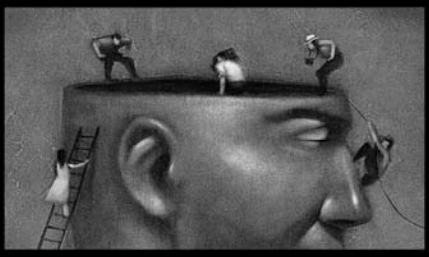
IDIOMS OF DISTRESS



psychosomatic disorders in medical and imaginative literature

LILIAN R. FURST

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Psychosomatic Disorders in Medical and Imaginative Literature

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Wer Augen hat zu sehen and Ohren zu hören, überzeugt sich, dass die Sterblichen kein Geheimnis verbergen können. Wessen Lippen schweigen, der schwätzt mit den Fingerspitzen; aus allen Poren dringt ihm der Verrat. Und darum ist die Aufgabe, das verborgenste Seelische bewusst zu machen, sehr wohl lösbar.

He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his finger-tips; betrayal oozes out of him at every pore. And thus the task of making conscious the most hidden recesses of the mind is one which it is quite possible to accomplish.

—Freud, *Bruchstück einer Hysterie-Analyse* (*Dora*)

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Preface

"It's all in your head"; "Isn't that what women are supposed to get?" These two responses to the word "psychosomatic" (incidentally, from well-educated individuals) are vivid illustrations of the uncertainties surrounding both the term and the concept. Neither formulation is wholly incorrect: the "head" (i.e., the mind) plays a cardinal role in psychosomatic disorders, and the gender ratio is weighted on the female side.[1] Yet each of these phrases is at best only partially valid; the one carries an undertone of dismissiveness, while the interrogatory form of the other indicates hesitancy.

Why are psychosomatic disorders so resistant to ready understanding? Their recalcitrant nature is due in part to their multivalence; chameleon-like, they can assume many different guises, appearing in every part of the body, although some, such as headaches and stomachaches, are more common than others. Also, they are hard to diagnose, for they do not yield signs of pathological changes in test results. They remain elusive, cryptic, posing a challenge to sufferers and physicians alike. And beyond their overt, often puzzling manifestations, psychosomatic disorders encompass a deeper problem in their close intertwining of psyche and soma, as their name suggests.

Yet the term itself is not a rarity. We apply it, with a wry smile, to a sudden headache, for instance, brought on by an annoying encounter that has rubbed us up the wrong way. By recognizing the headache as psychosomatic, we perceive it as a physical outcome of, that is, an outlet for, an emotional state. We know that it is not purely imaginary: it is real—we may take Tylenol or Advil or whatever pain medication we prefer. We do not immediately believe it to be a symptom of a grave pathological disturbance such as a brain tumor. But *how* are mind and body interacting? By what paths is the annoyance translated, converted into the headache or the stomachache or some other symptom? While recent advances in the

medical sciences offer some answers by reference to neurotransmitters, a great deal still remains unexplained at the beginning of the twenty-first century.

For this reason, all snappy definitions tend to be unsatisfactory. I have chosen as my title one I consider workable, "idioms of distress," which is taken from the latest edition of the American Psychiatric Association's *Diagnostic and Statistical Manual* (*DSM-IV,* 1994). The phrase was coined to designate what are known in medical language as somatoform disorders—"somatoform" having in the past twenty years superseded "psychosomatic" in professional terminology, as I shall later explain. Such disorders are described as "culturally shaped idioms of distress" that express concerns about a broad range of personal and social problems (450). Carefully worded though this definition is, it still begs a number of questions, not least the scope of "idiom."

According to the *Oxford English Dictionary,* an idiom is a form of expression, a construction, often having a meaning other than its grammatical or logical one. In its character as a construct, it denotes something newly created to fit a particular purpose, occasion, or situation. In its departure from (transcendence of) its strictly grammatical or logical meaning, an idiom moves toward metaphor, a mode of speech that entails a figurative transference from one medium to another. The word is, therefore, particularly apposite to psychosomatic disorders in shifting the focus from the manifest symptom itself onto its implicit metaphoricity.

This metaphoricity is one major source of the elusiveness so characteristic of the psychosomatic. We have difficulty in understanding not merely the term itself but what it represents because a kind of disguise is ingrained into the very concept. Not only does it comprise "a broad range of personal and social problems," it lacks a circumscribed psychopathology. The absence of a readily recognizable psychopathology to account for patients' complaints, while itself indicative of the potential for a psychosomatic disorder, intensifies the problem of distinguishing such an illness from organic disease. Physicians tend to be perplexed by patients whose symptoms do not fit into established syndromes and frustrated at having to run a long series of tests in order to rule out the possibility of an underlying pathology.[2] On the other hand, precisely this openness to multilayered interpretation and, above all, to metaphoricity make psychosomatic disorders an inviting terrain for reading from a literary angle. For literary study delights in the very ambivalence and figuration that are suspect to medicine, which must aim for the maximum certainty. Some of the fundamental issues at play in psychosomatic disorders are addressed in the opening chapter, "Speaking Through the Body."

Among the wide spectrum of somatoform disorders (pain disorder, hypochondriasis, body dysmorphic disorder, etc.), I have opted to concen-

trate on conversion disorders, whose hallmark is the translation of the distress into a physical symptom or symptoms, that is, its projection into the body as paralysis, deafness, blindness, muteness, or such lesser symptoms as headaches, palpitations, or gastrointestinal disturbances. Conversion disorders are the most common and striking among the psychosomatic disorders; they occur in 2.2 percent of the population, account for 5–10 percent of psychiatric consultations in general hospitals, and as high as 25–30 percent in Veterans Administration hospitals.[3] Their function as a nonverbal means of communication endows them with a metaphoric charge.

My study reaches from the mid-nineteenth century to the 1990s. Its second chapter, "Swings of the Historical Pendulum," offers a brief overview of the vicissitudes of psychosomatics in the past two centuries. The modulations in the cultural shapes of idioms of distress over the course of time have been examined by Edward Shorter in *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era.* Taking psychosomatic illness as "any illness in which physical symptoms, produced by the action of the unconscious mind, are defined by the individual as evidence of organic disease and for which medical help is sought" (x), Shorter catalogues its successive incarnations in a series of forms predominant at different periods: spinal irritation, disorders of the pelvic organs in women, motor disturbances (paralysis), dissociation (somnambulism and catalepsy), neurasthenia, pain, and chronic fatigue. His study illustrates, alongside the extraordinary range of psychosomatic manifestations, the varying and often bizarre theories about their physical manifestations. However, Shorter is concerned only with changing symptomatologies and belief systems without regard to their metaphoricity or psychological etiology, and he does not cover imaginative literature.

Shorter's book and other studies such as Janet Beizer's *Ventriloquized Bodies* raise an awkward terminological dilemma in their use of the word "hysteria." Commonly—and frequently rather loosely—it has been applied to the kinds of disorders subsequently deemed psychosomatic or nowadays somatoform. I prefer to use the more current terms for the sake of both greater precision and gender neutrality. As far as possible, I avoid "hysteria," since it carries pejorative connotations as well as considerable political baggage. Adopted enthusiastically in the cultural arena, it has quickly become hackneyed. Significantly, it has long been banished from psychiatric nosology because of its indeterminacy. I trace the evolution of psychiatric usage in the twentieth century in the third chapter, "The Mysterious Leap."

My primary focus is on the representation of psychosomatic disorders exhibited by fictional characters, not a biographical study of their authors' ills. If remote diagnosis in biography is a tricky enterprise, it is even more so in regard to fictional figures where the sole evidence consists of the

author's words. This difficulty is discussed in the fourth chapter, "Literary Patients." From the available information I relate the protagonists' symptoms to today's criteria for psychosomatic disorders. At the same time I maintain an awareness, in relation to the earlier works, of the shifts in terminology, such as changes in the understanding of the term "nerves."

But rather than attempting to pin a precise diagnosis on a fictional figure, I am experimenting with a medical humanities methodology. Its foremost strength lies in its capacity for a multidimensional approach that envisages a complaint as much from a social and psychological perspective as from a biomedical angle. As Dr. Allen Barbour learned in his work at the Stanford Medical Center's Diagnostic Clinic, patients have to be seen not solely as bearers of syndromes but "as persons in family and social systems."[4] Such a comprehensive vision is vital in dealing with psychosomatic disorders where the customary medico-scientific model draws a blank. For the center of gravity of psychosomatics resides, as Zbigniew Lipowski has insisted, in the "interactional aspects of man's functioning."[5] The core of the psychosomatic disorder is at the interstices of mind and body, individual and environment, conscious and unconscious, distress and illness. To cite Helen Dunbar's pioneering work, *Emotions and Bodily Change,* "[T]he problem of psychosomatic interelationships is continually a stumbling-block to the [medical] specialist";[6] the royal road to better understanding necessitates attention to the wider psychodynamic factors that form the frame for and often the basis of the disorder itself.

One result of this realization is to assign cardinal importance to literary works in the endeavor to grasp the etiology of psychosomatic disorders. Through its generous breadth the literary text is the ideal forum in which to show the psychosocial constellations that impell individuals to speak through their bodies. The literary work opens up to analysis the cultural factors that provoke and shape idioms of distress. The complex amalgam of tensions and pressures, inter- and intrapersonal conflicts is available for probing as the impetus to the gradual crescendo of distress that is ultimately converted into a physical idiom.

My aim is, therefore, to engage in dualistic readings in which the partly speculative medicalized perception of an overt text of bodily disturbance is partnered by a humanistic perspective that interprets the literal as a metaphoric figuration of a psychological subtext. Such an approach capitalizes on the special aptitude of literary portrayals for showing the web of social entanglements and personal relationships in which the individual is embedded and entrapped. A contextualizing view of this kind can trace both the processes that promote the growth of a psychosomatic disorder as it evolves and those that foster its dissipation as healing sets in.

My choice of texts, though seemingly idiosyncratic, is governed by certain principles. There are ample instances of conversion disorders in nine-

teenth- and twentieth-century literature, but often they are no more than slight, transient indispositions, such as the headaches that Jane Austen's and Proust's protagonists suffer at moments of reversal and discouragement. Even a severe conversion such as the mutism of the eight-year-old Clara Hutch, who is struck dumb after witnessing her mother's shooting of her two brothers and attempt to kill her in Caleb Carr's *Angel of Darkness* (1997), may form just a small, episodic part of a work.

Sometimes doubt arises whether a character has an organic disease. Milly Theale in Henry James's *The Wings of the Dove* (1902) is a good example. Her consultations with the eminent physician Sir Luke Strett for an "unnamed woe" (299) are remarkably inconclusive. Does she have "a bad case of lungs . . . that [are] past patching," as some in her circle aver (265)? Many readers assume with Susan Sontag that Milly has tuberculosis.[7] Rita Charon, on the other hand, argues that Milly undergoes psychotherapy with Sir Luke.[8] A clearer but still murky case of conversion is Lise, the adolescent in Dostoyevsky's *Brothers Karamazov* (1880). At the beginning of the novel she is in a wheelchair, her legs paralyzed. Later she makes a spontaneous recovery. The circumstances remain mysterious, rooted perhaps in the tension between her and her mother, a widow still young and eager for suitors. That domineering, unstable mother may wish to forestall competition from her blooming, attractive daughter by infantilizing—and disabling—her. As Lise matures and wins the admiration of Alyosha, she gains the confidence to rise to her feet.

But such a reading is largely conjectural, and that is the crux of the difficulty in many of the literary portrayals of a conversion disorder. My criterion has been to seek out works where the evidence is sound, providing sufficient density of circumstantial detail as a cogent basis for interpretation. Such density, together with an extensive temporal stretch, makes it possible to follow the psychosocial hurts that lead to a conversion disorder as well as its end stage in the manifest symptom. So, although the works discussed are quite dissimilar, they all share a common feature, namely that the psychosomatic disorder is both well delineated and absolutely central to the entire plot. Their very diversity reveals the wide spectrum of culturally shaped idioms of distress.

It is a great pleasure to acknowledge the help given to me by so many friends and colleagues from various fields. Roger Spencer, M.D., provided me with a starter reading list of the important recent medical writing on psychosomatics. Mark Perlroth, M.D. recommended Barbour's *Caring for Patients,* and during my summers at Stanford not only lent a willing ear but also offered provocative responses. Stephen M. Ford, M.D., Tom Boeker, M.D., and C. Fred Irons, M.D., have listened with infinite patience to my lamentations about the difficulties of this project and have contributed constructive suggestions. I am grateful to Janice H. Koelb for the long-term

loan of her *DSM-IV,* to Inger S. B. Brodey for drawing my attention to the *Synopsis of Psychiatry,* and to Peter Jacobson, M.D., for the loan of *Merritt's Textbook of Neurology.* Indeed, the entire Jacobson family—Peter, Karen, Kirstin, and Lars—has participated by suggesting works for inclusion. Diane McKenzie of the University of North Carolina's Health Sciences Library and Suzanne Porter of Duke University's Medical History Library have both given me valuable assistance. I am indebted to the University of North Carolina's Psychiatry and Literature reading group for introducing me to Flannery O'Connor's story "The Enduring Chill." My deepest gratitude goes to those who have bestowed on me the inestimable gift of encouragement: Joseph Frank, Edith Gelles, Steven and Madeline Levine, and, as ever, especially Esther Zago. A succession of graduate students have acted as my legs: S. Vida Grubisha, Gena Lewis, William A. Nolan, Thomas Spencer, and Marina Alexandrova; without their willing help this book could not have come into being.

PART I

Hiding and Seeking Distress

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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.

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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, progresively 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