses in regard to psychosomatic disorders are not surprising. Even with the latest technologies misconstructions are not unusual. To revert to Barbour's patients, Orvieta, for instance, had collected working diagnoses of irritable-bowel syndrome, tension headaches, lumbosacral strain syndrome, bursitis, neuralgia, and asthma. With disarming honesty Barbour adds, "I found myself in general agreement with the prevailing diagnoses,"¹⁹ before heeding her life situation and realizing that the overarching clue to her complaints lay in her exhaustion. Before the technological advances of the past hundred and fifty years or so, differential diagnosis was infinitely more difficult, not to say virtually impossible until the autopsy. For instance, toward the end of

the nineteenth century, Pierre Janet, the eminent French psychologist, observed a fourteen-year-old girl admitted to hospital with apparently neurotic symptoms; when she died soon afterward, the postmortem revealed a hydatid cyst on the brain.²⁰ The neurotic origin of general paralysis was disproven by the discovery in 1913 by H. Noguchin and J. W. Moore of the microorganism *treponema pallidum*, which pointed to the syphilitic causation of some paralyses.²¹ Pseudoseizures are distinguishable from genuine seizures by means of at least two criteria: the pupillary and gag reflexes are retained in pseudoseizures, and no postseizure increase in prolactin concentrations is found in blood tests. The establishment of the biological bases of epilepsy, in fact, led to its transfer from psychiatry to neurology.

The history of medicine confirms Sontag's assertion that "theories that diseases are caused by mental states and can be cured by will power are always an index of how little is understood about the physical terrain of the disease."²² A case in point is chronic fatigue syndrome: current opinion oscillates between the hypothesis of a viral etiology, on the grounds that some antibodies are elevated in some patients' blood, or its categorization as a psychosomatic disorder.²³ While medical advances have mostly fostered more precise diagnoses and the transfer of syndromes from the vague, capacious segment of emotionally caused disturbances, the crossover may also take place in the opposite direction. Hiram Houston Merritt's *Textbook of Neurology* does not use the term "psychosomatic," but it does suggest psychotherapy as a treatment for some cases of migraine (628–29), thereby tacitly conceding the possibility of psychological origins.

The potential for vastly differing interpretations of the same symptomatology is at the heart of Flannery O'Connor's amusing and ironic story "The Enduring Chill." Asbury, an aspiring playwright, comes back to his southern home from New York with attacks of fever. His mother, who meets him at the train, gives a little involuntary cry as she glimpses his shockingly sick appearance and his bloodshot eyes. Perversely, he is "pleased that she should see death in his face at once" (110). For "he had felt the end coming on for nearly four months. Alone in his freezing flat, huddled under his two blankets and his overcoat, with three thicknesses of the New York *Times* between, he had had a chill one night, followed by a violent sweat that left the sheets soaking and removed all doubt from his mind about his true condition" (110). After his return, his rapid decline continues. So convinced is he of his imminent death that he has the priest come. He looks out toward the pasture, where his grave will be, and visualizes his funeral. His mother, in what seems like denial, thinks he is having "a nervous breakdown" (113), while his sister scoffingly blames his illness on his failure at writing. Asbury drafts a self-explanatory letter to his mother that fills two notebooks. Much of "The Enduring Chill" is devoted to exposition of the tense family dynamics between mother, son, and

daughter, thereby hinting at a psychological source for Asbury's illness. He refuses to let the local family doctor, Block, come to see him: "What's wrong with me,' he repeated, 'is way beyond Block'" (113). Finally, in alarm, his strong-willed mother insists on bringing in the country doctor, who cheerfully counters Asbury's protest, "'What's wrong with me is way beyond you'" with "'Most things are beyond me.—I ain't found anything yet that I thoroughly understand'"(121). Thanks to a blood sample Dr. Block diagnoses undulating fever. Disobeying his mother, Asbury had drunk unpasteurized milk, an act of defiance whose rashness is underscored by the black farm hands' refusal to do likewise. The artist's psychosomatic illness unto death is unmasked as a foolish, risk-taking behavior that had caused a physical disease.



So "What Does the Word 'Psychosomatic' Really Mean?" Lipowski asks in an article written in 1984.²⁴ Though a sound starting point for exploration of the field, the article does not provide any categorical answers. Its title, consisting of a query, suggests a quest rather than conclusions, a point confirmed by its subtitle, "A Historical and Semantic Inquiry."

Lipowski's inquiry was prompted by the questions that students, colleagues, and lay people frequently asked him not only about the meaning of the term but also about the scope of the field. The mere necessity for such questions in itself already testifies to the perplexity intrinsic to the concept. Lacking clearly delineated limits, "psychosomatic" runs the risk of amorphousness, like nineteenth-century "neurasthenia." "Psychosomatic" itself was first used in 1818 by a professor of psychiatry in Leipzig, Johann Christian August Heinroth, who applied it to insomnia.

Nor do dictionary definitions help with "psychosomatic"; on the contrary they create more problems than they solve because they raise the extremely tricky issue of the mind-body relationship. *Webster's* dictionary gives "(a) of or pertaining to those bodily symptoms which arise from or are traceable to mental conditions; (b) pertaining to both body and mind as a single entity." The word did not make its way into the *Oxford English Dictionary* until a 1982 supplement, where it appeared as an adjective: "involving or depending on both the mind and the body as mutually dependent entities." *Medical Meanings*, refers to the derivation from "psycho-" plus Greek *soma*, "the body," to arrive at the description: "whatever has an integral mind-body relationship." The *Synopsis of Psychiatry* gracefully sidesteps too ready a definition by envisaging "psychosomatic" as a diagnosis that "reflects the clinician's assessment that psychological factors are a large contributor to the symptoms' onset, severity, and duration" (617). *DSM-IV* opts for an exclusionary method by endorsing the criterion that "psycho-

somatic” denotes those complaints for which an adequate medical explanation cannot be found.

Medical textbooks, on the other hand, eschew the problem of the mind-body relationship. Lipowski dismisses as “rather facile” the discussions that “have raged about its alleged metaphysical connotations, that is, whether it [psychosomatic medicine] affirmed the unity or duality of mind and body.”²⁵ Such meditations, he says, are avoided in the medical arena as belonging to theology and philosophy. In the last resort, the interface between mind and body remains uncharted territory despite momentous advances in medicine. For instance, with many of the newest psychotropic drugs experimentation proves that they work for some patients, but their precise mechanisms are not known. Evidence shows that while the mind-body relationship is a potent force, it is not as yet fully amenable to rational understanding. The authors of *Abnormal Psychology*, for example, cite the connection between an important exam and an upset stomach or a headache. Observation and experience bear out the incidence of such a correlation; indeed it is so common as to be rarely scrutinized. Yet, the authors admit, it is “not easily explained” (248); they conclude that “the translation from ‘mind’ to ‘body’ occurs in a way that defies medical logic” (238). Thus the proposition that the psyche may speak through the body has attained widespread acceptance, although the pathways of this process remain in many respects mysterious.

The difficulty of discovering “what the word ‘psychosomatic’ really means” therefore hinges on the much deeper underlying problem of the mind-body relationship. Medical writers have repeatedly, even in the past twenty years, conceded the impasse in varying terminology. “The final answer is still a controversial issue,” Wolman acknowledges, and the term “psychosomatic” itself “quite ambiguous.”²⁶ In his 1982 survey of “Contemporary Research and the Mind-Body Problem” Weiner concedes that psychosomatic medicine is often criticized for not being able to offer an answer to the question how “social experience and/or psychological conflicts and induced emotions could be possibly translated (transduced) into bodily physiology leading to illness” (223). To some extent the recognition of the confluence of functional and organic has mapped some of the intermediary steps in such a process of conversion, but without addressing the ultimate enigma of the mind-body interaction.

Of all those who have sought to define “psychosomatic” Lipowski is both the most outspoken and the most authoritative. He does not shun indeterminacy or even a rather negative response to his own query, “What Does the Word ‘Psychosomatic’ Really Mean?” Indeed, “really” comes across as almost ironic in light of Lipowski’s statement: “The meaning of the term ‘psychosomatic medicine’ remains unclear and no generally agreed upon definition of it exists.”²⁷ Equally direct is his assertion that

“the field of psychosomatic medicine abounds in semantic and conceptual confusion. There is no general agreement regarding the meaning of basic terms, not enough distinction between what are data of observation and theoretical concepts and explanatory hypotheses, and little consensus about the scope of the discipline and its position within the larger fields of medicine, psychiatry, and human biology” (27). Lipowski judges the word to mean “no more than we agree that it should mean, and we delimit its boundaries by defining it” (4). He also warns that “sharp delineation of the field [is] difficult if not actually undesirable” (133). In arguing against sharp delineation—and so by implication in favor of a certain openness—Lipowski goes against the mainstream of somatic medicine, which aspires to exact diagnoses, and moves psychosomatic medicine toward a more pronouncedly humanistic mode. That, of course, is exactly what Barbour learned to do with his patients.

Nevertheless, Lipowski does not stop at mere demonstration of the misguidedness of pursuing a definitive meaning of “psychosomatic.” He argues that psychosomatic medicine has to insist on “the inseparability of mind and body as well as their mutual dependence” (120). So it must affirm an “antidualistic stance” (120), perceiving mind and body as one or as only separate aspects of a person or an organism as a whole. The fundamental outlook of psychosomatics is therefore essentially “*holistic*” (120) in contradistinction to the fragmentation of late twentieth- and early twenty-first-century somatic medicine, with its system of specialties and subspecialties. The definition that Lipowski proposes toward the end of his article underscores the holism that he sees as the core connotation: “*Psychosomatic* is a term referring or related to the inseparability and interdependence of psychosocial and biologic (physiologic, somatic) aspects of humankind” (133). He goes on:

Psychosomatic medicine (psychosomatics) refers to a discipline concerned with (1) the study of the correlation of psychologic and social phenomena with physiologic functions . . . , and of the interplay of biologic and psychosocial factors in the development, course, and outcome of diseases; and (2) advocacy of a holistic (or biopsychosocial) approach to patient care and application of methods derived from behavioral sciences to the prevention and treatment of human morbidity. (133)



In defining psychosomatics Lipowski uses a term that has been assuming increasing prominence and that comes as close to the “meaning” of psy-

chosomatic as is feasible: “biopsychosocial.” He introduces the term in quotes at the opening of his article, where he expresses the hope that it may replace “psychosomatic” because it is free of “the ambiguity and controversy” (119) that continue to surround “psychosomatic.”²⁸

“Biopsychosocial” is a term first launched by George Engel in a series of articles published in the late 1970s and early 1980s. Engel takes care to spell out the angle from which he comes to psychosomatics: “[M]y training and personal identity is that of an internist with special interest in its psychosomatic and psychosocial aspects. I have had no formal psychiatric training and have never had a psychiatric practice. I have tried to achieve the level of competence in psychiatry than any competent physician should have.”²⁹ It is his experience in internal medicine that convinces him (like Barbour, later) of the absolute necessity of heeding dimensions beyond just the biological in the treatment of disease.

Engel’s key example, which he elaborates in detail in an article in the *American Journal of Psychiatry* in 1980, “The Clinical Application of the Biopsychosocial Model,” and to which he refers in succeeding publications, is that of Mr. Glover, a fifty-five-year old married real estate agent with two adult sons, who is brought to the hospital with symptoms similar to those he had experienced six months earlier when he had had a heart attack. He responds well at first to the prompt institution of coronary care, but thirty minutes later, in the midst of the continuing workup, he abruptly loses consciousness and goes into ventricular fibrillation. After successful defibrillation, Mr. Glover makes an uneventful recovery.

Engel analyzes what happened in this case from two parallel but distinct perspectives: the biomedical and the biopsychosocial. The normative biomedical model, which is followed in the hospital, is by far the simpler: “For the reductionist physician a diagnosis of ‘acute myocardial infarction’ suffices to characterize Mr. Glover’s problem and to define the doctor’s job. Indeed, once so categorized Mr. Glover is likely to be referred to by the staff as ‘an MI’” (538). Engel criticizes this routine method as reductionist because it is predicated on the premise that the cause of Mr. Glover’s complaints and the requirements for his care can be localized to the injury to the tissues, cells, and molecules of one particular organ. In this scenario the patient’s feelings and reactions are given virtually no attention. The aim of the dominant biomedical model—to diagnose and treat the disease as quickly as possible—encourages neglect of psychosocial dimensions, which may turn out to be decisive. There is no better illustration of this tendency than Barbour’s patients, with their multiple diagnoses, drugs, and surgeries as a direct consequence of neglect of elements in their lives beyond the strictly medical.

By contrast, the biopsychosocial model envisages Mr. Glover not only as a person with a damaged heart but also as an individual within a family

and a community. Engel emphasizes that “[i]n the continuity of natural systems every unit is at the very same time both a whole and a part” (537). So the patient may be importantly influenced by processes at the psychological and interpersonal levels of organization. Mr. Glover, for example, initially denies the seriousness of his symptoms, specifically, the possibility of another heart attack; although aware of the similarity of his symptoms to those of his earlier heart attack, he prefers to see them as fatigue, or muscle strain, or indigestion, or emotional tension. He stays at work, alternating between sitting quietly at his desk and pacing the office; he avoids other employees, and takes Alka-Seltzer. Engel interprets Mr. Glover’s behavior as an expression of complex feelings: fear of losing his job and control over his own destiny as well as an assertion of his personal values of responsibility and independence. Only the intervention of his employer enables him to accept the need for hospitalization and patient status. The psychological stabilization attendant on this decision has stabilizing effects on other systems too, so that by the time Mr. Glover reaches the hospital, he no longer has chest pains and feels relatively calm and confident.

What then precipitates his dangerous relapse when he is already under medical care? Engel attributes it to a massive rise in Mr. Glover’s anxiety, coincident with his loss of confidence in the competence of the medical staff, which is prompted by the house officer’s difficulty in drawing arterial blood. Such difficulty is not uncommon, as arteries are elastic and tend to jump away at the touch of a needle. For the uninformed patient the ten-minute unproductive efforts to carry out this procedure are painful, disagreeable, distressing, even frightening. When the house officer leaves to fetch help, Mr. Glover feels let down by the medical personnel whom he had trusted as powerful to help him. Now instead, he feels victimized by inexperienced physicians, and angry at having allowed himself to become entrapped in this predicament. Blaming himself, he has a growing sense of helplessness. Concomitantly he gets hot and flushed, and the chest pain returns. These are the circumstances under which the life-threatening ventricular fibrillation sets in.

Engel contends, convincingly, that the difficulty over the arterial puncture should have been recognized early as a risk for the patient, not just a technical problem for a junior doctor. Mr. Glover’s failure to complain should also have been recognized as characteristic of his psychological style of denial rather than as an untroubled acquiescence. In short, the episode of the ventricular fibrillation could have been avoided if an inclusive approach had been taken that took into account Mr. Glover’s feelings and reactions, his conflicts about hospitalization and his anxieties about the implications for his work and family of his repeated heart attacks.

Engel seeks to win acceptance of the biopsychosocial model by presenting it as a scientific one. He charts the reciprocal interactions of the psychological and the physiological during the fruitless attempts at arterial puncture and the subsequent cardiac arrest (figs. 5 and 6, 540). He readily grants that the example of Mr. Glover is an “oversimplification” (543), although his arguments for the mutual interdependence of the patient’s feelings and his heart condition are persuasive. More problematical is Engel’s advocacy of the clinical application of the biopsychosocial model in an emergency situation such as an acute heart attack. The imperative for speed in delivering immediate care is likely to result in the setting aside of any investigation of the patient’s psychological style and social environment in favor of more urgent needs. The biopsychosocial model becomes wholly appropriate, however, in the context of Barbour’s Diagnostic Clinic, to which the cases most resistant to diagnosis are referred and where rapidity is no longer a primary concern.

Whatever the obstacles to the application of the biopsychosocial model in the emergency room, it is without doubt ideally suited to the analysis of illness in literary characters. For while the literary work is inevitably weak on those kinds of quantitative information on which modern medicine relies so heavily, it compensates for this shortfall by qualitative strength in the density of the characters’ psychological traits and their social environment. Novels, short stories, and plays normally show the context of the action, the circumstances that lead to the choice of one course over another, and the motivation for behaviors. Their spatial and temporal expansiveness creates a forum for the portrayal of interpersonal relationships as they develop over a period of days, months, or often years. Family conflicts, stresses arising from work, the impact on individuals of their physical and human surroundings, sources of guilt, the see-saw of losses and gains, evasions, deprivations, frustrations, and hurts: all these form the subject matter of literature, and all are highly conducive to the elaboration of the dynamics of psychosomatic disorders.

The aptitude of literature for the in-depth representation of illness is best illustrated by imagining Mr. Glover as a figure not in a medical article but in a novel. Engel himself engages in some speculation as part of his plea for greater heed to the patient’s social environment. He maintains, for instance, that the “continuity of systems makes attention to Mrs. Glover’s well-being a necessary element in Mr. Glover’s care” (543) for if Mrs. Glover were to suffer a breakdown or illness, or even death, Mr. Glover’s prospects would be affected too.

The introduction of Mrs. Glover opens up large vistas for the literary imagination onto a medley of factors that could have been instrumental in

precipitating Mr. Glover's two heart attacks. In a novel or play the nature of the marriage could have been exposed: Was it a Strindbergian battle of the sexes? Was Mrs. Glover a nagging wife, goading her husband to better their lives by making more money? Were there sexual problems such as impotence on the part of the aging man? Had a dirty secret recently been brought to light? Had some life-sustaining illusion long cherished by the Glovers been shattered? Does Mr. Glover like his work in the real estate office? Does he get on well with his colleagues, or does competition for listings and sales foster rivalries and animosities? Does Mr. Glover have a tendency to, or even a history of depression? Does he harbor grudges or is he forgiving? Does Mrs. Glover work? Does she enjoy it for the companionship, or does she resent it as a reminder of her husband's inadequacy as the family's breadwinner? And what about the two adult sons? Do they give their parents satisfaction or grief? Are they committed to respectable work, or in jail? What are their marriages like? Do the Glovers like their daughters-in-law? Are there grandchildren? Are they a source of pleasure or of worry to their grandparents? Does Mr. or Mrs. Glover have an aged parent who imposes the strain of constant vigilance as well as a financial drain?

These various facets of Mr. Glover's social context and psychological profile could be depicted in a literary work to fill out his entire history leading up to the heart attacks. His life would be interpreted as a series of responses at crucial junctures, largely conditioned by his upbringing, his previous experiences, and his disposition. The biological event of the "MI" would be seen as the outcome of a lengthy, complicated psychosocial development. For literature presents characters in the way in which Joseph Sapira, in his 1992 presidential address to the American Psychosomatic Society, argues that patients should be viewed: "Patients not only exist as collections of organs, cells, molecules, ions, and so forth but also as individuals and members of romantic dyads, families, geographic units, language clans, religious units, sexes, ethnic groups, nations, and so forth. Furthermore, they bring to any illness situation their past individual experiences as total organisms whose individual histories cannot be grasped by an exclusively reductionist approach."³⁰ The questions that Sapira urges doctors to ask patients about their lives as individuals are precisely those that Barbour put to his patients—and that literary works ask and answer. The humanistic vision of literature has the capacity to offer a rich etiology of the psychosomatic illness along biopsychosocial lines by exploring how the patient comes to be driven to speak through the body.