The Tragic Drama of Psychosomatic Illness


Reviewed by Ian Wickramasekera

This book on the history of psychosomatic illness is interesting and easy to read. In pursuit of a central hypothesis, the author has uncovered very rich historical material. Shorter’s hypothesis is that symptom formation in psychosomatic illness (he later calls symptom formation somatization) is determined by the medical-cultural conditioning of the unconscious mind. According to Shorter, the dominant medical theory of disease at any point in time and the related “symptom pool” influence the unconscious mind to generate somatic symptoms consistent with medicine’s most credible explanatory constructs of the moment. Had Shorter only made better use of his rich historical research, he would have seen that his argument covers only a narrow portion of psychosomatic reality.

Shorter’s history of psychosomatic medicine ranges from the eighteenth-century to the twentieth-century, and as he moves from past to present he informatively elaborates on many theories and concepts, including “spinal irritation,” reflex theory, hysteria, neuropathology, the “psychological paradigm,” and immunology. He correctly points out that today immunology and microbiology have become the “queen bee of the medical sciences in the way that pathology was in the nineteenth century.” Accordingly, he writes, “psychosomatic patients who want their symptoms to keep abreast of scientific progress wish to see the underlying source of their problems as immunological in nature.” In this context, Shorter thoughtfully comments on the loose relationship between the symptoms of chronic fatigue syndrome and Epstein-Barr virus infections. He correctly points out that the current popular symptoms in primary care are chronic pain (as in fibromyalgia) and chronic fatigue, and that both are “useful” because they are empirically unfalsifiable. He also correctly points out that the mass media have undermined medical authority and have become a new source of “medical theory” and symptoms.

He makes a valid distinction between (1) patients who have somatic symptoms but in whom no lesions exist (or, more logically in my view, have not been found) and (2) patients who have lesions but whose somatic symptoms are exaggerated. In my own work, I call the first group transducers because they unconsciously convert psychosocial perceptions of threat into symptoms—for example, perceived threats like “my boss is on my back” into chronic low back pain. In some patients, specific psychosocial risk factors drive somatic symptoms independent of pathophysiology. I call the second group of patients amplifiers (Wickramasekera 1988, 1992A). In these patients pathophysiology can be demonstrated, but the somatic symptoms are exaggerated.

I learned many things of historical value in this book. The author identifies many salient concepts and discusses a selection of important people who coined useful clinical terms or procedures. The concepts and people include somatization (Wilhelm Stekel), psychogenic pain (Binswanger), the “anatomical-clinical method” used powerfully by the nineteenth-century Frenchman Jean Charcot (1825-1893), who treated hysteria with hypnosis, and the concept of unconscious or conscious “coaching” (today called the demand characteristics of an experiment) as practiced in Charcot’s clinic in Nancy, France.
Shorter's historical knowledge of Charcot is impressive. But I note here that he fails to recognize in the numerous facts he cites about Charcot that this illustrious nineteenth-century neurologist (who made many permanently important contributions to neurology, like the description of multiple sclerosis) was probably the first person to recognize clearly that there was a link between hypnotic ability and psychosomatic disease. This is a critical point, and I will return to it.

Psychosomatic Illness through a Single, Imperfect Lens

Shorter's grip on his subject is not always sure. He recognizes the salient role of several important clinical concepts and observations in only a partial or fractured way. For example, he devotes at least two chapters to comments on suggestion, dissociation, and hypnosis, and mentions the importance of support systems and also the impact of a major life change as a triggering event, but he fails to incorporate in a systematic way these important observations or concepts (Wickramasekera 1988, 1992A, 1992B) into his medical-cultural conditioning theory of psychosomatic illness.

Similarly, he refers to Franz Mesmer (1733-1815), dissociation, and hypnosis as if they were peculiar to eighteenth- and nineteenth-century European medical history and theory. He appears to be unaware that in the last 75 years, empirical research (Barber 1969, Fromm & Shor 1979, Hilgard 1965) has shown that Mesmer's and Charcot's pioneering work in hypnosis was simply a European manifestation of the study and clinical application of what appears to be a universal and stable personality trait called hypnotic ability (the ability to be hypnotized), which appears to have major implications for psychosomatic illness and mind-body interaction (Barber 1984; Brown & Fromm 1986; Wickramasekera 1976, 1979, 1983, 1986, 1988; Wilson & Barber 1982). Across time and cultures, hypnotic phenomena and suggestion have been elicited in people who have hypnotic ability under various labels, and in various settings—sleep temples in Greece, for example. Shamanism (Cardena 1988), faith healing (Frank 1973), acupuncture (Knox & Gekoski 1981, Spiegel & Spiegel 1978), trance healing, Zen meditation, voodoo, and psychic surgery all likely involve hypnosis and suggestion. It has also been shown that procedures like sensory restriction (or deprivation) and physiological activation or relaxation (used in the above religious or secular healing rituals) can temporarily increase the hypnotic ability of only moderate or low hypnotic ability (Wickramasekera 1977, 1988).

Another example of Shorter's partial grip on this subject is his statement that hypertension is unlikely to be a psychosomatic illness. But he fails to distinguish between primary (or essential) hypertension, which has no known cause apart from a positive family history, and secondary hypertension. In fact, the bulk of all hypertension—80 percent—is primary, and while positive family history may be an essential element in primary hypertension, it is not a sufficient cause.

Shorter makes an implicit if not explicit distinction between psychological factors and biological factors in disease, a distinction that is no longer tenable. The bulk of growing empirical evidence suggests that even psychological factors operate through electrophysiological and biochemical mechanisms and that both top-down and bottom-up interactions occur between psyche and soma. Terms like psychological, behavioral, and physiological pertain only to the level of description and analysis of biological phenomena.

Shorter becomes fascinated in repetitiously describing multiple case histories of dramatic, angry, and destructive symptom-generating interactions between somatizing patients and their physicians. He cites numerous instances of physicians who specialized in treating somatizing or psychosomatic patients and who resorted to extreme "therapeutic measures" (mutilating surgery, for example, or the threat of Dr. Silas Weir Mitchell, a famous American physician of the nineteenth century, to disrobe and get into
bed with a patient). He describes the high “theatre” of Charcot and the adjoining Salpetriere hospital “as a circus.” In tedious almost voyeuristic detail, he reports on the faith-eroding role enactments of chronic psychosomatic patients and their physicians (Frank 1973; Wickramasekera 1972, 1988) in which both patients and some of their physicians became “absorbed” or “entranced” in destructive complementary role enactments, to the point that they both suspend their critical analytic brain functions. I have labeled current manifestations of this the “crock, quack, and shrink” interaction (Wickramasekera 1988). Sternbach (1974) calls them “pain games.”

Shorter fails to recognize, in what he himself describes as destructive or iatrogenic doctor-patient relationships, the powerful activity of the negative forces of the unconscious mind. Modern pharmacological research has shown (Wickramasekera 1985) that faith in a therapist—positive transference—and in a treatment can powerfully amplify the active ingredients in a drug. In fact, the mean placebo effect in surgery is probably larger than in drug therapy (Wickramasekera 1985). But skepticism and anger—negative transference—can actually reverse the direction of activity of even an active drug like Ipecac (Shapiro 1971). Shorter points out that Freud abandoned hypnosis. But he does not seem to know that Freud later stated, “What he [Bernheim, a leader of the Nancy School, which held that hypnotic ability was a psychological phenomenon] called suggestibility is nothing else than the tendency to transference. . . . We have to admit that we have only abandoned hypnosis in our methods to discover suggestion again in the shape of transference” (Wickramasekera 1972).

Unfortunately, the iatrogenic high drama of psychosomatic illness continues to be performed even today, rationalized on the stage of high biomedical technology (Relman 1980), with bottom-up reductionist biomedical theory, with invasive tests, and in mutilating surgical theatres; and enacted under new labels like chronic pain, chronic sleep disorders, and chronic anxiety. The tragic drama of psychosomatic theatre, with escalating fees, plays in many hospitals in every major city in the world, driven not only by unconscious patient-physician interactions (Wickramasekera 1988) but also by unrealistic patient expectations about the “miracles” of new medical technology, glamorized by the mass media (Ingelfinger 1978). There are other driving factors (Wickramasekera 1989)—the financial incentives for physicians to treat psychosomatic illness only medically (if you only have a hammer, everything can look like a nail), the copayment policies of medically dominated insurance companies that encourage patients to consciously or unconsciously repackage their psychosocial stress somatically, the practice of defensive medicine fueled by the fear of lawsuits (Tancredi & Barondess 1978), and the low scientific status of psychiatry. But above all else there is the medical fear of “missing something organic,” which produces the standard practice of arriving at a diagnosis of psychosomatic illness by first excluding all conceivable organic causes (Wickramasekera 1992C).

The most significant weakness of this book is that Shorter fails to recognize that in all periods of human history only a minority of the general population become stuck in chronic psychosomatic patient “roles” (Parsons 1965). This is a major limitation of his otherwise scholarly historical account of psychosomatic illness. He points to the brilliant English physician and educator, Sir William Osler, as a more cautious contemporary of Charcot who did not become personally ensnared in the psychosomatic “circus.” But he fails to note that Osler himself recognized the importance of individual differences to all diseases in his famous dictum “Sometimes it is more important to know what kind of patient has a disease than what kind of disease the patient has.” The question is, why do only a minority of people become stuck in psychosomatic “patient” roles?

Shorter seems unaware of the importance of individual differences in the three-way person-situation-disease interaction, in explaining, predicting, and controlling psychosomatic illness (Wickramasekera 1988,
1992A, 1992B). Psychosomatic disease is a complex phenomena that requires a multifactorial model that carves psychophysiological phenomena at its natural joints Wickramasekera 1979, 1988). Simplistic unifactorial models of psychosomatic illness—including loneliness, self-disclosure, hardness, type A behavior, hostility, alexithymia, and, as Shorter would have it, cultural conditioning of the unconscious mind—do violence to the awesome complexity of a natural psychophysiological system. Shorter brings to the analysis of complex and multifaceted psychosomatic illness only one analytic lens—medical theory and the cultural conditioning of the unconscious mind. It is an excellent lens, but it cannot encompass the breadth and depth of the tragic drama of the phenomena he addresses.

Had he looked at his subject matter with more of the lenses that he himself notes over the course of an illness (among them, support systems, major life changes, suggestibility, and hypnosis), but whose significance he fails to grasp, he may have written a less naive history. (Perhaps needless to say, he would also not be vulnerable to these criticisms had he simply written a factual history of psychosomatic illness. But he begins his book stating that his cultural conditioning theory will organize the historical facts of the last 200 years.) His limited theory obscures both the big issue of individual differences and the more subtle but equally salient factors (including the placebo effect, positive and negative unconscious transferences, defensive medicine, diagnosis by exclusion, and third-party reimbursement policies) that influence somatization.

Hypnotic Ability and Psychosomatic Illness

I return now to Charcot and his view that high hypnotic ability was an essential and sufficient condition for the development of psychosomatic disease. Shorter quotes a student of Charcot, Charles Fere, as saying sarcastically that Charcot, who originally viewed hypnotic ability as a pathological condition with a genetic source, died in 1893 becoming “the star pupil of the Nancy School”—that is, he had come to the view that hypnotic ability was a psychological phenomenon. While empirical research in the last 100 years has validated the Nancy view that hypnotic ability in the middle range is a normal, stable individual difference variable (Piccione et al. 1989), it has also shown that Charcot may be right with respect to a weaker form of his hypothesis, connecting hypnosis and psychosomatic disease. This is a formulation that I have proposed, that there is a special link between both high and low hypnotic ability and psychosomatic disease (Wickramasekera 1979, 1983, 1986, 1988, 1992A, 1992B).

It appears that high and low hypnotic ability is a risk factor for psychosomatic illness when it interacts with or is in the company of “negative activity” (Watson & Clark 1984) or repressed negative affectivity (Weinberger et al. 1979), also called neuroticism. Neuroticism is a genetically based personality trait (Bouchard et al. 1990) that is statistically unrelated to hypnotic ability but is known to amplify somatic symptoms. I have hypothesized that people who are high in hypnotic ability can amplify neuroticism to lethal levels, generating somatic symptoms with or without organic lesions (Wickramasekera 1979, 1988, 1992A, 1992B). People who are low in hypnotic ability but who are high on neuroticism will repress and transduce their psychosocial distress (hostility, depression, fear) into somatic symptoms like headache, back pain, or primary hypertension. For example, a person who is low on hypnotic ability but high on neuroticism and is angry at the boss who is “on my back” may unconsciously (Kihlstrom 1987) transduce his/her anger into a headache or backache. Because this type of chronic pain is resistant to conventional medical therapy and unfalsifiable, the patient may end up either addicted to a pain killer like Fiorinal or insisting on and receiving multiple unnecessary back surgeries.

There is evidence that both hypnotic ability (Hilgard 1965, Wickramasekera 1988)
ability, and transference in the varied fabrics of psychosomatic illness knit by Mesmer, Charcot, and Freud, stretching from the unconscious mind into the conscious mind.

REFERENCES:


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