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**UNDERSTANDING SOMATIZATION:
A PHENOMENOLOGICAL-HERMENEUTIC APPROACH**

Lori Teresa de Laplante

**A thesis submitted to the School of Graduate Studies of the
University of Ottawa in partial fulfillment of the requirements
for the Degree of Doctor of Philosophy**

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Acknowledgements

The completion of this theoretical dissertation has been an intensely challenging and personally rewarding experience. There are many people who have helped me bring this project to fruition.

First and foremost, I am deeply indebted to my thesis advisor, Dr. Bertha Mook, for her invaluable guidance and support. Not to be intimidated by my lack of philosophical training, Dr. Mook has consistently expressed her confidence in my ability to carry out this project. By giving me the time and space to arrive at a thesis topic that had personal significance for me, she has been instrumental in helping me shape my future career plans. Through our work together, she has provided me with a solid foundation for assessing the value of theories and therapeutic approaches in psychology. This is something that I had been seeking for a long time. Finally, I am grateful to Dr. Mook for showing, by her example, that it is possible to meet the challenges of a rewarding professional career while maintaining a creative and enriching personal life. She has given me many life goals to strive for.

I would also like to thank my committee members, Drs. Evelyn Gagné, Monique Lortie-Lussier and Augustine Meier, for their guidance, encouragement and support over the years. Their appreciation for the novel nature of this project has been particularly helpful.

My family has encouraged and supported me through this process in more ways than I can count. Through all ups and downs of my many years in the program, they have never lost faith. My parents have been particularly helpful in the final stages, as they provided me with a place to stay and wonderful home-cooked meals so that I could focus exclusively on my thesis. During my long days and weeks of working in isolation, it has been wonderful having such caring parents to come home to every night.

I am deeply indebted to three of my dearest friends for helping me keep my sanity and sense of humour throughout my years in the program. To Jim Foster, for the many personal sacrifices he has made to help me attain the goals that I set for myself so many years ago. His deep caring and concern for my well-being has helped me through many periods of worry and self-doubt. To my long-time friend, Nancy Davin, for rejuvenating my spirits countless times

with memorable evenings of wining, dining and great conversation. If not for her, my world would likely have shrunk to the size of my office. And last, but not least, I am eternally grateful to Jane Bailly for her unbridled encouragement and support. Her courage, honesty, and creativity in meeting her own challenges have been a tremendous inspiration to me. No one has made me feel more proud of the attempts I have made to meet the personal and creative challenges of this project.

Finally, I would like to thank Ron Chapman, my spiritual mentor, for his on-going guidance and unwavering support. During an existential crisis many years ago, Ron asked me if I had ever considered becoming a therapist. Since that time, he has never allowed me to give up until this dream became a reality.

Abstract

Somatization is a phenomenon that poses a tremendous challenge for patients and physicians alike. No health problem raises more confusion, anxiety, frustration and helplessness than distressing physical symptoms, such as pain or fatigue, which doctors are unable to explain. A phenomenological-hermeneutic investigation was therefore conducted to better understand this mysterious phenomenon and to determine why the Western health care system has such difficulty understanding and treating somatizing patients who suffer from medically unexplained physical symptoms. It was hypothesized that flawed philosophical, theoretical and/or methodological assumptions are partially at fault. As such foundational assumptions are implicit and taken-for-granted their validity is rarely questioned, yet their implications for treatment are profound. To explore this hypothesis, four models of somatization were reviewed and critically evaluated to identify how their foundational assumptions may be contributing to or impeding progress in the conceptualization and treatment of somatization. These include the neuropsychiatric, biopsychosocial, psychoanalytic and narrative models of somatization.

After outlining the foundations of a phenomenological-hermeneutic approach, the models of somatization were presented, along with a description of how the symptoms of a particular clinical case would likely be conceptualized. Each model was then evaluated in three stages: 1) explication of foundational assumptions, 2) evaluation of strengths and weaknesses, and 3) implications for the problematic of somatization. As a result of this evaluation, specific foundational assumptions have been identified which interfere with the ability of certain models to adequately capture the richness and complexity of somatization as it is lived and experienced by individual sufferers. These flawed foundational assumptions result in inaccurate or incomplete conceptualizations which hinder the ability of proponents to design effective treatments. As a result, some models are contributing inadvertently to the suffering experienced by their patients. While the models varied significantly in terms of their strengths and weaknesses, a cross-model comparison identified a number of foundational, conceptual and treatment issues that remain unresolved or inadequately addressed by the models as a whole. The final chapter described how a phenomenological-hermeneutic approach can begin to address these issues and provide a novel contribution to the understanding and treatment of somatization.

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I. INTRODUCTION

For centuries, doctors have attempted to understand and treat patients who present with medically unexplainable physical symptoms, ranging from paralysis and seizures in the 19th century to chronic pain and fatigue in the 20th century (Shorter, 1992). Older terms, such as *conversion hysteria*, *hypochondria*, *melancholia* and *neurasthenia*, have been replaced by more recent terms, such as *functional somatic syndromes* and *somatoform disorders*, to refer to a phenomenon called *somatization* that remains poorly understood (Malt, 1991; van der Feltz-Cornelis & van Dyck, 1997). As a result, many sufferers of medically unexplainable symptoms are receiving inadequate treatment, leading to a serious personal and public health concern.

According to Lipowski (1988), somatization is "a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them" (p. 1359). If pathology exists, it is insufficient to account for the severity of social and occupational impairment experienced by the patient (Kellner, 1994). It may be acute or chronic, and concurrent physical illness may be present. It is neither a discrete clinical entity, nor the result of a single pathological process and it cuts across diagnostic categories (Kellner, 1990; Kirmayer, 1986). Some somatizers may have concurrent mental diagnoses (particularly mood disorders), and many will acknowledge that psychological factors may be contributing, at least in part, to their symptoms. However, this generally happens only when psychological issues are recognized by the physician and raised with the patient (Kirmayer, Robbins, Dworkind, & Yaffe, 1993). According to Kirmayer and colleagues, only a small minority of somatizers (about 10 percent) persistently refuse to acknowledge the significance of psychological factors after they have been raised by the physician. These patients are at the greatest risk of developing persistent, disabling symptoms.

The territory encompassed by somatization is vast. It includes (a) somatic symptoms with no medical explanation, (b) somatic symptoms that are partially explained by pathophysiological disturbances, and (c) functional somatic syndromes such as irritable bowel syndrome, chronic fatigue syndrome, fibromyalgia, and multiple chemical sensitivity syndrome. These functional somatic syndromes have been termed "borderland" conditions (Lipowski, 1986), given the

controversy amongst media sources, scientific researchers, and sufferers regarding the relative role of organic versus psychogenic factors. The most common complaints experienced by somatizers include pain (especially involving the back, abdomen, chest, head, pelvis, muscles and joints), fatigue, gastrointestinal symptoms, dizziness, shortness of breath, and palpitations (Lipowski, 1987a).

Much of general medical practice is devoted to the care of patients who are symptomatic but not seriously ill. In approximately 50% of all primary care visits, no medical cause is found to explain physical symptomatology (Bakal, 1999; Barsky & Borus, 1995; de Gruy, 1996).

Symptoms without medical cause also occur with great frequency in the general population. Community data show a lifetime prevalence of close to 25% for chest pain, back pain, dizziness, headache, and abdominal pain (Kroenke, 1992). In addition, 50-70% of primary care patients with a diagnosable psychiatric disorder initially present with somatic symptoms (Barsky & Borus, 1995). As a result, psychiatric disorders are frequently masked by somatic symptoms and left untreated.

While the prevalence of somatization has steadily increased over the past 30 to 40 years (Barsky & Borus, 1995), it has received little attention from physicians and psychiatrists until recently. Referred to as "medicine's unsolved problem" (Lipowski, 1987b) and one of "medicine's blind spots" (Quill, 1985), it exists in the land that borders medicine and psychiatry. The medical profession lacks a satisfactory model for explaining and managing physical symptoms in the absence of physical cause. In fact, Wickramasekera (1998) believes that somatizing patients represent one of the largest single challenges facing primary care medicine. Because they are difficult to identify and difficult to treat, they are extremely costly to the medical system.

With respect to identification, the requirement that a somatic complaint cannot entirely be explained by a physical disorder implies that a medical workup has failed to disclose a physical cause. However, there is no agreement as to what constitutes an adequate or exhaustive workup (de Gruy, 1996). One doctor's workup may not be considered extensive enough by another doctor. Given the fear of malpractice and the fact that many somatizers also suffer from physical illness, extensive medical investigations are frequently undertaken, and patients are often referred

to a variety of specialists for further expensive and invasive testing.

With respect to treatment, it is clear that physicians experience a great deal of frustration, confusion, and helplessness with this population. In medical circles, persistent somatizers have been described as "hypochondriacal," "neurotic," or "hysterical" to suggest that the symptoms serve some unconscious symbolic function for the person, or through the sick role, helps the person to attract attention or manipulate others (Bakal, 1999). An internist describes it thus: "symptoms are among the leading reasons patients visit doctors, yet are among the last things a doctor wants to see" (Kroenke, 1992, p. 3). This tongue-in-cheek statement captures the frustration felt towards those who remain undiagnosed, and thus unreassured, after frequent medical investigations and referrals reveal no physical disease (Ford, 1983; Lipsitt, 1970).

This frustration often leads to strained doctor-patient relations and poor treatment. Medical treatment seldom results in satisfactory resolution of the symptoms, and efforts by professionals to attribute these symptoms to psychological factors leave patients feeling stigmatized, misunderstood and resentful for the inference that their bodily symptoms are not "real" and only exist "in their heads" (Bakal, 1999). For this reason, a third to a half of primary care patients refuse their doctor's referral to mental health professionals (de Gruy, 1996). While some seek out further medical advice, others, particularly in the past decade, look to holistic practitioners for alternative solutions (Astin, 1998; Verhoef, Sutherland, & Brkich, 1990). Those who follow through on a mental health referral may be difficult to engage, particularly if they are expected to accept a psychological explanation for their symptoms right away. Thus, much of the conflict between patients and health professionals revolves around the moral issue of who or what is responsible for their illness.

This conflict over causality is costly from many perspectives. Economically, somatization contributes significantly to health care costs, disability and lost wages (Smith, 1994). Ford (1983) estimated that somatization cost the U.S. as much as \$20 billion annually in health care alone, as somatizing patients are disproportionately high users of medical services, laboratory investigations, and surgical procedures (Barsky & Borus, 1995). In fact, the health care costs of patients with a life-long pattern of somatization (i.e., somatization disorder) was found to be nine times the national average (Smith, 1994). Somatization also accounts for a large share of

disability payments and missed work days (Kleinman, 1986).

Living with an "invisible chronic illness" also has a profound impact on the personal lives of somatizers (Donoghue & Siegel, 1992). In comparison with medically ill patients, patients with somatization disorder displayed more psychological symptoms and social disability (affecting work and parenting), were more preoccupied with their health, and were more likely to describe themselves as severely ill (Smith, 1994). While not all somatizing patients experience the same level of disability as those with somatization disorder, they may experience an increased health risk resulting from exposure to multiple prescription drugs, and risky or unnecessary medical procedures (Barsky & Borus, 1995; Kleinman, 1986; Smith, 1994). The most serious complaint of somatizers, however, is having the validity of their symptoms questioned by friends, family, and health professionals alike (Donoghue & Siegel, 1992). The moral ambiguity surrounding their status as patient contributes significantly to their psychological distress, and can exact a tremendous toll on their personal relationships.

Why is it that somatization poses such a problem for Western medicine? This thesis will argue that the inadequacy of current conceptualizations of somatization can partly be traced back to their philosophical and theoretical foundations. For example, medical practice is founded upon ontological assumptions regarding the nature of the human body, epistemological assumptions regarding the validity of scientific knowledge, and normative assumptions regarding health and illness. These foundations are largely based upon the modernistic assumptions of a natural scientific worldview. The therapeutic implications of these assumptions are profound, and yet the medical profession has largely failed to acknowledge or question them. Since the 1970s with the rise of the post-modern movement, a wide range of intellectual disciplines have come to reject modernist assumptions outright (Giorgi, 1970; Rosenau, 1992). Objectivity, rationality, causality and universality have been replaced by an emphasis on partial, perspectival, socially constructed knowledge that is embedded in a social, historical and linguistic context (Anderson, 1997; Rosenau, 1992; Smith, 1997).

It is within the context of these paradigmatic shifts that four models of somatization have evolved. The neuropsychiatric, psychoanalytic, and biopsychosocial models are influenced, in varying degrees, by the modernistic assumptions of a natural scientific worldview. Similar to the

medical profession, proponents of these models have largely failed to question and examine the implications of their implicit foundational assumptions. Emerging from the post-modern era is a narrative, language-based model of somatization that presents a radical alternative to the more conventional models. It emphasizes the social construction of medically unexplained symptoms and the importance of working with patient's narratives (Griffith & Griffith, 1994). Aside from a limited critique of each other's perspective, there is little interface or dialogue between these models.

To identify implicit assumptions that may be contributing to the problematic of somatization, there is a clear need to rigorously and respectfully evaluate these models and assess the impact of their foundational assumptions on the conceptualizations and treatment recommendations that are put forward. A phenomenological-hermeneutic approach¹ is ideally suited to this task, given that it stands outside of these approaches and does not have a model of somatization to defend. Instead, it provides a rich, philosophical and theoretical perspective on human nature that is grounded in lived experience rather than a particular theory, and is not based upon the modern or post-modern assumptions of current treatment models that may be contributing to the problematic. In addition, although earlier attempts were made to understand psychosomatic illness from an existential-phenomenological perspective (e.g., Boss, 1979), no one has taken a systematic, comprehensive look at how the foundations of existential and hermeneutic phenomenology could contribute to a deeper understanding of somatization.

Therefore, the purpose of this thesis is to:

1. Present the foundations of a phenomenological-hermeneutic approach.
2. Review and critically evaluate four models of somatization from a phenomenological-hermeneutic perspective.

¹ Unless otherwise indicated, the term *phenomenological* in this thesis will refer to existential-phenomenology, the term *hermeneutic* will refer to hermeneutic phenomenology, and the term *phenomenological-hermeneutic* will refer to the combined insights of these two approaches.

3. **Identify the unresolved issues and deficiencies that currently exist in the conceptualization and treatment of somatization.**
4. **Demonstrate how a phenomenological-hermeneutic approach can begin to address these unresolved issues and provide a significant contribution to the understanding and treatment of somatization.**

The foundations of a phenomenological-hermeneutic approach will be presented in Chapter II. This chapter will describe how the human being is viewed by prominent philosophers in phenomenology, existential phenomenology, and hermeneutic phenomenology. It will also describe the main characteristics that distinguish psychology as a natural science from psychology as a human science (i.e., based upon phenomenology and hermeneutics). As a number of models base their study of somatization on natural science assumptions, this section will help clarify these assumptions and avoid undue repetition.

A review and critique of the four models of somatization will be presented in Chapter III. This chapter will begin with a comparison of modern and post-modern perspectives toward somatization. These perspectives are critical to understanding the context from which the problem of somatization and the current treatment approaches have emerged. The review of each model will then be presented in three parts: 1) background theory, 2) application to somatization, and 3) therapeutic implications. Next, a clinical case will be used to illustrate how each model would hypothetically account for somatized symptoms in a patient referred to as Mary. Finally, each model will be critically evaluated in three stages: 1) explication of foundational assumptions, 2) evaluation of strengths and weaknesses, and 3) implications for the problematic of somatization. A summary of the critical evaluation will be presented at the end of the chapter.

In Chapter IV, issues arising from the literature review as a whole will be reflected upon. Comparing and contrasting the four models, this chapter will identify novel hypotheses and treatment approaches, similarities, contradictions, and omissions or deficiencies. It will conclude by describing the foundational, conceptual and treatment issues that remain unresolved or inadequately addressed.

Chapter V will demonstrate how a phenomenological-hermeneutic approach can begin to address these unresolved issues and provide a significant contribution to the understanding and

treatment of somatization. It will begin by providing a sense of the lived experience of somatization, based upon findings from qualitative research studies. This will be followed by a conceptualization of somatization based upon the works of existential-phenomenological philosophers and therapists. Next, the therapeutic implications of existential and hermeneutic phenomenology will be presented. Finally, a conceptualization of Mary's case will be presented to provide a comparison with the conceptualizations put forward by the other models. The chapter will conclude by summarizing and describing the implications of a phenomenological-hermeneutic approach to the problematic of somatization.

Chapter VI will summarize the conclusions of this study, discuss its limitations, and make recommendations for future research.

II. FOUNDATIONS OF A PHENOMENOLOGICAL-HERMENEUTIC APPROACH

Before launching into a discussion of the foundations, it is important to clarify what we mean by a phenomenological-hermeneutic *approach*. The term “approach” has a somewhat unique meaning within the human sciences. It refers to the theoretical, philosophical and “common sense” presumptions regarding human nature and one’s field of interest that every scientist or practitioner brings to their work (Giorgi, 1970). As one’s approach is often taken-for-granted and implicit, its influence over the method or content of one’s investigation is rarely acknowledged. The choice of method or type of phenomena to be studied inevitably implies a certain stance or approach, impacting powerfully upon the conclusions and recommendations that are made.

From a phenomenological-hermeneutic perspective, sciences such as psychology and medicine need to be much more aware of the foundational assumptions that guide their work. They place the natural scientific conception of the world in a privileged position, and tend not to question whether the worldview and methods of the natural sciences are appropriate to the study of human experience. Instead, natural scientific methods are typically imposed in an a priori manner, regardless of the type of phenomena being studied. According to phenomenology, there needs to be a constant dialogue between the approach, the method, and the content of the phenomenon being studied, as well as an openness to the viability of other approaches and methods than one’s own (Giorgi, 1970). By reflecting on the overt and covert characteristics of one’s approach (e.g., presuppositions, biases, criteria), one may uncover hidden factors that have been stumbling blocks to progress in the field. In addition, one may be able to identify methods that are more uniquely designed to access the particular phenomena of interest.

These philosophical and methodological issues have great relevance to the phenomenon of somatization. As mentioned in Chapter I, there are at least four different models for conceptualizing and treating somatization. In order to address the problematic of somatization, the foundational assumptions of each model need to be uncovered and reflected upon, not with a view to support or negate them, but to gain an increased understanding of how they may be impeding or contributing to progress in the understanding and treatment of somatization.

Given the importance attached to making foundational assumptions explicit, this chapter will describe the foundations of a phenomenological-hermeneutic approach. First, a philosophical view of the human being will be presented from the perspective of existential and hermeneutic phenomenology. This will be followed by a discussion of the main characteristics that distinguish psychology as a natural science from psychology as a human science. The purpose of this chapter is to provide a basic understanding of the foundations from which current models of somatization will be evaluated, and to articulate the parameters for an understanding of somatization based upon a phenomenological-hermeneutic approach.

Philosophical View of the Human Being

This section will introduce some of the seminal ideas of the primary contributors to phenomenology, existential phenomenology, and hermeneutic phenomenology. To help situate the progression of thought, a brief description of the relationship between these approaches is first provided.

Phenomenology was founded at the turn of the century by Edmund Husserl, a German philosopher, who argued that philosophy must go back "to the things themselves" and attempt to describe phenomena as they are lived and experienced, not as theory may imagine them to be. To this end, he developed a philosophy which included a rigorous method for the study of how human consciousness comes to "know" its world (Husserl, 1931, 1960, 1970). While many Continental philosophers objected to some key aspects of his phenomenology, most were profoundly influenced by his views on the intentionality of consciousness, the phenomenological method, and the life-world, using these ideas as a springboard for their own original works (Kockelmans, 1994). In Kockelman's opinion, "his work has generated a number of great philosophical works in which the seeds planted by the father of the modern phenomenological movement have come to fruition, even though they may have produced fruits of a different kind" (p. 348).

Existential phenomenology represents one of the main "fruits" of Husserl's labour. It is a philosophical discipline that represents the convergence of phenomenology and existentialism.

Existentialism originated with Soren Kierkegaard in the mid-19th century. The aim of his philosophy was to address the concrete existence of the individual person and attempt to elucidate the fundamental experiences with which humans struggle (e.g., freedom, guilt, anxiety, responsibility) (Valle, King & Halling, 1989). Husserl's main successors, Martin Heidegger and Maurice Merleau-Ponty, integrated existentialism and phenomenology such that phenomenology became the method of existentialism. Heidegger (1962) was primarily interested in the ontology of Being. He employed phenomenological methods to study the nature or "way of being" of human existence, and is most well known for his analyses of *Being-in-the-world* and *temporality*. Merleau-Ponty (1962, 1963, 1968) was profoundly influenced by the writings of both Husserl and Heidegger. He worked out his own phenomenology of lived experience, emphasizing the primacy of perception and what it means to be an embodied-subject-in-the-world.

Hermeneutic phenomenology is a philosophical tradition that employs phenomenological methods to explicate the nature of understanding and interpretation as it is lived in everyday experience. Heidegger and Merleau-Ponty had an influence on the development of hermeneutic phenomenology, offering foundational insights into the nature of understanding and the significant role of language and speech. As a student of Heidegger, Gadamer (1975) expanded upon Heidegger's insights and developed his own theory of understanding, emphasizing the unavoidable influence of language, culture, and history. Shifting the emphasis from ontology to epistemology, hermeneutics has been put forward by Paul Ricoeur (1981) as the most appropriate method for the human sciences. He has developed a theory of interpretation (Ricoeur, 1976) and has contributed extensively to a hermeneutic understanding of narratives (Ricoeur, 1984).

The foundations of existential and hermeneutic phenomenology will form the core of our phenomenological-hermeneutic approach. As Husserl's phenomenology is not as directly relevant to our topic of investigation, only a few of his key contributions will be discussed. These will be followed by a description of some foundational concepts in existential phenomenology that have originated from the works of Heidegger and Merleau-Ponty. Finally, the works of Gadamer and Ricoeur work will be discussed briefly to introduce relevant insights from hermeneutic phenomenology.

Phenomenology

Edmund Husserl (1859-1938)

As a philosopher, Husserl was dismayed by the impasse that existed between the realists, who affirmed the independent existence of the object, and the idealists, who affirmed the priority of the subject (Spiegelberg, 1965). To resolve this impasse, he developed a philosophy which views acts of consciousness and objects of consciousness as *intentionally* related and inseparable, in that consciousness is always directed toward its object (Husserl, 1960). He also argued that philosophy must be as rigorous and radical a science as possible. However, the object of philosophy is not factual, or empirically measurable, but *ideal*, having its origin in consciousness. Therefore, Husserl (1965) developed a *phenomenological method* to study the data of consciousness in a rigorous manner. His aim was to establish a transcendental philosophy that would give science a strict foundation by arriving at a scientific knowledge of the essences of things, as given in experience. In his later years, Husserl attempted to show how a return to the *life-world* of our immediate, pre-reflective experience was necessary for the empirical sciences to address the more meaningful questions of human existence. Following is a brief elaboration of these concepts.

The Intentionality of Consciousness

Husserl (1960) posited certain structures as being universal and essential features of consciousness of the world. The notion of intentionality was originally formulated by Brentano but significantly modified and extended by Husserl. According to Husserl, "the word intentionality signifies nothing else than this universal property of consciousness: to be consciousness *of* something" (p. 33). This represents the first feature of intentionality: that consciousness is always "directed toward" or "in relation to" an object (thing, person, idea, etc.). A second feature of intentionality is the inseparability or interdependence of consciousness and its objects. It is only by objects that consciousness is revealed and vice versa. One cannot investigate objects independently of investigating the conscious acts of which they are objects.

Some profound implications follow from this notion of intentionality. It has been understood as a way of overcoming the Cartesian dualisms between subject and object, mind and body, and in a broader sense, self and world, because we are always in relation to that which is beyond us (Hammond, Howarth, & Keat, 1991). In fact, Luijpen (1960) refers to phenomenology as a "philosophy of *encounter*" (p. 97). Phenomenology posits that consciousness can never be understood in cause-effect terms because it is an expression of the intentional and meaningful relationship between person and world. In addition, this view of consciousness contrasts with the prejudice of *sensationalism* within psychology, which views mental life as purely made up of "sensations," such as pain, colour, or mental images (Hammond, Howarth, & Keat, 1991). Instead, the whole of the objective world and the whole of conscious life are believed to constitute a unity (Husserl, 1960).

The Phenomenological Method

Husserl believed that philosophy needed an entirely different starting point and method from the natural sciences. He wanted to develop a science of phenomena that would clarify how it is that objects are experienced and present themselves to our consciousness. When he first began to describe objects phenomenologically, he wanted to know what accounted for the *givenness* of an object; that is, the sense that the object is "nonreducible to and independent of consciousness" (Carr, 1974). He discovered that the origin of an object's givenness could be found in the act of consciousness which was directed toward it. He then asked himself, how can we account for the givenness of the world? The sense that the world exists? His phenomenological analyses led him to uncover a fundamental *natural attitude* that he believed was responsible for this sense. He considered it to be the nature of consciousness to ontologize, and to assume that the world has an objective, independent, real existence that can be explained and understood through natural laws (Kockelmans, 1994). This is the attitude of everyday life. He realized that philosophy could not gain access to primordial phenomena within this attitude.

Therefore, to enable a philosopher to shift from this natural attitude to a *phenomenological attitude* without presuppositions, he developed a phenomenological method and outlined a series of reductions that he considered central to this method (Husserl, 1931,

1960).² The term *phenomenological reduction* is similar in meaning to *epoché*: one attempts to suspend, bracket or set aside all of one's preconceptions and assumptions when attempting to understand a given phenomenon. In particular, it requires setting aside all existential assumptions taken for granted in the natural attitude, to arrive at intuitive insights into the ideal objects or essences of things. The epoché would be applied when describing conscious acts or cogitations (such as remembering, deciding, judging, perceiving), as well as the "objects" which the conscious acts are directed towards (e.g., what it is that is judged or remembered). What emerges from Husserl's phenomenological method is the realm of transcendental being or transcendental subjectivity: that of the pure, transcendental Ego and its cogitations. Husserl believed that this realm provides evidences which are both primary and beyond doubt.

Life-world

In "The Crisis of European Sciences and Transcendental Phenomenology," Husserl (1970) made some significant changes to his earlier notion of "world," referring to it as the *life-world* or *Lebenswelt* - the world as we encounter it in everyday experience, prior to any reflection on it. It is the world which is immediately given in our individual and social experience, including cultural objects that have human meaning and serve human needs (e.g., books, buildings, art). "Because the world has such objects at all and therefore provides the framework within which we live our human life, we refer to it as our life-world" (p. 127). The term *life-world* also has a historical-social implication: a life-world is relative to a given society at a certain time in history (Kockelmans, 1994). The beliefs, conceptions, and opinions that are prevalent in society shape how the world appears to us. Husserl particularly expressed concern that the objective, determinate picture of the world posited by modern science had been accepted as reflecting an absolute truth about the world, rather than as one view among other possible viewpoints.

Husserl (1970) came to view the natural sciences as a serious threat to Western culture because it had degenerated into an unphilosophical study of facts, ideal constructs, and

² The reader is referred to Kockelmans (1994) for a description of Husserl's three stages of reduction.

theoretical abstractions, with no real understanding of the life-world which its theories were abstracting from. As a result, it was in no position to help resolve some of the serious human issues of his day. Science, according to Husserl, was in desperate need of his transcendental phenomenology to re-establish contact with the pre-theoretical life-world through the process of phenomenological reduction. In contrast to the mediated character of scientific thought, the life-world represents the underlying soil or "meaning-fundament" from which all theory is derived (Carr, 1974). Thus, from Husserl's perspective, the life-world is primary and represents the only valid starting point for all knowledge, including scientific knowledge.

Summary

While certain aspects of Husserlian phenomenology have been critiqued, including its transcendental nature and presuppositionless ideal, Husserl remains the founder of phenomenology and has had a profound impact on the phenomenologists who followed (Spiegelberg, 1965). He was the first philosopher to fundamentally challenge the validity of the Cartesian-based natural scientific worldview and its appropriateness for the study of human experience. This included a rejection of the Cartesian dualistic view towards subject-object, mind-body, and self-world. He was also the first of many philosophers to recognize the importance of investigating phenomena as they are lived and experienced, rather than as they are "theoretically imagined to be." In addition, he insisted on the importance of becoming aware of one's presuppositions, particularly those that are taken for granted, so that their impact on the phenomena being studied can be reflected upon. All of these themes have been carried forward and transformed through the works of existential and hermeneutic phenomenologists.

Existential Phenomenology

Martin Heidegger (1889-1976)

Heidegger worked in close cooperation with Husserl from 1920-23, but gradually moved away from Husserl in his thinking. In 1927 he published his major work, "Sein und Zeit" (Being

and Time). It received great critical acclaim and assured him a place in history as one of the most important and influential philosophers of the twentieth century. Aside from a period of turmoil during the First World War, Heidegger continued to lecture and publish essays on such issues as Being, truth, technology, and language.

“Being and Time” posed a radical challenge to the way Being had been conceptualized in Western philosophy for over 2000 years. According to Barrett (1990), the word “being” has two meanings. As a noun, it is a name for things that exist (e.g., a table or a tree; anything that *is*). As a verb, “Being” signifies the “to-be” of things. Heidegger’s contention was that Western thought had shown an exclusive preoccupation with being as “the thing which is” (i.e., being as a substance), and had neglected the question of what it means *to be*. This had resulted in an abstract, empty concept which failed to capture the distinctively human way of Being. He traced the “fall” of Being to Greek times when there came a shift in Plato’s writings from *a-letheia* or *un-hiddenness*, as the mark of truth, to the correctness of an intellectual judgement, as the meaning of truth (Barrett, 1990). Truth henceforth resided in the intellect, which led to the gradual estrangement of humans from their own sense of Being. The aim of “Being and Time” was to conduct an ontological inquiry into the meaning of Being *in general*, not just the meaning of being human. However, given that man is the only Being that has the ability to transcend itself and *reflect* upon the meaning of its existence, Heidegger began his inquiry with an analysis of human existence, which he called *Dasein* (“Being-there”)³. In his words, “*fundamental ontology...must be sought in the existential analytic of Dasein*” (1962, p. 34). He analysed the a priori conditions under which one’s existence is made meaningful, and set out to describe Dasein’s “average everydayness,” challenging traditional interpretations of the knowing subject (e.g., Descartes) which had only analyzed how one exists when engaged in detached reflection.

Heidegger (1962) wed phenomenology and hermeneutics in a unique way to serve his ontology. He used phenomenology to describe everyday human existence as directly and concretely as possible, and saw the disclosure of Dasein as the primary task of phenomenology: “*Only as phenomenology, is ontology possible*” (p. 60). He also believed that ontology must, as

³ Dasein refers to that aspect of the human being which is concerned with the awareness of its own existence and is capable of inquiring into its own Being.

phenomenology of Being, become a “hermeneutic” of existence. Phenomenology provided the means to disclose and describe existential phenomena, but a hermeneutic approach was needed to understand and interpret the *meaning* of Dasein in the context of its world. “The phenomenology of Dasein is a *hermeneutic* in the primordial signification of this word, where it designates this business of interpreting” (p. 62). Interpretation focuses on the meaning of things which are not immediately obvious. Hence, the meaning of Being, which is half-hidden in everyday existence, can only be known through the hermeneutic process which always proceeds in a circular fashion based upon one’s pre-understanding of a phenomenon. In Heidegger’s hands, hermeneutics, which had traditionally been used to interpret texts, became an ontology of understanding and interpretation. The phenomenology of Husserl, which required all presuppositions (including our belief in the existence of the world) to be bracketed, was applied and extended to include a hermeneutic dimension. The latter aimed to acknowledge and explicate presuppositions, while recognizing that the historical nature of Dasein precludes the possibility of setting them completely aside.

The following section summarizes some of the key concepts presented in “Being and Time.” The first part focuses on Heidegger’s existential analysis of Dasein. It consists of a series of *existentials* which reflect a priori modes of existence (ways of being) that are presupposed in any experience and make that experience possible. Heidegger provides answers to such broad questions as, what does it mean for us *to be* in a world? *To be* with others? *To be* one’s self? Growing more specific, the next part examines a series of existentials associated with how Dasein becomes aware of its Self in the world, and the difference between authentic and inauthentic modes of existence. This is followed by a discussion of *care*: Heidegger’s single existential that most vividly describes Dasein’s particular way of existing. The final part shifts to Heidegger’s ontological analysis of Dasein, where it is described how authentic existence is possible, and how Dasein and the existential structure of care is ontologically grounded in temporality.

Existential Analytic I: Being-in-the-world

According to Heidegger (1962), “Dasein’s Being...must be...understood *a priori* as

grounded upon that state of Being which we have called “‘Being-in-the-world’” (p. 78). In contrast with Descartes, who asserted a dualistic subject-object relationship between humans and their environment, Heidegger asserted that the world is an essential, irreducible constituent of man’s way of existing. Dasein refers to a field or region which is immersed in world, prior to any separation of self and object. Heidegger’s ontological meaning of *world* is not to be taken as the sum of objects in our environment. It is closer to what might be called our personal world, referring to the intricate web of relationships that each of us has with the people and things in our lives that we are involved with, that hold personal significance. The world itself is nothing but this relation-whole in which we understand ourselves among other beings. Thus, Dasein and its world are co-constitutive and interdependent, each depending upon the other for the meaning of its existence. The *prior* capacity within us that allows us to relate and be affected by the world is the *a priori* existentielle, Being-in-the-world.

Although Being-in-the-world stands for a unitary phenomenon, Heidegger broke it down further into three ways of being: “Being-alongside-the-world,” “Being-with Others,” and “Being-one’s Self.” These were later reformulated by Binswanger (1963) as *Umwelt* (enviroming world), *Mitwelt* (social world), and *Eigenwelt* (personal world). These ways of being are described below.

Being-alongside-the-world. Heidegger (1962) describes two main ways in which we encounter the things in our world: practically (“ready-to-hand”) and theoretically (“present-at-hand”). In our practical involvement in the world, we do not see things as material objects which happen to be there in a universal space, but as utensils or equipment which we use *for the sake of* carrying out our tasks. For example, when typing a letter, the typewriter is encountered as part of a web of significant relations associated with its actual use. Typing is *in order to* create a covering letter, which is *for* sending out a resumé, which is *for the sake of* being a person with a new job. Thus, in our primordial relationship with the world, things are ontologically defined as ready-to-hand for our use, with their being submerged in the movements the body performs without thought. As an example, the meaning or function of a typewriter is disclosed, not to the theoretical, analytical gaze, but in the brief moment that it *breaks down* and stops functioning, showing at once what a typewriter *is*.

This understanding of a typewriter is very different from one that would be obtained from a more theoretical perspective, by viewing it as a “present-at-hand” object with certain measurable characteristics that are independent of its function or use. Heidegger acknowledges that the theoretical approach can be valuable when investigating things scientifically. However, the belief in Western science and philosophy that the world is *only* present-at-hand, has created many “pseudo-problems” within philosophy (e.g., the false distinctions between subject-object, mind-body, self-world) and has led to the interpretation of humans as just another object. While viewing the ready-to-hand and present-at-hand modes as different and incomplete ways of seeing, Heidegger maintains that the practical is primary, while the theoretical is secondary and derivative.

In addition, Heidegger views the *spatiality* of Dasein as more primordial than the abstract space of “objects.” The spatiality of Dasein is not an objectified notion of space. Rather, it is a space generated by the way in which Dasein sees things as “close” or “far away,” based upon what it is concerned with in the moment. According to Heidegger (1962), Dasein’s spatiality has the characteristic of *de-severance*, “making the remoteness of something disappear, bringing it close” (p. 139). For example, one would feel closer to a friend walking towards them, than to the car that one is leaning against. Similarly, things can be brought close in a purely cognitive manner, as when one recalls the events of a trip, or envisions a future event happening. These modes of spatial awareness, whether “felt” or “thought,” exist a priori as a constitutive element of Dasein’s Being-in-the-world.

Being-with Others. Heidegger (1962) argues that Dasein is already in the world; a world in which other persons are likewise given. He states: “By ‘Others’ we do not mean everyone else but me....They are rather those from whom...one does *not* distinguish oneself - those among whom one is too” (p. 154-55). Because Being-with is an existential characteristic of Dasein, its understanding of Being already implies the understanding of others as Beings with the same *for the sake of* character as us, in which things are ontologically defined as ready-to-hand for our use.

Heidegger (1962) introduced the concept of *care-for* or *solicitude* as the way of care appropriate to being-with other Daseins in a mutually shared world. He describes two possible ways of solicitude that represent extremes: a “leaping in” mode and a “leaping ahead” mode. In

the first mode, one leaps in to take care of things that are the responsibility of the Other. This mode of caring-for is widespread and can lead to the Other becoming dependent and dominated without being aware of it. The second mode is a kind of solicitude which “leaps ahead” and liberates the Other, “not in order to take away his ‘care’ but rather to give it back to him authentically as such for the first time” (p. 159). Between these two extremes lie a range of mixed modes of caring-for, including an indifferent mode reflecting an un-caring toleration of the Other.

Being-one’s Self. Heidegger (1962) describes two possible ways for a Self to exist: an owned (or authentic) existence, and a disowned (or inauthentic) existence. He argues that, for the most part, Dasein is absorbed in the world of its concern, and is not its Self. Rather, “the Self of everyday Dasein is the *they-self*,” which he distinguishes from the “*authentic Self*” (p. 167). One frequently loses one’s awareness of one’s Self in the inauthenticity of the anonymous “they.” In everyday being-together, we are inclined to “fall captive to the world,” to drift along with the crowd, doing what “one” does, enacting stereotyped roles, and thereby losing our ability to define our own lives. We use others as a measuring stick for how we are doing, and how we should be. As Heidegger states: “Everyone is the other, and no one is himself” (p. 165). He argues that this happens due to the “fallenness” (*Verfallen*) of man’s Being, a distinctive existentials of Dasein. Fallenness refers to the tendency of Dasein to “move away” from itself by seducing itself to seek its own fulfillment in the explanations of self and world made public by “them.” As Heidegger (1962) states, “Being-in-the-world is in itself *tempting*” (p. 221). Hence, for the most part, man understands himself not from his own being, but from what other people think.

As Barrett (1990) eloquently states, “So long as we remain in the womb of this externalized and public existence, we are spared the terror and the dignity of becoming a Self” (p. 220). To be authentic is to face up to one’s responsibility for what one’s life is adding up to as a whole. Before one’s existence can be properly one’s own, it has to be “wrested” back from its absorption in the world. This is a very challenging task that involves “a clearing-away of concealments and obscurities...a breaking up of the disguises with which Dasein bars its own way” (Heidegger, 1962, p. 167).

Now that Dasein’s three ways of being in the world have been described, the presentation

will shift to examine how Dasein becomes aware of its Self in the world.

Existential Analytic II: The “Being-in” of Dasein’s “Being-in-the-world”

According to Heidegger (1962), our lives are meaningful not only because of what *is*, but also because of what *might have been* and what *might be*. This section describes two ways of Being (or existentials) which are equally primordial: “state-of-mind” (*Befindlichkeit*) and “understanding” (*Verstehen*). A third, equally fundamental existential, is “discourse” or “talk” (*Rede*), which reveals one’s state-of-mind and understanding. All three existentials disclose the Beingness of Dasein. Being equiprimordial, they are all fundamentally necessary to make sense of who we are. As each of these existentials are ways of being one’s Self, they may be authentic or inauthentic. In this section, Heidegger describes how these existentials are manifested inauthentically in the everyday “fallen” existence of Dasein.

State-of-mind (*Befindlichkeit*). A more literal translation for *Befindlichkeit* is “the state in which one is to be found” (Gelven, 1989, p. 86). Heidegger uses the term *Stimmung* (mood) as well as *Gestimmtheit* (being attuned) to designate the existential fact that the state or mood that we “find ourselves” in at any given time is not ours to determine. Rather, it is dependent upon how we respond to the *thrownness* or *facticity* of our existence: that is, being thrown into a world without having a say in the unalterable facts of our life (i.e., the biological and sociological givens that result from being born into a particular family, culture, socioeconomic status, historical era, etc.). We always have a basic feeling (pro/con) toward the inevitable aspects of our life that are beyond our control. Our mood is also dependent upon how we are affected by the beings (people, things) in the world which we are attuned to. Heidegger is not talking about moods as psychological constructs but as modes of Being. Mood is a general attitude towards the world and not towards any particular objects in the world. Thus, moods do not simply reflect an internal state. Rather, “A mood assails us. It comes neither from ‘outside’ nor from ‘inside,’ but arises out of Being-in-the-world” (Heidegger, 1962, p. 176). Feelings would not be possible if they were not grounded in attunement, which reveals Dasein as capable of being affected and moved by whatever it encounters. For example, the mood of fear would not be possible if nothing in the world mattered to us. However, because of the tendency of Dasein to “fall captive

to the world,” Dasein typically lets the world “matter” in such a way that it evades its very Self, as mentioned earlier. Thus, the essential characteristic of states-of-mind is that *“they disclose Dasein in its thrownness, and...for the most part - in the manner of an evasive turning-away”* (p. 175).

Rather than viewing moods as irrational or of lesser value than one’s thought processes, Heidegger sees them as indicators of “how one is” at a much more primordial level than “how one *thinks* one is.” He states, *“the possibilities of disclosure which belong to cognition reach far too short a way compared with the primordial disclosure belonging to moods”* (1962, p. 173). Dasein always finds its self in a mood which exists *prior* to any act of cognition or volition. While Heidegger agrees that Dasein can, and should, attempt to “master” its moods through knowledge and will, it always does so by way of a counter-mood. Hence, we are never free of moods.

Understanding (*Verstehen*). Equiprimordial with state-of-mind is *understanding*. Understanding reveals to Dasein its “potentiality-for-Being” or its “ability-to-be.” In Heidegger’s words, “Dasein is not something present-at-hand...it is primarily Being-possible” (1962, p. 183). My own existence is a possibility stretching out before me which I concern myself with and have some control over. Heidegger describes the function of understanding as “projection” or “throwing forward.” Understanding operates by projecting before Dasein its possibilities. What I am right now makes sense to me only in terms of my looking ahead. Each moment of the day, I see the things and people that I am practically involved with as existing *for the sake of what I am about to do*. For example, the long hours worked by a graduate student can only make sense to that person if they are seen as *for the sake of* obtaining their degree and beginning a career. At a more mundane level, a carving knife is only understood in terms of one’s projected carving of something, such as a turkey. Hence, we understand the world in terms of our projects, our possibilities.

The understanding Heidegger refers to is not restricted to the mind’s cognitive activities, but is the existential structure in Dasein which makes our ordinary conceptual understanding possible. Barrett (1990) describes it as a kind of pre-conceptual understanding that is “experienced in one’s bones,” before one has any words to articulate it. It is a kind of knowing

that is tied closely to existing, which challenges the traditional way of describing the knowing process with its subject-object distinctions.

After laying out the ontological basis of understanding as the projection of possibilities, Heidegger examines the epistemological role of understanding through an analysis of *interpretation*. The chief function of interpretation is to *make explicit* what is already understood. As Heidegger (1962) states, “that which is *explicitly* understood - has the structure of *something as something*” (p. 189). When one makes explicit the as-structure of something, one is pointing out the *meaning* - i.e., purpose or use - of that thing. For example, when we see a fork *as* a fork, we have a primordial understanding that it *is* for the purpose of eating. When we merely stare at something, without seeing it *as* something, we fail to understand it. Thus, understanding is incomplete without interpretation.

However, in contrast with Husserl, Heidegger (1962) states, “an interpretation is never a presuppositionless apprehending of something presented to us” (p. 192). Rather, every interpretation is grounded in a body of taken-for-granted assumptions based upon Dasein’s *use* of the world as ready-at-hand. Heidegger refers to this pre-understanding as the *fore-structure* of understanding. Thus, the validity of arriving at a so-called “objective” interpretation is directly challenged by Heidegger’s analysis of how understanding operates. The hermeneutic circle is a structural element of every human attempt to interpretively understand phenomena. For one can only interpret a new phenomenon from the perspective of the pre-understanding that one brings to it. The understanding of the new phenomenon that is achieved, will in turn, change and deepen the original pre-understanding from which the interpretation had been made.

Discourse/talk (*Rede*). Heidegger’s third existentials, *Rede*, has been translated as “discourse”, “speech” or “talk.” As the existential foundation of language, speech is readily overlooked. Due to the “objective” nature of words preserved in books, the impression is given that language consists of word-things to which meanings are added. The truth, according to Heidegger (1962), is exactly the opposite: “An intelligibility which goes with a state-of-mind - *expresses itself in discourse*. The totality-of-significations of intelligibility is *put into words*.... But word-Things do not get supplied with significations” (p. 204). Language is thus derived from speech which is the articulation of existential understanding. Through discourse, mood and

understanding are made known. Mood is disclosed through intonation, modulation and tempo of voice. Understanding is shared through all forms of discursive speech, including speaking, hearing, listening and keeping silent. Barrett (1990) provides an example of two people talking together. Attuned to each other and understanding each other, they fall silent. This silence speaks louder than words, reflecting the primordial attunement of one Being to another, in an unexpressed context of mutual understanding. Thus, the roots of language lie in human existence, not in grammar or logic. As Palmer (1969) explains, “Man does not invent language any more than he invents understanding, time or being itself” (p. 152-3).

Care as the Being of Dasein

The goal of Heidegger’s existential analytic was to discover what it means to be Dasein as Dasein; that is, to arrive at a single existential structure that would encompass all that is unique to human existence. The result is “care” (*Sorge*) which he describes as the primordial structure which underlies and unifies the three distinctive existentials of Dasein: understanding, state-of-mind, and fallenness. In summary, what it means for one *to be* is *to care*. The ontological meaning of care differs from what care normally refers to. Care is the primordial pull to fulfill one’s innate potentialities; to become all that one can be, given one’s circumstances. It is the turning away from “everydayness” and becoming “resolute” in the pursuit of personal authenticity. It is not a condition of the mind but the fundamental structure of Dasein itself, which makes all ways of Dasein’s being actually possible. All of the existentials find their central locus in care, which can be subdivided into caring *about* things in the world that are not Dasein (“concern”), and caring *for* other Daseins (“solicitude”). To nurture the development of one’s own potential for Being, as well as the potential of others, is the ultimate call of human existence and experience. It is a call to experience life, in relationship with others, to the fullest.

Ontological Analysis: Dasein and Temporality

Once Heidegger’s existential analytic revealed care as the Being of Dasein, he shifted his inquiry to reflect upon the *ontological* ground of the existential structure of care. What must be presupposed in order for such a structure to be possible? Having described Dasein’s Being as

care, he still needed to interpret its meaning. In the second half of “Being and Time,” Heidegger investigates death and authentic existence, to round out his existential analytic. These analyses lead into his ontological discussions on temporality, historicity and the temporal structure of care.

Being-towards-death. Heidegger uses the term “Being-towards-death” to signify the existential awareness of the possibility that one could die at any time. He uses the three existentials of Dasein to uncover the ontological meaning of death. The existential of *understanding* projects the possibility before me that I am really going to die, and that my death cannot be shared or taken over by someone else. The *state-of-mind* that reveals to me the unalterable fact that I will die, is “dread” or “anxiety” (*Angst*). Dread reflects an “uncanny” sense of feeling “not-at-home” in one’s daily existence, as though one is watching oneself perform familiar actions from a distance, thus forcing one to focus on one’s *own* self, rather than the *they*-self. To know that one is capable of *not-being* also reveals that one is capable of *being*. However, the *fallenness* of everyday Dasein typically leads one to avoid confronting the meaning of death (and thus one’s freedom *to be*), by turning away from it. The dread gets “dimmed down” and becomes manifest as fear of some definite object. As Heidegger (1962) states, “Fear is anxiety, fallen into the ‘world,’ inauthentic, and, as such, hidden from itself” (p. 234).

Authentic existence. In contrast with the above, an authentic awareness of death recognizes the full significance of man’s finitude and the possibility of not-being. In this case, “anxiety makes manifest in Dasein...its *Being-free for* the freedom of choosing itself and taking hold of itself” (Heidegger, 1962, p. 232). Reflecting on one’s impending death can make one aware of one’s possibilities that are not yet fully realized. It is in the realm of possibilities that authentic existence is actualized. Heidegger describes it as “*an impassioned freedom towards death - a freedom which has been released from the illusions of the ‘they’, and which is factual, certain of itself, and anxious*” (p. 311). The ultimate locus of authenticity is freedom. By taking responsibility for one’s choices, one can avoid becoming caught in the web of inauthenticity.

So how does one’s authentic self come to light? According to Heidegger (1962), it is revealed through the *voice of conscience*. He states: “The call of conscience has the character of an *appeal* to Dasein by calling it to its ownmost potentiality-for-Being-its-Self; and this is done by *summoning* it to its ownmost Being-guilty” (p. 314). It is not the *actual* experience of guilt

that is authentic, but rather the *wanting* to feel guilty if there are grounds to do so. The form of discourse that discloses conscience is keeping silent, which Heidegger refers to as *reticence*. If we are to hear the call of conscience, we must be quiet to listen to it. Heidegger uses the term *resoluteness* to refer to the resolve to assert one's own existence, freely grounded in the responsibility and guilt that is disclosed through one's conscience.

Temporality. Already in the preface, Heidegger (1962) presented his position on how Being and time were to be related: "Our provisional aim is the Interpretation of *time* as the possible horizon for any understanding whatsoever of Being" (p. 1). In the second half of "Being and Time," Heidegger tries to show the primordial meaningfulness of time, and how temporality provides the ontological foundation for the ordinary and scientific conceptions of time. He does not contend that these conceptions of time are wrong; just that they are secondary to and derived from Dasein's primordial experience of time.

The ordinary, everyday interpretation of time arises from the temporality of Dasein in its fallen, inauthentic state. Here, time becomes the measure of change which makes social interaction at the level of the "they" possible. Everyday time is measured using clock-time and calendars to indicate the quantity of available time. As Gelven (1989) states, it is in this domain that people claim they have "no time for...". The objective notion of time derived from the natural sciences has become part of our everyday conception of time, in which time is seen as an endless, irreversible, succession of "now-moments" which pass away. The past is taken to be definitively past, the present is dominant, and the future is understood from the perspective of the present. But time is not infinite. Dasein's projection of possibilities has its end in death, as discussed earlier.

Heidegger's phenomenology of time is based upon the primordial experience of time by Dasein in its authentic mode of existence. As King (1964) states, "The phenomenon of time can be *originally* experienced only in owned existence" (p. 170). Primordially, the future does not mean a *now* which has not yet come to pass. Rather, anticipating death makes Dasein constantly come toward itself; *to be* a human being means *to become*. In this sense, Dasein's mode of Being-toward-death implies the *future*. Heidegger views the future as primary because it is the region toward which Dasein projects its possibilities and in which it defines its own Being.

Dasein's temporality also extends to the "having been," which Heidegger distinguishes from the "past." For Heidegger, the past is not a "now that is gone," but a "gone that is still here" (Kockelmans, 1990). This "having been" is how we experience our past; it is what I have been and still am in some way. If Dasein is to understand itself authentically, it needs to accept its thrownness, what it already *is*. According to Heidegger, what constitutes Dasein's genuine *present* are the possibilities of Dasein's future as they have been opened up by what has been. The genuine meaning of the present consists in a "making present." The things and people in Dasein's world can only be noticed as present if Dasein *makes* them present through its practical involvement in the world.

Contrary to traditional theories, Heidegger does not consider these different phases of time as distinctly separate from one another. He refers to them as *ekstases* of time, meaning that they "stand out from the general flow of time" and reciprocally imply each other, as noted above (Gelven, 1989). They can only be considered separate from one another if one applies the external framework of everyday time to them. In a sense, the future is the genuine completion of the "having been," with both phases existing together in the present (Kockelmans, 1965).

If Dasein understands itself authentically, then it knows that it is not only inherently temporal, but also *historical*. Time actualizes the unity of one's life as it "stretches along" from birth to death and reveals the historicity of human existence. Persons are not merely *in* history; their past constitutes their conception of themselves and their future possibilities. In addition, Dasein's "having been" far exceeds a person's own life. It includes the past of its own generation, and all periods of history which have shaped that generation. Heidegger shows that Dasein is not temporal because it "stands in history," but rather that Dasein exists historically only because it is temporal to its very core. Barrett (1990) sums it up thus: "As temporality is to time, so is historicity to history; as we make clocks to measure time because our being is essentially temporal, so man writes histories or makes history by his actions because his very being is historical" (p. 229).

Finally, Heidegger responds to his original question regarding the ontological foundation of care, by demonstrating how the three existentials of care are grounded in the three ekstases of time. Primordial *understanding* discloses Dasein's being as "Being-ahead-of-itself," which is

grounded in the future. Primordial *state-of-mind* discloses Dasein's being as "Being-already-in-the-world" in its thrownness and facticity, which is grounded in the "having been." Discursive speech discloses the *fallenness* of Dasein's "Being-alongside," which is grounded in the present. Or as Krell (1977) describes it: "I pursue possibilities for my future, bear the weight of my own past, and act or drift in the present" (p. 65). What is meant by temporality is precisely the unity of this structural whole. These three structures define human existence as a temporal unfolding.

What, then, is the "self," the "I"? Rather than being an isolated subject with substantial properties, Heidegger sees the self as an "I who cares," an "I" who is already in the world. As Gelven (1989) states, "[the self] is that which is exposed through *authentic* existence and is covered up in *inauthentic* existence" (p. 176). It is that which is aware, through the primordial connectedness of death, guilt, and conscience, of what it means *to be* a temporal and historical Being. It is thus, a characteristic of existence, not an entity or substance.

Summary

Heidegger never considered himself an existentialist. Yet his insights into the nature of everyday human existence have captured the imaginations of many who have made the effort to comprehend his unique terminology and obscure style of writing. His existential analyses of Dasein's practical engagement in the world represent a significant challenge to the theoretical interpretations of subjectivity, objectivity, spatiality and temporality shared by Western philosophy and science. In contrast with the subject-object dualism of Descartes, Heidegger defined the essential nature of humans as a Being co-constituted and interdependent with its world. He also viewed understanding and interpretation, along with mood and discourse, as existential structures rather than only cognitive activities or affective states. Applying Husserl's phenomenological method and extending it to include a hermeneutic dimension, he demonstrated the need for both traditions to come together to provide an appropriate methodology for describing, understanding and interpreting the meaning of Dasein in the context of its world. His concept of Being-in-the-world and his perspectives on understanding, temporality, historicity and language have been taken up and developed further by philosophers such as Merleau-Ponty, Gadamer and Ricoeur.

Maurice Merleau-Ponty (1908-1961)

With Sartre, Merleau-Ponty was responsible for introducing the philosophy of Husserl to France. Impressed by Husserl's notions of the life-world and of the intentional structure of consciousness, Merleau-Ponty followed Heidegger in providing these notions with an existential foundation that attempted to overcome the idealistic overtones of Husserl's phenomenology. However, Merleau-Ponty went further than Heidegger, seeking to emphasize not only the world-relatedness of the human subject, but above all, its bodily nature. In his first work, "The Structure of Behavior," Merleau-Ponty (1963) challenged the scientific explanations for behaviour put forward by the psychologists of his day. He developed a psychology and philosophy of form that held all behaviour to be structured and meaningful, and emphasized the distinctiveness of human behaviour over other forms of organismic life. In the "Phenomenology of Perception," Merleau-Ponty (1962) worked out a detailed phenomenology of perception, extending it to the body and to the intersubjective realm. His later work, "The Visible and the Invisible" (1968), reflects his attempt to develop a phenomenological ontology that overcomes the last traces of subject-object and other dualisms that existed in his earlier works. Relevant ideas from these works are briefly described below.

The Structure of Behavior

This work begins with an investigation of three major psychological approaches to human behaviour in the 1930s (i.e., experimental, behavioural, and Gestalt). Merleau-Ponty (1963) showed how these approaches were based upon realist or idealist assumptions that could not be supported when the life-world was examined without theoretical prejudice. He chose to study the notion of behaviour because he believed it to be "neutral with respect to the classical distinctions between the 'mental' and the 'physiological' and thus can give us the opportunity of defining them anew" (p. 4). His analyses of behaviour led him to the notion of *form* or *structure* as an alternative to viewing behaviour as a dimension of reality that is a thought (Idealism) or a thing that exists in-itself (Realism). Merleau-Ponty then applied the notion of structure to inanimate, biological and human beings to make clear the distinctions between them. He also offered his

own understanding of the relationship between body and soul, or what is referred to today as body and mind; a problem that continues to plague Western philosophy, and is clearly relevant to the thesis topic at hand.

Meaning-structure of behaviour. In Merleau-Ponty's existential phenomenology, structure (or form) is a basic, foundational concept. In general terms, it refers to a pattern of relationships between parts within a whole. More specifically, "there is form whenever the properties of a system are modified by every change brought about in a single one of its parts and, on the contrary, are conserved when they all change while maintaining the same relationship among themselves" (1963, p. 47). Merleau-Ponty's unique contribution was to formulate the notion of structure as an interconnected pattern of *meanings* that are intentionally related. Rather than viewing behaviour as a thing (object) or idea (constituted by a subject), he proposed that all behaviour is structured and meaningful, arising from the "circular dialectical interchange between man and world" (p. xiv). In opposition to the prevailing views that behaviour was caused by mental or physical events, he argued that it was *realism* that must be called into question. He states, "from the moment behaviour is considered 'in its unity' and in its human meaning, one is no longer dealing with a material reality nor, moreover, with a mental reality, but with a significative whole or a structure which properly belongs neither to the external world nor to the internal world" (p. 182). Thus, the only "reality" is the immanent meaning of the structure. Introspection or external observation are simply different perspectives on the same structure or form.

Because a structure operates as a whole, behaviour can never be understood in cause-effect terms by breaking it into its component parts. Similar to music, "it is no more composed of parts which can be distinguished in it than a melody...is made of the particular notes which are its momentary expression" (Merleau-Ponty, 1963, p. 137). Rather, it is an object of perception, a perceived whole that is an expression of the irreducible intentional relation between person and world. For example, a football field is not an "object" to a player. Rather, there is a dialectical relationship between the field and the player's actions. As the player moves through the field, the field calls for certain actions without the player's conscious awareness. In Merleau-Ponty's words, consciousness is "a network of significative intentions which are sometimes clear to

themselves and sometimes, on the contrary, lived rather than known” (p. 173). Objects of perceptions are *lived* as realities, rather than *known* as “true objects.” Human behaviour can only be understood by analyzing the immanent meaning of an action and its intentional structure.

The physical, vital, and human orders. Merleau-Ponty (1963) criticized the Gestaltist’s theory of form for being unable to let go of postulates based on Realism. It holds that biological and mental structures are founded on physical structures, which exist *in* nature as real things. Instead, Merleau-Ponty believed that the physical, vital (biological) and human orders of activity or behaviour must be distinguished as they are structurally different. Analyzing the notion of form in inanimate, living, and human beings, Merleau-Ponty found that distinctive types of relations were manifest at each level.

In the physical order, forces or particles cannot be explained by referring to absolute laws or properties, as has been done in classical physics. Rather, Merleau-Ponty (1963) proposes that all physical laws express a structure: “each form constitutes of a field of forces characterized by a law which has no meaning outside the limits of the dynamic structure considered” (p. 138). A physical form will redistribute its forces in response to external pressures to conserve a state of equilibrium or reduced tension. Thus, physical phenomena cannot be explained without considering the integrated whole, the dialectic of laws in a given structure.

The main difference between the physical and vital orders is that the behaviour of advanced biological organisms has a *meaning* that depends upon the vital significance of situations. As Merleau-Ponty (1963) states, “The unity of physical systems is a unity of correlation, that of organisms is a unity of meaning [signification]” (p. 155-6). The relationships at this level are oriented toward a set of tasks. For example, the instinctive aptitudes that structure such animal behaviours as building a nest or seizing a prey can only be recognized when one is attentive to the meaning of these behaviours (Bannan, 1967). Similar to physical phenomena, organismic behaviour cannot simply be explained by cause-effect relations between independent parts.

The originality of the human order is manifest in its symbolic behaviour. An animal cannot vary its point of view or view an object as having multiple potential uses. Signs only serve as “signals” and cannot become “symbols” (Madison, 1981). Humans, on the other hand, are able

to orient themselves to all the *possible* or *virtual* ways in which an object can be viewed, opening it up to a multiplicity of uses. Genuinely human consciousness is thus a symbolic consciousness; it has the ability to transcend the sign and “go beyond created structures in order to create others” (Merleau-Ponty, 1963, p. 175). Mook (1987) describes this continual movement of transcendence as the most fundamental character of the human order. Humans are thus able to create new possibilities and transform their own structures of meaning.

Merleau-Ponty shows that the structures of behaviour in the physical, vital, and human orders represent three irreducible dialectics. While the higher orders cannot be reduced to the lower ones, they are founded on them. The human order constitutes a new level of existence or a new form of unity that integrates and reorganizes the lower levels of behaviour. As Merleau-Ponty (1963) states, “the relation of each order to the higher order is that of the partial to the total” (p. 180). Each of these orders is related, but subordinate to, the higher order. An important implication of this differentiation is that the meaning of distinctively human behaviour can never be fully understood by applying theories and methods that have been used to study biological organisms or physical systems.

The relations of body and soul (matter and mind). It is important to first clarify what is meant by *soul* in this context. Corresponding to the Greek *psyche*, the soul has been purported to be an entity that makes self-consciousness possible, and that accounts for our personal identity (Audi, 1995). Descartes’ arguments for the incorporeality of the soul were challenged by his contemporaries and have been heavily criticized ever since, given that no satisfactory account could be provided for how an immaterial soul⁴ and a material body could interact. However, Descartes’ theory has had a tremendous influence, including its foundational role in the mind-body dualism that is currently entrenched in Western attitudes toward health and illness.

As mentioned earlier, Merleau-Ponty views physical, vital and human structures as three forms of signification, and not as three orders of reality that are causally related. He sees the matter-mind or body-soul problem as intimately related to perception. In contrast to the realist and idealist perspectives, he proposes a revised conception of body-soul relations based upon the

⁴ For the purpose of this discussion, mind and soul will be used interchangeably, as “mind” has come to replace the term “soul” in the secular language of our times.

philosophical primacy of perception. He describes the soul as “mind which comes into the world,” and emphasizes that the soul acts on the *phenomenal* body, not the objective body (1963, p. 106).

According to Merleau-Ponty (1963), normal development should be considered as a “progressive and discontinuous structuration of behavior” (p. 177). Normal behavior is organized such that the structure or form that is constituted gives an integrated meaning to behaviour. The more weakened, inadequate, or fragmented the structurations are, the greater it appears that a causal explanation of behaviour would be viable, as these weakenings allow more rigid structures to develop that appear to have a certain autonomy. Thus, when weak, fragmented or rigidified structures are operating, as can happen in cases of mental or physical illness, a certain duality *appears* to exist between soul and body. The apparent autonomy of these fragmented structures is often perceived as evidence of a cause-effect relation between body and soul. But this appearance of separation is not a duality of substances. Rather, Merleau-Ponty describes a “functional” (versus substantial) opposition that exists between body and soul. To the degree that one’s instinctual life (e.g., gratifying one’s own needs and desires) is integrated into a higher level of properly human behaviour (such as making sacrifices for a loved one), the body “has truly become a human body” and “his soul and his body are no longer distinguished” (p. 202-3). In this case, soul is not a new kind of being or substance but a new form of *unity* (Madison, 1981).

The Phenomenology of Perception

As Merleau-Ponty’s descriptions of form advance to the human level, form becomes more and more a structure *for* consciousness; that is, the world is meaningful only for a *consciousness* which perceives it. However, the meaning in question is not an idea constituted by consciousness, or something “real” that belongs to the world. It is something that is perceived at a primordial level by a consciousness that is bound inseparably to the world. “The Structure of Behavior” thus called for a study of natural, pre-reflective experience which Merleau-Ponty took up in the “Phenomenology of Perception.” The principal goal of this work was to move beyond the intellectual constructs of traditional philosophy and return to the world as we actually experience it as embodied subjects prior to all theorizing. In addition to a sustained criticism of

all natural scientific and reductionist views, Merleau-Ponty carried out an extensive phenomenological investigation of perception and perceived reality. Some key concepts are described below.

The primacy of perception. Merleau-Ponty (1962) was acutely critical of the assumption implicit in most sciences that their theories constituted a more truthful account of reality than one based on direct lived experience. He pointed out that the reduced worlds of the sciences are mere abstractions from the phenomenal world which remains their ultimate ground and measure. Instead, the task should be “to rediscover phenomena, the layer of living experience through which other people and things are first given to us, the system ‘Self-others-things’ as it comes into being” (p. 57). Influenced by the later works of Husserl, Merleau-Ponty used the term *lived world* to refer to the pre-reflective phenomenal or perceptual world. In vivid language he states: “To return to things themselves is to return to that world which precedes knowledge, of which knowledge always *speaks*, and in relation to which every scientific schematization is an abstract and derivative sign-language, as is geography in relation to the countryside in which we have learnt beforehand what a forest, a prairie or a river is” (p. ix). The primacy of perception grounds Merleau-Ponty’s phenomenology just as the primacy of the subject informs idealism and the primacy of the object informs realism (Madison, 1981).

According to Merleau-Ponty (1962), perception is more primordial than reflection, and has an anonymous or pre-personal character. “Every perception takes place in an atmosphere of generality and is presented to us anonymously....So, if I wanted to render precisely the perceptual experience, I ought to say that *one* perceives in me, and not that I perceive” (p. 215). Merleau-Ponty refers to this anonymous perceptual consciousness as the *tacit cogito*, which is foundational for all other modes of consciousness, including the Cartesian *cogito*. From this position, “All consciousness is, in some measure, perceptual consciousness” (p. 395).

The lived body as “embodied-subject-in-the-world”. Merleau-Ponty (1962) was the first philosopher to address the fundamental role of the body in human existence and its intentional role in mediating our relationships to the world. For Merleau-Ponty, the body is first of all a *lived body*. We do not experience our body as an object or an anatomical mass but as the “living envelope of our actions” through which we perceive and interact with the world (p. 188). As

Merleau-Ponty states, “consciousness and body are but two sides or aspects of a certain presence to the world” (p. 240). Our experience of being *present* in the world reveals that our phenomenal body is essentially a *knowing* body. From Merleau-Ponty’s perspective, perceptual consciousness must be understood as a *bodily* awareness of the world, and the perceiving subject as an *embodied* subject (albeit a pre-personal, anonymous subject), from which all other forms of knowledge are derived.

By viewing consciousness and body as an intertwined unity, Merleau-Ponty (1962) broadened the notion of intentionality beyond Husserl’s conception of an intentional consciousness. However, he retained Husserl’s distinction between *operative intentionality* and the *intentionality of act*. When something is present to operative intentionality it is *comprehended* or *grasped* and when something is present to the intentionality of act it is *consciously known*. Merleau-Ponty uses the notion of operative intentionality to support his position that every human word, every gesture, has meaning, even if we are not consciously aware of it. For example, if I grow tired of a discussion and fall silent, my silence expresses a certain lack of interest, even though I may only relate it to fatigue. Thus, the sphere of lived intentions is much larger than that of conscious thought.

To clarify the notion of an embodied-subject-in-the-world, let us use the example of knitting a sweater. The needles, wool, and instructions “offer themselves to the subject as poles of action” which call for a certain kind of work (Merleau-Ponty, 1962, p. 106). The phenomenal body is a living instrument in the subject-world system, and the task to be performed “elicits the necessary movements...by a sort of remote attraction” (p. 106). The knowing-body is immediately aware of *where* its limbs are as all of its senses work in unison to *project* itself towards the world of its tasks. Bodily existence thus implies a spatiality of *situation* rather than a spatiality of *position*. “Consciousness,” as Merleau-Ponty writes, “is being towards the thing through the intermediary of the body” (p. 138-9).

Bodily existence also implies temporality. The body is seen to comprise, like two distinct layers, the *habitual body* and the *present body* (Langer, 1989). The former signifies the phenomenal body that has lived in the past and has acquired certain habitual ways of relating to the world. With its “two layers,” the body is the meeting place of past and present which is

carried forward into the future. Merleau-Ponty (1962) describes how the “phantom limb” experience of some amputees brings to light the temporal structure which characterizes our existence as incarnate beings. “Feeling” an arm which one no longer has is a way of refusing handicap, of continuing to live by means of a “bodily schema” which one had formerly learned through contact with the world (Madison, 1981). As the lived body is not an object, “we must...avoid saying that our body is *in* space, or *in* time. It *inhabits* space and time” (Merleau-Ponty, p. 139).

Thus, the lived body is neither a subject nor an object. Rather, “the experience of our own body...reveals to us an ambiguous mode of existing” (Merleau-Ponty, 1962, p. 198). It manifests an ambiguous union of the subject and object. Rather than a system of externally related parts, it displays a bodily spatiality, temporality, unity, and intentionality, which distinguish it radically from the scientific object posited by traditional schools of thought.

The role of language. Merleau-Ponty reconsiders our experience of language to indicate, again, how the mind-body dualism is inappropriate. Our usual tendency is to regard speech as a simple translation of autonomous thoughts into words. According to Merleau-Ponty (1962), this tendency arises from our failure to distinguish between authentic speech, and second order language. Authentic or first-hand speech refers to instances where meaning is formulated for the first time, such as “the child uttering its first word...the lover revealing his feelings...or...the writer and philosopher who reawaken primordial experience” (p. 179). When a new meaning comes into being as a person speaks, his speech is not preceded or accompanied by thought. Rather, “his speech is [*italics added*] his thought” (p. 180). Just as the speaker and listener have no need to visualize their limbs in order to move them, so they have no need in communication to visualize the words in order to speak them. From this perspective, it is just as erroneous to regard thought as separable from its expression in speech, as to regard music as detachable from its expression in sounds (Langer, 1989).

In contrast to authentic speech, second order speech does not elicit new thoughts or meanings but merely reinforces already existing ones. Second order speech thus conceals the existential significance of authentic expression by giving us the illusion that we possess thoughts independent of words. In fact, we do not know our own thoughts until we formulate them in

“internal or external speech” (Langer, 1989). “Thus speech...does not translate ready-made thought, but accomplishes it” (Merleau-Ponty, p. 178). Like other forms of behaviour, speech is an activity that realizes a potential use of the body as the embodied subject projects itself toward the world. By pointing to an essential relationship between thought and the pre-reflective experience of the body, Merleau-Ponty hoped to resolve the mind-body dualism that underlies traditional approaches to language.

The perceived world. The new conception of the lived body as perceiving subject requires a new conception of the *world* and the perceived object. Merleau-Ponty’s theory of the body is, implicitly, a theory of perception. Every external perception is immediately synonymous with a certain perception of our body. It is through the primordial, bodily act of looking or touching that certain things in our perceptual field come to have existence and meaning for us, while others remain in the background. The perceived world and the lived body are thus intentionally related such that neither can meaningfully exist without the other. As Merleau-Ponty eloquently writes: “The lived body...is in the world as the heart is in the organism: it keeps the visible spectacle constantly alive, it breathes life into it and sustains it inwardly, and with it forms a system” (cited in Mook, 1998, p. 237).

For example, a woman is reading a book when a song catches her attention on the radio. As a primordial, knowing body, she instinctively turns up the volume without consciously knowing why. Soon, the song is recognized as a favourite from her childhood, and she is instantly transported to a scene from the past. In the next moment, a timer goes off to remind her to check the roast in the oven. These things in her world - the book, the radio, the timer - are not experienced as independent objects or “things-in-themselves,” but “things-in-themselves *for her*.” They register in her perceptual field because they have meaning for her. If her husband was in the room, he would relate to these “objects” differently (if he perceived them at all). As Merleau-Ponty (1962) explains, “In the natural attitude, I do not have *perceptions*, I do not posit this object as beside that one, along with their objective relationships. I have a flow of experiences which imply and explain each other both simultaneously and successively” (p. 281).

In light of Merleau-Ponty’s thought, Mook (1998) views the phenomenon of children’s play as an excellent example of this body-world relatedness. She writes: “Being situated bodily

in the play world, the playthings offer themselves as ‘poles of action,’ and potentialities are mobilized through the intentional threads woven between his phenomenal body and his playthings....From within his own sedimented layers of experience, his lived body discovers and ascribes meanings to his evolving play world” (p. 239). In this pre-personal world of perception, the child, as a pre-subject, loses himself in the pre-objective world. It is from this primordial level of perception that both things and ideas come into being.

The world of Others (intersubjectivity). For Merleau-Ponty (1962), the solution to the “problem” of other people is based upon the ambiguous existence of the lived body, which is neither subject nor object, but a dialectical synthesis of the two. My experience of other people is based upon the perception that I have of my own body. If my body is not an object for me, the body of the other is not one either. I understand the behaviour of the other’s hands because my hands are similar to the other’s and I know them from the inside. When I suddenly touch my right hand with my left one, my right hand ceases for a moment to be a sensing “subject” and becomes a sensed “object.” From this, I experience “half-way” the possibility of being an “other.” As embodied-subjects-in-the-world, we are “brought together in the one single world in which we all participate as anonymous subjects of perception” (p. 353).

Merleau-Ponty (1964) also used the infant’s experience of the world to demonstrate how it develops relations with others. For example, children under six months lack a visual notion of their own body. At this stage, Merleau-Ponty points out, the infant “cannot separate what *he* lives from what *others* live as well as what he sees them living” (p. 135). During this period of syncretic sociability when the self-other distinction is absent, an infant will, for example, open his mouth when a mother pretends to bite his fingers. In fact, the infant discovers its own bodily capabilities through mimicking the corporeal behaviour of others. It perceives others’ bodies with its own phenomenal body and thereby directly perceives their intentions. For the child, the intersubjective world is self-evident. “Others’ intentions and its own form a single pre-reflective intersubjective system in which there is no need for any translation” (Langer, 1989, p. 100). As Merleau-Ponty (1962) states, “It is through my body that I understand other people, just as it is through my body that I perceive ‘things’” (p. 186). In a similar fashion, the comprehension of “spoken” gestures (or authentic speech) comes about through the reciprocity of one’s intentions

with that of the other. Expression and comprehension are thus achieved through the body first and foremost, with conscious reflection coming later.

The Visible and the Invisible

This incomplete manuscript reflects some major changes in Merleau-Ponty's thinking from 1945 to 1959. The first is a radical change in terminology: terms such as *flesh*, *interweaving*, and *chiasm* have no equivalence in the history of philosophy. In one of his working notes, Merleau-Ponty (1968) writes: "the problems posed in [the *Phenomenology of Perception*] are insoluble because I start there from the 'consciousness'-'object' distinction" (p. 200). These changes have led some interpreters to speak of a "turn" in Merleau-Ponty's later work. For example, Madison (1981) sees "The Visible and the Invisible" as a radical "calling into question" of his earlier writings, by taking up the same issues and transposing them to the field of ontology. Others, such as Dillon (1988), see these modifications as reflecting more of a continuous development than a radical shift in his thought. Dillon thinks that the new terminology was conceived to articulate ideas that were seeking expression in the earlier work, but were held back by the subject-object language inherited from Husserl's transcendental phenomenology. His intent still appeared to be the same - to carry Western philosophy beyond the dualism of subject and object - but he had come to realize that the primacy of perception in his earlier work needed to be developed and deepened into a new phenomenological ontology in which the phenomenal interwovenness of things became primary.

The ontology of the "Flesh". The notion of the *flesh* is key to Merleau-Ponty's ontology. To be a "phenomenology of origins," he asked himself: What is this intentional relation between subject and world founded upon? Why do they exist for each other? What he posited is that the bodily subject (the seer) and the perceived world (the visible) are not only intentionally related but are actually differentiations of the *same* material; woven from the same *fabric*. They are both expressions of a more profound reality. "We must not think the flesh starting from substances, from body and spirit - for then it would be a union of contradictions - but we must think it as an element, as the concrete emblem of a general manner of being...the formative medium of the object and the subject." (Merleau-Ponty, 1968, p. 147). Madison (1981) provides a simple

analogy to clarify this notion. Flesh is our medium or element just as water is the element of fish. Water allows it to encounter and be present to all other marine beings, but, being the medium of its life, the fish never sees the water. In a similar fashion, flesh refers to a “sub-phenomenal” reality (neither matter nor spirit) which is the source of all intentional relations but is never visible.

Similar to a spider’s web, the world is posited as an *interweaving* of phenomena, a folding of flesh back upon itself. It is the relation of flesh to itself that Merleau-Ponty (1968) describes in his notion of *reversibility*. This notion is modelled on the phenomenon of one hand touching the other. The roles of touching and being touched are reversible because they are played by a unitary body. However, the touching hand is never identical to or coincident with the touched hand: in order to perceive the touch, there must be a distancing or difference within the identity. He later extended the notion of reversibility to encompass perception, intersubjectivity, language and thought. Thus, Merleau-Ponty rejects monism and dualism in favour of a fundamentally ambiguous “identity-within-difference” that is articulated in his thesis of reversibility (Dillon, 1988). The reversibility of subject and object thus allowed Merleau-Ponty to contend that both roles are played by an elemental reality - flesh - without requiring him to collapse the distinction between them.

Summary

Building on the phenomenology of Husserl and Heidegger, Merleau-Ponty’s thought evolved from a criticism of natural scientific accounts of human behaviour, to a belief in the primacy of perception, to the development of a phenomenological ontology which he hoped would finally resolve all dualisms in Western philosophy. He provided a thoroughly original approach to the understanding of human behaviour, by describing it as intentionally related, through the lived body, to the rest of the world in a structured, meaningful way. Neither subject nor object, the ambiguous existence of Merleau-Ponty’s lived body displays a spatiality, temporality, and unity which differs radically from the scientifically “objectified” body posited by Western thought. He also contributed significantly to our understanding of intersubjectivity, language and thought.

Hermeneutic Phenomenology

Hermeneutics generally refers to the art and science of interpreting written texts. It has evolved significantly as a discipline since the days when it focused primarily on the interpretation of biblical texts. According to Palmer (1969), Frederick Schleiermacher was the first to suggest that hermeneutics should be broadened to study the art of understanding itself. Wilhelm Dilthey subsequently proposed that hermeneutics should provide the epistemological foundation for the *Geisteswissenschaften* (human sciences), given that the aim of these disciplines is to interpret externalized expressions or “objectifications” of human experience (e.g., art, literature, history, drama, etc.). He felt that the methodology of the natural sciences could be used to *explain* nature, but a radically different methodology was needed to *understand* human beings. What makes the human sciences distinct from the natural sciences is that one is able to draw on one’s experience as a human being in order to understand the “object” of one’s study, i.e., the meaning of another being’s work. Dilthey’s aim was to formulate a methodology of understanding that would transcend the reductionistic objectivity of the natural sciences and return to the fullness of lived experience. He hoped that, by developing methods to recreate or reconstruct an author’s inner world of experience, he could arrive at an “objectively valid” interpretation of their work (Palmer, 1969).

A number of hermeneutic approaches have developed out of this tradition, including the hermeneutic phenomenology of Heidegger, Gadamer and Ricoeur, the methodological hermeneutics of Betti and Hirsch, and the critical hermeneutics of Habermas (Woolfolk, Sass & Messer, 1988). All hermeneuticists object to the view that the methods and criteria of the natural sciences represent the only valid form of intellectual inquiry. In response, each of these hermeneutic approaches have attempted to provide philosophical, methodological or cultural alternatives to the natural scientific worldview. This thesis will focus on the philosophical tradition of hermeneutic phenomenology, given its focus on the ontological and epistemological nature of understanding and interpretation.

Hans-Georg Gadamer

Born in 1900, Gadamer studied with Husserl and especially with Heidegger. His work has centered around Greek philosophy, hermeneutics, practical philosophy and the social sciences (Hahn, 1997). Late in life at the age of 60, Gadamer (1975) published his first major systematic work, "Truth and Method." This original masterpiece was hailed as the most important classical work to emerge in the German philosophical tradition since Heidegger's "Being and Time." In it, Gadamer develops the implications of Heidegger's ontology, including his conceptions of understanding, language, and history, marking a new phase for hermeneutical theory based upon existential phenomenology. With understanding conceived as a basic mode of human existence rather than an act of human subjectivity, Gadamer views hermeneutics as "a universal aspect of philosophy, and not just the methodological basis of the so-called human sciences" (p. 433). From his perspective, hermeneutics should not only be conceived as a method for the human sciences, but primarily as a philosophical effort to account for all experiences of understanding as comprehensively as possible. The result is Gadamer's philosophical hermeneutics which explicates the historical, dialogical, and linguistic nature of all genuine attempts to understand and interpret phenomena.

The central argument of Gadamer's hermeneutics is intimated in the title of his book, "Truth and Method". Since Descartes, method has represented the "royal road to truth" in terms of the correspondence between fact and proposition (Bleicher, 1980). However, Gadamer (1975) was very critical of the distancing imposed by the methodology of the natural sciences in the name of objectivity. He stressed that the experience of "belonging" to the world at a primordial, pre-reflective level, always *precedes* any form of distantiation in the human sciences (Mook, 1999a). Because we belong to language and history, we cannot step outside of this primordial relation to arrive at "objective" interpretations through the use of scientific methods. Gadamer does not deny the importance of formulating methodological principles for the natural or human sciences. However, from his perspective, scientists ought to be aware of the role of pre-understanding and how it can be used positively to allow the truth of the subject-matter to reveal itself. His theory of understanding is briefly presented below.

The historicity of understanding. Gadamer builds on Heidegger's analysis of the fore-structure of understanding and the historicity of human existence by reviving the notions of *prejudice* and *tradition*. Since the Enlightenment, those in the human sciences who interpreted texts or historical events tended to believe that suspending their prejudices and applying methodical rules would enable them to reconstruct the meaning of the past event or text in an objective way. However, according to Gadamer and Heidegger, prejudices are not something that can simply be suspended or dispensed with. Rather, they constitute the historical reality of our being and are the basis of our being able to understand history at all. The obsessive concern with method has obscured the insight that "understanding is not...an action of one's subjectivity, but...the placing of oneself within a process of tradition, in which past and present are constantly fused" (Gadamer, 1975, p. 258). The historicity of our existence entails that the past can only be seen and understood through our vantage point in the present, which is partially constituted by the preconceptions that we have unconsciously inherited from the past, through the invisible medium of our tradition. Accordingly, there is no way to step outside our historical situatedness and overcome our prejudices. As all understanding is "prejudicial," absolute objectivity in interpretation is not possible, inside or outside of science.

To counteract the negative connotations associated with the notion of prejudice, Gadamer (1976) emphasized its positive and productive role in the process of understanding. He states, "Prejudices are not necessarily unjustified and erroneous, so that they inevitably distort the truth. In fact...prejudices...constitute the initial directedness of our whole ability to experience. They are simply conditions whereby...what we encounter says something to us" (p. 9). Thus, the prejudices held by the interpreter constitute a necessary and productive starting point by providing a horizon of possible questions for the interpreter to put to the text. From Gadamer's perspective, the only way to reduce the potentially distorting impact of one's prejudices is to bring them to awareness and attempt to bracket them as much as possible, "so that the text may...be able to assert its own truth against one's own fore-meanings" (1975, p. 238). Understanding can only be successful when one allows one's standpoint to be constantly revised so that the past can "make it's own meaning heard" (p. 272).

Once the historical nature of understanding is acknowledged, one can see that the

interpretation of a text is an event that takes place in time, and that the meaning arrived at is not like a changeless property of an object but is always a meaning “for us.” It is bringing what is essential in the past into our personal present, which is never permanent and fixed. As Gadamer (1975) explains, “it is part of the historical finiteness of our being that we are aware that after us others will understand in a different way” (p. 336). That is not to say that the “meaning” arrived at in the present will be absolutely different from what it will be to future readers. Given that a great work appears to express certain truths of being, one can assume that its *essential* truth can be brought to light and applied at different points in time without asserting the idea of a changeless “truth in-itself” or a perennially right interpretation (Palmer, 1969). Thus, Gadamer’s assertion of the historicity of understanding rejects the Enlightenment interpretation of tradition and prejudice as the enemies of reason and rational freedom. From his perspective, the human sciences can only be freed from their identification with natural science methodologies if the historic character of their object is acknowledged positively, rather than as an impediment to objectivity. Instead, one must attempt to distinguish between fruitful presuppositions and those that impede one’s ability to think and remain open to the phenomena at hand.

The dialogical nature of understanding. Where previous hermeneuticists focused more specifically on interpreting written texts, Gadamer extended the object of hermeneutics to the broader field of human communication, including verbal conversations, children’s play, and art (Mook, 1994). In fact, Gadamer uses dialogue or human discourse as a model for explicating the process of hermeneutic understanding. Mook (1991, 1994) succinctly describes how understanding is arrived at, according to Gadamer. Two partners, operating from within the historicity of their unique horizon of understanding,⁵ share their perspective on a topic and listen to each other in an attempt to grasp what the other is saying. Understanding is born at the moment that an agreement between partners is reached through a *fusion* of their mutual horizons. “To understand means to grasp and be grasped by the meaning of what the other communicates” (Mook, 1994, p. 47). When understanding is arrived at, the perspectives of the individual

⁵ One’s *horizon* represents “the range of vision that...can be seen from a particular vantage point” (Gadamer, 1975, p. 269).

partners are transcended, leading to a new and broader perspective. In Gadamer's words, "To reach an understanding with one's partner in dialogue is not merely a matter of total self-expression and the successful assertion of one's own point of view, but a transformation into a communion, in which we do not remain what we were" (1975, p. 341). Understanding is therefore a productive endeavour, leading to a new understanding for both partners (Mook, 1991).

Gadamer views dialogue as analogous to the interpretation of a text. While he acknowledges that a text does not "speak" to us in the same way as another person, he asserts that the task of hermeneutics is to bring the text back into the "living present of dialogue" through a dialectic of question and answer (Palmer, 1969). Real questioning presupposes an admission that one does not know the answer and is willing to explicate one's prejudices and put them "at risk" in a genuine attempt to "make the text speak" (Gadamer, 1975). The text questions the prejudices of the interpreter while the interpreter attempts to find the question to which a text represents the answer. To understand a text is to understand the question that "called it into being." However, one must also go *behind* what is said to ask what the text did *not* say. As Gadamer states, "We understand the sense of the text only by acquiring the horizon of the question that...necessarily includes other possible answers" (p. 333). It is only through this dialectic of question and answer that the text can disclose itself in its fullness.

In a similar vein, our verbal statements can only be adequately understood if one takes into consideration what is "unsaid" but "begs for understanding" (Grondin, 1995). The hermeneutical relation of the said to the unsaid is referred to by Gadamer as the *speculative* dimension of language. In Latin, "speculative" means "mirror," suggesting that statements are always a mirroring of a meaning that is never entirely uttered. Gadamer uses the example of police or judicial interrogations to illustrate how focusing solely on what is said (and ignoring the unsaid) can easily lead to one's statements being misinterpreted and taken out of context. Thus, proper understanding must always go beyond the sentence or utterance.

Gadamer's dialectical approach to truth is similar to that of the ancient Greeks, who tried to allow their thinking to be guided by the nature of what was being understood. His is a dialectic of question and answer between one's own horizon and that of "tradition." Textual understanding

therefore has a dialectical character and a circular structure which Heidegger called the hermeneutic circle (Mook, 1991). Gadamer (1975) describes the hermeneutic circle as follows: "The circle...is neither subjective nor objective, but describes understanding as the interplay of the movement of tradition and the movement of the interpreter. The anticipation of meaning that governs our understanding of a text is not an act of subjectivity, but proceeds from the communality that binds us to the tradition....Thus the circle of understanding is not a 'methodological' circle, but describes an ontological structural element in understanding" (p. 261). Gadamer views his dialectical approach to truth as a way to overcome the limitations of method, which is rooted in modern, dualistic, subject-object thinking.

The linguisticity of understanding. Following Heidegger and Merleau-Ponty, Gadamer explores the ontological significance of language and explicates the crucial role it plays in the understanding of self and others. From the perspective of hermeneutic phenomenology, the self is not "real" in the metaphysical sense of being a thing or a "substance" (Madison, 1988). Rather, it is something that is achieved by means of language. In strong terms, Gadamer (1975) asserts: "Being that can be understood is language" (p. 432). Madison interprets this to mean that: "the self requires language in order to be told what it is, and it cannot properly be said to 'be' a self outside of this telling" (cited in Mook, 1989, p. 256). However, unlike the perspective of some post-modernists who view the self as *only* a linguistic construct, language is considered meaningless to hermeneutic phenomenologists without *experience*. As Mook (1989) states, "our lived experience is expressed in our language and confers onto it its meaning" (p. 256). Experience is not something "outside" of language, or something that language simply "refers" to. Rather, there is a mutual belonging between the two, in that "language is the meaning *of* experience" (Madison, 1988, p. 17). In fact, from the perspective of hermeneutic phenomenology, language is *subordinated* to experience (Mook, 1999a). It is not language which is most important, but that which *comes* to language which must first be addressed. Gadamer (1975) demonstrates this principle in "Truth and Method" by exploring the hermeneutic experience of art and the ontological significance of play before turning his attention to language (Mook, 1999a).

Gadamer also joins Heidegger and Merleau-Ponty in emphatically rejecting the "sign"

theory of language. As Gadamer (1975) states, “everywhere that word is seen in its mere sign function, the primordial relationship of speaking and thinking is turned into an instrumental relationship” (p. 363). Language is not simply a system of “signs,” nor a means of expressing “thoughts” that it has no relation to. Rather, “speech is contained, in a hidden way, in thinking” (p. 351), such that our thoughts reflect an intrapersonal dialogue that we are engaged in. Thus, the self is seen as constituting itself in and by means of language, through the process of narration (Madison, 1988; Mook, 1989).

However, we are not only constituted through the stories we tell ourselves. We are also *co-constituted* through the dialogues we exchange with others. In Gadamer’s words, “only through others do we gain true knowledge of ourselves” (cited in Madison, 1988, p. 21). Our understanding of our selves is broadened each time that we engage in genuine conversation, as our personal, familial and socio-cultural stories become intertwined and enmeshed. This intersubjective agreement that emerges from conversation - this “fusion of horizons” that takes place - could not occur without the medium of language. Similarly, the truths handed down through tradition could not be made intelligible by hermeneuticists if they were not communicated in linguistic terms. Hence, from the perspective of hermeneutic phenomenology, experience, thinking and understanding are linguistic through and through. This “belongingness” to language is viewed as the real ground of the hermeneutical experience (Madison, 1988). It is the medium through which a shared understanding or “fusion of horizons” is achieved between persons in conversation or between interpreter and text.

Summary

With the publication of “Truth and Method,” hermeneutical theory entered a phase in which the implications of the ontological and phenomenological nature of understanding could no longer be ignored. While Gadamer was not directly concerned with formulating methodological principles for interpretation, his development of Heidegger’s insights into the nature of understanding brought to light the limitations of any striving for “objectively valid” interpretations in the human sciences. Given the historical nature of Dasein, understanding is always prejudiced by the preconceptions one has inherited from one’s tradition. Gadamer

demonstrates how the acknowledgement and explication of one's prejudices can be used productively rather than as an impediment to objectivity. He also masterfully reveals the dialogical and dialectical nature of understanding through his description of the fusion of horizons that takes place, as the meaning of a conversation or text is finally grasped. It is only through an open, earnest dialectic of question and answer that the truth-claims hidden in a text can be revealed. Understanding also requires the medium of language, through which the experiences of others, handed down through tradition, can be communicated in a way that has meaning for us. Due to the historical, dialogical, and linguistic nature of understanding, Gadamer suggests that his dialectical approach to truth is the only way to overcome the limitations of a methods-based approach that is rooted in dualistic, subject-object thinking. In his concluding words, he states: "what the tool of method does not achieve must - and effectively can - be achieved by a discipline of questioning and research, a discipline that guarantees truth" (1975, p. 447).

Paul Ricoeur

Born in France in 1913, Ricoeur is a philosopher of international stature whose works reflect a broad range of interests, from phenomenology and hermeneutics, to linguistics, politics and the social sciences. In contrast with some phenomenological philosophers, Ricoeur disagreed with the view that self-understanding could be arrived at through direct reflection (i.e., that human consciousness is transparent). Instead, he believed that philosophy must interpret those forms of language that indirectly express human existence, such as symbols, metaphors and poetry. Thus, the interpretation of written texts became his foremost task. Even though Ricoeur's interest shifted to linguistics and hermeneutics, he never lost sight of the value of phenomenology. In his opinion, hermeneutics presupposes the question of meaning that is central to phenomenology, and phenomenology needs the presupposition of explication that is central to hermeneutics (Mook, 1999a). He thus views the mutual affinity between phenomenology and hermeneutics as a necessary and fruitful one.

In order for hermeneutics to make a substantial contribution to the human sciences,

Ricoeur believed that it was necessary to return to the epistemological questions which had been left unresolved since the time of Dilthey. While respecting the rich insights put forward by Heidegger and Gadamer on the existential-ontological nature of understanding and interpretation, he argued that the need for an appropriate epistemology and methodology was equally important. Based upon his semantics of discourse, Ricoeur (1976) put forward a theory of interpretation that transcends the explanation-understanding dichotomy that has plagued the human sciences. Ricoeur (1984) also made an outstanding contribution to a hermeneutic understanding of narratives. The following section provides a brief description of Ricoeur's theory of interpretation and his understanding of narrative structure.

Theory of Interpretation

In contrast with Gadamer, Ricoeur (1981) argues that the experience of *belonging* contains within it an element of *distance* which must also be considered in the process of understanding and interpretation. Ricoeur (1976) views "distanciation" as the dialectical counterpart to Gadamer's notion of belonging. In this dialectic, there is a "struggle between the otherness that transforms all spatial and temporal distance into cultural estrangement and the ownness by which all understanding aims at...self-understanding" (p. 43). Hence, Ricoeur views the process of interpretation as an attempt to "render near what is far" (1981, p. 11), to "make estrangement and distanciation productive" (1976, p. 44). In his words, "mediation by the text is the model of a distanciation which would not be simply alienating...but which would be genuinely creative" (1981, p. 111). This dialectic between belonging and distanciation is central to Ricoeur's theory of interpretation and his hermeneutic philosophy in general (Mook, 1999a).

The distanciation that takes place when discourse is fixed in writing leads to an "objectification" of the meanings inscribed in the text. This kind of objectification is necessary if explanatory methods are to be applied. Ricoeur (1981) maintains that meaningful human action can *also* be regarded as a text. In his words, "action itself...may become an object of science, without losing its character of meaningfulness, through a kind of objectification similar to the fixation which occurs in writing" (p. 203). Based upon his demonstration of the similarities between written texts and meaningful human actions, Ricoeur proposes that his hermeneutic

approach to text interpretation can serve as a general paradigm for interpretation in all of the human sciences.

Ricoeur's (1976) theory of interpretation offers a methodological solution to one of the most longstanding debates in the human sciences: that of the relation between the methods of *erklären* (explanation) and *verstehen* (understanding, comprehension). Romantic hermeneuticists, such as Dilthey, described this relation as a contrasting duality, with explanation applied to the natural sciences and understanding to the human sciences. Interpretation was seen as a derivative of understanding. However, this left the human sciences with a paradox: if understanding is separated from explanation, how can the human sciences be considered scientific without some level of objectivity? Ricoeur's hypothesis is that the kind of objectification which takes place at the level of written texts and human actions makes possible a scientific approach based upon methods derived from the human sciences rather than the natural sciences. His solution is based upon an original conceptualization of the relations between understanding, explanation, and interpretation.

Ricoeur sees understanding in a similar fashion as Gadamer. It always involves a pre-understanding given its historical nature, and it occurs when one grasps, and is grasped by, the meaning of a text as a whole (Mook, 1994, 1999a). While there is some overlap between understanding and explanation, he views explanation as being more directed towards the analytical structure of a text, with a certain level of distancing involved in the process (Mook, 1994). Ricoeur (1976) writes: "in explanation we explicate or unfold the range of propositions and meanings, whereas in understanding we comprehend or grasp as a whole the chain of partial meanings in one act of synthesis" (cited in Mook, 1999a, p. 48). Rather than viewing explanation and understanding in dualistic terms, Ricoeur sees them as related in a complex, dialectical fashion. As Mook (1994) describes, "the term *interpretation* applies to the whole dialectical process that encompasses both understanding and explanation as two different stages in a unique hermeneutic circle" (p. 48-49). This interpretation occurs in two phases: a movement from understanding to explanation, and a movement from explanation to comprehension. In the first phase, a naive grasp of the meaning of a text is arrived at through a dialectical relation between understanding as "guessing" and explanation as validation. Rather than using a logic of empirical

verification to determine which interpretation is more *true*, validation procedures developed by Hirsch (1967) are used to determine which interpretation is more *probable*, given what is known from the text. In the second phase, explanatory procedures (e.g., structural analysis or depth analysis) support a more comprehensive, sophisticated mode of understanding (Mook, 1994). In contrast with the natural sciences, explanation is thus viewed as a mediation between two stages of understanding. If explanation is isolated from this concrete process of interpretation, it becomes “a mere abstraction, an artifact of methodology” (Ricoeur, 1976, p. 75).

To understand Ricoeur’s (1976) theory of interpretation, it is essential to grasp the dialectical relation between distancing and appropriation that is central to the interpretive process. The ultimate aim of all hermeneutics is to appropriate and “make one’s own” what was previously foreign so that one’s self-understanding is increased (Mook, 1994). In Ricoeur’s words, “interpretation is the process by which disclosure of new modes of being...gives to the subject a new capacity of knowing himself” (cited in Mook, 1994, p. 50). One eventually comes to see one’s self in light of the text’s world, through the referential power of the text. In this way, appropriation enlarges the horizon of the reader. In a similar fashion, the process of distancing, which uses explanatory procedures to objectify the text, enlarges the horizon of the text beyond the limited horizon of the author’s own intentions, historical situation, and addressees. Ricoeur (1976) compares this process to Gadamer’s concept of the fusion of horizons: the world horizon of the reader is fused with the world horizon of the writer, leading to a new understanding.

Narrative Structure

Beyond the significant contributions that Ricoeur has made in bridging epistemological and ontological issues in the human sciences, he has also contributed greatly to a hermeneutic understanding of the structure of narratives. In Ricoeur’s original work, “Time and Narrative” (1984), he demonstrates that a reciprocal relationship exists between the activity of narrating a story and the temporal character of human experience. Like two halves of a circle, narrativity and temporality reinforce each other in a dialectical fashion (Mook, 1989). In Ricoeur’s words: “time becomes human time to the extent that it is organized after the manner of a narrative; narrative in turn, is meaningful to the extent that it portrays the features of temporal experience” (Mook, p.

259).

Using the literary narrative as a model, Ricoeur describes how the temporal aspects of human experience are presupposed, and then transformed, by the activity of narrating a story. Before one can imitate or represent action in a plot, one must first have a pre-understanding of what human acting is, in its semantics, its symbolic system, and its temporality. Every narrative presupposes a practical understanding of such action-terms as agent, goal, means, or conflict, as well as an understanding that a story is made up of events. In addition, the act of emplotment transforms this practical understanding to a narrative understanding by a configurational act which organizes successive events into an intelligible, temporal whole. It is through the act of emplotment that the heterogeneous elements of goals, causes, characters, and actions are “grasped together” or configured into a story. A final process of transformation takes place through a refiguration process, as the world of the text is applied to the reader’s own world of experience and action. Through this “fusion of horizons,” our world is illuminated and transformed by enabling us to see it, and ourselves, in new ways. These processes as a whole constitute the structure of a narrative. Ricoeur thus shows how narrative activity constructs order out of temporal chaos by synthesizing a heterogeneous range of characters, events, goals and causes into a meaningful, coherent structure.

Mook (1989) succinctly summarizes Ricoeur’s view on the relationship between narrative and experience: “Ricoeur shows us how the configurations of narratives are rooted and pre-figured in our action and experiences. As such, experience has a pre-narrative structure and is in demand of narrative” (p. 260). To demonstrate this pre-narrative quality of experience, Ricoeur (1984) provides the example of psychoanalytic therapy which attempts to draw, from the bits and pieces of stories and dreams, a narrative that will be more coherent and intelligible. In his words, “This narrative interpretation implies that a life story proceeds from the untold and repressed stories in the direction of actual stories the subject can take up and hold as constitutive of this personal identity” (p. 74). It is these “as yet” untold stories that constitute a genuine demand to be narrated. To understand who we are is to be able to follow and make sense of our stories, “because in the last analysis human lives need and merit being narrated” (p. 76).

Summary

The contribution of many intellectual traditions inform Ricoeur's work, providing him with a unique perspective on hermeneutic phenomenology. In contrast with Gadamer, Ricoeur challenges the view that truth and method cannot be reconciled, insisting that interpretation includes a critical distance from the text (distanciation) as well as existential involvement (belonging). His theory of interpretation provides a solution to the long-standing debate regarding the role of explanation and understanding in the human sciences. For not only must the initial understanding be subject to independent procedures of validation, but the final appropriation must be attained through a depth interpretation mediated by explanatory methods (i.e., structural analysis or depth analysis). Instead of viewing them as contradictory methods, he demonstrates how understanding and explanation are two complementary processes in a single act of interpretation. For the first time in the history of hermeneutics, epistemological and ontological concerns are addressed in one theory.

Ricoeur (1984) also contributes to a hermeneutic understanding of narrative structure by analyzing the relationship between time and narrative. The mediating role of emplotment enables Ricoeur to demonstrate the reciprocal and co-constitutive nature of the relation between temporal lived experience and narrative discourse. His view that "action is in quest of narrative" provides a thought-provoking perspective on the role of narratives in constituting our personal identity. With the importance placed on the refiguration of the text by the reader, and the reader's application of the text to his own world of experience and action, it is clear that the goal of Ricoeur's hermeneutics is to increase self-understanding through the process of interpretation.

Psychology as a Natural Science versus Human Science

The purpose of this section is to present an overall critique of the natural science approach to psychology from a human science (i.e., phenomenological-hermeneutic) perspective. As a number of models base their study of somatization on natural science assumptions, this critique will help avoid undue repetition of similar criticisms across models.

In the latter part of the 19th century, psychology was motivated by a desire to break away

from philosophy and establish itself as an autonomous discipline. The idea that psychology is, or should be, a natural science has been with psychology since its inception. According to Miller (1992), it developed more specifically out of a desire to resolve the epistemological debate between rationalists and empiricists who argued that the foundation of knowledge lay in the reasoning mind versus the senses. The founders of experimental psychology hoped to resolve this impasse by studying the brain and demonstrating how physiological variables and psychological experiences are directly linked, thus aiming to resolve the mind-body problem that lay at the core of the philosophical debate. It was assumed that the assumptions and methods of the natural sciences would apply equally well to humans.

Some of the assumptions appropriated from the natural sciences include the dualisms posited by Descartes between subject-object and mind-body. Phenomenologists, such as Merleau-Ponty (1962, 1963), pointed out that the internal-external and experience-behaviour dualisms follow from Descartes position. From a Cartesian perspective, people are viewed as objects in nature, existing independently from the things and people in their environment. They have an outward, objective side, referred to as their behaviour, and an inward, subjective side, referred to as their private world of experience. Similarly, there is a split between the observable, objectified body, and the unobservable, subjective mind. The material body and the immaterial mind are considered separate and real aspects of life. Consciousness is conceived as an internal, self-enclosed “container” that is filled with contents such as thoughts, feelings, and sensations (Karlsson, 1995). Other assumptions based upon a natural science paradigm include the view that humans are biological objects whose every thought, feeling, and action can be said to be determined by a complex network of multiple causes (von Eckartsberg, 1998). People are viewed in terms of objective properties such as personality traits and intelligence quotients, which interact with the objective properties of their environment in a causal, mechanistic, or stimulus-response fashion.

In terms of method, no philosophical movement has had more of an impact on psychological research than empiricism, and in particular, *logical positivism*. The latter developed at the end of the 19th century and flourished in the 1920s. In proposing logical positivism, a group of philosophers known as the “Vienna Circle” put forth a radical solution to

the empiricism versus rationalism debate. Their basic position was that no statements could qualify as true knowledge unless all terms in a statement could be verified by the senses (Miller, 1992). The only exception was the logical operators from mathematics (if-then, and, or, etc.). They also maintained that the goal of science is to develop “covering laws” from which deductions can be made, leading to the development of hypotheses that can be tested. Even though this movement was unable to overcome many of the challenges to its claims, it is clear from the goals and methods discussed below that many of its basic tenets have been incorporated into experimental psychology.⁶

The primary goal of natural science research in psychology is to explain psychological phenomena in terms of causal relationships by using empirical observation to verify the validity of hypotheses derived from theories. These explanations are derived by laws which express regularities in the observable data. While statistical correlation and verification has replaced the rigid causal laws of classical physics, the overall goals for explanation are unchanged. The hope is that these laws can serve as a basis for predicting, and thus controlling, the phenomenon under consideration.

To meet these goals, specific procedures have been designed to collect objective, reliable data. First of all, these data must reflect objective facts versus subjective meanings. Therefore, rather than studying meaningful experience directly, variables are abstracted from experience and *operationalized* so as to turn them into “observable” facts which can be measured. Similarly, in order to describe humans in objective terms, a detached, value-neutral stance must be adopted by the researcher toward the human subjects who are the object of study. It is assumed that these objective, observable facts can be identified and recorded in a manner free from interpretation. Hence, data collection is not considered to be influenced by theory.

Data are analyzed in terms of statistical means so that explanatory laws derived from theories can be generalized from individual cases. The truthfulness of these laws are evaluated by procedures designed to assess how well the theoretical explanation corresponds with reality.

⁶ As the positivist, empiricist paradigm is most dominant in experimental psychology, it will be used as an exemplar of the natural scientific approach in psychology. Researchers in cognitive psychology may hold slightly different assumptions.

According to the *correspondence theory of truth*, valid theories are those that provide accurate descriptions of how things factually are in the world. In other words, a statement or proposition is considered true if there exists a fact corresponding to it. Therefore, in the natural sciences it is assumed that the factual data arrived at through objective, empirically-validated research accurately describes, or corresponds with, reality. This perspective assumes that truths regarding the real world can be directly accessed through the use of objective, interpretation-free methodologies.

In summary, psychology as a natural science operates from within an empiricist, positivist framework. It can be described as objective, analytic, quantitative, causal, reductionistic and deterministic. It is concerned with searching for regularities and predictive laws which will help to explain the causal interactions of human organisms with their environment.

The natural scientific view of psychology stands in stark contrast to the views that have been put forward by proponents of a human science approach. Since psychology's inception as an autonomous science, many thinkers (e.g., Dilthey, Brentano and Husserl) have challenged this overly hasty, uncritical adoption of natural scientific concepts and practices to the study of humans. Dilthey (1977) was the first to make a distinction between the natural versus human sciences, emphasizing the different methods required for each. He argued that the objective, mechanistic and reductionistic methods for explaining natural phenomena were inadequate to the task of understanding and interpreting the richness and complexity of human experience. He and others have argued that the human sciences need to develop their own approach, models, and methods, based upon a philosophical foundation that is more in tune with the essence of being human (e.g., Giorgi, 1970; Polkinghorne, 1983; Ricoeur, 1981). Natural science psychologies have been criticized for being unable to account for important existential issues such as freedom, choice, anxiety and responsibility. Distinctly human phenomena such as empathy, hate, guilt, or altruism are rarely investigated. For such reasons, it has been argued that a natural scientific approach to psychology has significant limitations, particularly if it is presented as the *only* way of doing research in psychology. Despite these challenges, the natural science model continues to dominate mainstream psychology and its research efforts.

Rooted in the philosophy of existentialism and the methods of phenomenology and

hermeneutics, the human science approach undercuts the Cartesian dualisms that are central to the natural science model. For an intentional embodied subject-in-the-world, there is no dualistic cause-effect relationship between subject-object, mind-body, or person-world. Instead, Being and world are seen as co-constituted. Because of this interdependence, human action can never be understood outside of its cultural, historical, *lived* context. Instead, a person is seen as intentionally related to his/her world in a structured, meaningful way - a way that is distinctly different from the structural relationships found in physics and biology. Meaning emerges from the interrelatedness of behaviour and experience in the life-world as it manifests itself through the lived body. Being both subject and object, the lived body has a very different spatiality, temporality and unity than the objectified body posited by the natural sciences. The “mind-body” problem is seen as a pseudo-problem created by the view that these two domains have nothing in common with each other. Experience and behaviour, as manifestations of the mind and body respectively, cannot be reduced to either the mental or physical sphere.

In contrast with the passive nature of perception underlying the deterministic, empiricist view, perception is viewed as an active, constitutive way of being-in-the-world through which one shapes and takes hold of one’s reality. Consciousness is an activity guided by human intention rather than determined by mechanical causation. Although the role of personal agency is believed to play a dominant and leading role, freedom is not considered to be absolute. While constrained by the unalterable facts of one’s life, each person has the freedom to take hold of the possibilities open to them and to make responsible choices. From Heidegger’s perspective, the notion of Care reflects this primordial pull towards authentic living; i.e., to become all that one can be, given one’s circumstances.

Phenomenological psychology and hermeneutic psychology have developed two different approaches to human science research. A phenomenological approach developed out of a desire to apply the valuable insights of existential-phenomenological philosophy to psychological theory and research. In contrast with the *explanatory* goal of natural science research, its aim is to arrive at a comprehensive *understanding* of psychological phenomena as they are experienced in everyday life. Given the perspective that experience is fundamentally meaningful and irreducible, a phenomenological approach refuses to quantify everyday experience. Instead, the life-world is

seen as the ground for both everyday understanding and scientific knowledge. Therefore, it is descriptions of everyday lived experiences which form the “raw data” for empirical research (Giorgi, 1970; von Eckartsberg, 1998). These descriptions are obtained through a dialogical relationship with each subject, in which the researcher asks questions to help the individual articulate as full and accurate a description as possible of a particular experience. Rather than attempting to be neutral or detached, the researcher is engaged, open, and curious.

Once a description has been transcribed into a text, the researcher submits the text to a rigorous process of disciplined analysis and reflection, referred to as *phenomenological reduction* (Giorgi, 1985). The description is first broken down into *meaning units* or blocks that seem to express a self-contained meaning. These meaning units are then transformed, through a process of reflection and imaginative variation, into “common sense” psychological language that is as descriptive and atheoretical as possible. Meanings are revealed through a dialogical relationship with the text in which the researcher goes *into* the text to grasp the meanings of the phenomenon as lived for the subject, and then *withdraws* to reflect upon them. The researcher then proceeds through a series of steps to synthesize and integrate the transformed meaning units into a phenomenological description which traces out the structure, or essential constituents, of the phenomenon under study. The synthetic process of phenomenological reduction is different from induction or simple generalization, in that it requires an intuitive “grasping” of the whole in order for the constituents to be understood. Thus, the goal of phenomenological research is to arrive at an understanding of *what* the phenomenon essentially is as a lived human meaning or “meaning-structure,” and *how* it is lived by individuals in the context of their everyday lives (Packer & Addison, 1989). The intent is to be as faithful to the experience as possible by setting aside one’s presuppositions and not imposing explicit theoretical frameworks in order to interpret the data. However, as it is not considered possible to completely bracket one’s presuppositions, it is important for the researcher to make them explicit so that their influence can be minimized. Validity is assessed by the extent to which the general meaning-structure is faithful to and consistent with the phenomenon as it is described in the original protocols (Polkinghorne, 1989).

While both phenomenological and hermeneutic research aim at understanding and explicating the meanings of lived experience, they differ in the goal and subject-matter of their

investigations. In contrast with a phenomenological approach which seeks to *understand* psychological phenomena, a hermeneutic approach aims to *interpret* externalized expressions of human experience as they are “fixed” or objectified in literature, art, history, rituals and other cultural products (Packer & Addison, 1989). Given the view that understanding and interpretation are existential ways of being, the question of understanding human behaviour is viewed as “doubly” hermeneutic, in that the observer is trying to understand a being who is also trying to understand and interpret his/her world (Miller, 1992). This, as Dilthey (1977) pointed out, is what distinguishes the human sciences from the natural sciences.

Hermeneutic inquiry operates from the paradigm put forward by Ricoeur (1976, 1981) that human action and products of human activities can be understood as *texts* or *text-analogues* that are in need of interpretation. It involves an open-ended dialogue between reader and text, as the reader attempts to uncover hidden meanings and arrive at a deeper understanding via the hermeneutic circle. Cognizant of the role that one’s personal, cultural and historical perspective contributes to the interpretive process, the researcher’s preconceptions are reflectively explicated and laid open to be questioned by the truth-claims implicit in the text (Packer & Addison, 1989). The outcome of interpretive inquiry is validated by demonstrating that the researcher’s interpretation is more probable than other interpretations (Ricoeur, 1976). Although the phenomenological and hermeneutic branches of research are motivated by different goals (i.e., understanding versus interpretation), Ricoeur’s (1976) demonstration of the interrelatedness of these two processes has led a number of hermeneutically-informed authors to argue that phenomenological research also involves some interpretation (e.g., Titelman, 1971; von Eckartsberg, 1986, 1998).

In summary, psychology as a human science operates from within an existential-phenomenological and hermeneutic framework. It can be described as descriptive, qualitative, structural, dialogical, and seeking understanding and interpretation. It is concerned with understanding the meanings of uniquely human phenomena in a psychologically rigorous and valid way that is guided by the primary criterion of fidelity or faithfulness to lived human experience. The method and content of human science inquiry clearly stands in sharp contrast to the mainstream psychological research that is conducted from a natural scientific perspective. It

is from this human science perspective that the various models of somatization will be evaluated.

III. REVIEW AND CRITIQUE OF CURRENT MODELS OF SOMATIZATION

Overview of Chapter

Literature Review

It was noted in the first chapter that the conventional models of somatization (i.e., neuropsychiatric, biopsychosocial, and psychoanalytic) share many assumptions of the modern era, and that the narrative model has emerged from the post-modern era. Before proceeding to review and critique these models, it is important to clarify what is meant by *modern* versus *post-modern*, and to demonstrate how the assumptions of these eras have respectively informed the biomedical and social constructionist perspectives toward somatization. They are referred to as *perspectives* because they reflect general opinions regarding the etiology of somatization, rather than specific attempts to explain the causes, mechanisms and methods of treatment. As these perspectives have significantly influenced the current models of somatization, they will be described first to provide some contextual background.

The review of each model will then be presented in three parts: 1) background theory, 2) application to somatization, and 3) therapeutic implications. To reduce the risk of misinterpretation and bias, hermeneutic principles were applied as follows. Each model was approached with a sincere intention to understand and articulate the perspectives of its proponents as faithfully as possible. This involved a conscious, but necessarily incomplete, attempt to set aside theoretical preconceptions and personal prejudices and listen with curiosity and open-mindedness to the ideas being presented. Unclear texts were re-read many times and sources are quoted frequently to present the concepts and principles as accurately as possible.

Once each model has been reviewed, a conceptualization of the case of Mary will be presented to illustrate how proponents of each model would hypothetically conceptualize the case of an individual somatizing patient. It is hoped that providing a concrete, clinical example will help clarify each model's conceptualization and serve as a useful basis for comparison. The description of this case will be provided before the models are reviewed.

Critical Evaluation

After the literature review and case conceptualization have been presented, each model will be critically evaluated. This evaluation will take place in three stages. The first stage will involve an *explication of the foundational assumptions* which underly each model of somatization. These will include assumptions regarding human nature, epistemology and methodology. Following are the questions that will be asked:

- 1) How is the mind related to the body?
- 2) How is the person related to his/her world?
- 3) What is the role of personal agency and freedom versus determinism?
- 4) How is knowledge regarding somatization to be obtained and validated?

The second stage will involve an *evaluation of the strengths and weaknesses* of each model according to four criteria: comprehensiveness, consistency, research relevance and congruence with the foundations of a human science approach. The first three are standard evaluation criteria that have been widely used to evaluate theories in the natural and/or human sciences (cf. Monte, 1995; Pervin and John, 1997; Polkinghorne, 1983). The fourth criteria refers to a critical evaluation of each model's foundational assumptions from the perspective of the phenomenological-hermeneutic philosophers presented in Chapter II. The following questions will be asked of each model:

- 1) *Comprehensiveness*: How well does the model account for the "facts" of somatization? Are these facts accounted for in a general, abstract way or with detail and precision?
- 2) *Consistency*: Does the explanation of somatization follow in a clear, logical manner from the model's stated assumptions, theoretical principles and empirical data (including clinical observations)?

- 3) **Research relevance:** To what extent has the model stimulated new hypotheses and/or research into somatization? Are the model's hypotheses capable of being verified through empirical (natural or human science) methods?
- 4) **Congruence with the foundations of a human science approach:** How congruent are the model's foundational assumptions with those of existential-phenomenology and hermeneutic-phenomenology? How suitable is the model's approach to studying the experience of somatization?

The final stage will involve a reflection on the *implications* of each model's foundational assumptions as they pertain to the problematic of somatization. The goal will be to gain an understanding of how these assumptions may be contributing to or impeding progress in the conceptualization and treatment of somatization. A summary of the critical evaluation will be presented at the end of the chapter.

It is important to note that this evaluation will focus on the *models* of somatization and not the broader theories upon which they are based. Models are *mid-level constructs* which serve to translate a broad theory (e.g., systems theory) into hypotheses, variables and observables that are relevant to a specific phenomenon (Sluzki, 1983). While there will naturally be some overlap, the critique will not attempt to encompass the larger background theories from which the models are derived.

Modern and Post-Modern Perspectives Toward Somatization

Modern versus Post-Modern Era

In pre-modern times, religious beliefs provided the primary foundation for meaning and certainty in the world. With the founding of modern philosophy and science in the beginning of the 17th century, Descartes and Newton ushered in a whole new era. Modernity challenged the certainty of religious worldviews by offering a new scientific foundation for discovering certainty

and truth, with man as rational being at the center. Basic assumptions of modernism include the notion that universal, timeless truths or laws exist and can be *known* or discovered through objective, empirical methods. The knowledge arrived at by these methods is believed to correspond with an independent, objective reality. There is also an unquestioned faith that scientific progress will continuously provide new and better ways for dealing with human and societal problems. As Pokewitz (1984) summarizes, “Science’s claim to authority has been premised on its appeal to experience mediated by a purportedly value-neutral, logical-empirical method which promised the growth of rational control over our selves and our worlds” (cited in Lather, 1990, p. 65).

Post-modernism, on the other hand, represents a complex set of cultural and socio-political reactions to the assumptions of modernism. Characterized by diversity and competing currents, it is a broad-based movement that has its roots in a variety of disparate traditions, including structuralism, existentialism, romanticism, critical theory, Marxism, hermeneutics, feminism and nihilism (Rosenau, 1992). As Anderson (1997) describes, post-modernism has emerged “as an alternative form of inquiry among scholars across disciplines who are in the midst of questioning the metanarratives, the certainty, and the methods and practices of modernism in traditional science, literature, history, art, and the human sciences” (p. 34). Given the radical social transformations of the 20th century and the inability of science to prevent such tragedies as Hiroshima or the Holocaust, the assumptions and presuppositions of modernism have come under increasing attack since the 1950s and 60s.⁷ Post-modernists have come to reject the modernist assumptions of universality, objectivity, regularity, and progress (Rosenau, 1992). As a result, the credibility of all scientific knowledge and practice has been put into question. In fact, some post-modernists view modernism as a source of subjugation and oppression, given the power yielded by those who conduct research and decide what knowledge is legitimate (Kvale, 1990). The inability of modernism to fulfill its promises has thus culminated in the call for a new worldview that will have the capacity to meet the complexities and challenges of our rapidly changing and uncertain times. In the words of Parry and Doan (1994), “a delegitimized,

⁷ While many criticisms had been voiced prior to this time, including those of the phenomenological and hermeneutic philosophers, it was not until the past few decades that challenges to the dominant paradigm began to take place in a wide range of disciplines.

postmodern world is a place without any single claim to a truth universally respected, and a growing realization that no single story sums up the meaning of life” (p. 10).

In response to the shortcomings of modernity, post-modernists have shifted the emphasis from objective, certain knowledge to partial, perspectival knowledge. Acknowledging the complexity, relativity and inter-relatedness of human experience, all knowledge is viewed as socially constructed through the specific language, history and culture of each community. The relationship, rather than the individual, is seen as the locus of knowledge, in that ideas, truths, or self-identities are “multi-authored” in a community of relationships through social interaction (Anderson, 1997). Hence, the emphasis is on the local, contextual basis of meaning, with an appreciation for the diverse range of socially constructed narratives that exist. Ultimately, it is believed that the “objective” nature of modernist science must be deconstructed to yield a useful critique of unquestioned dominant practices and ideologies. Without any basis for arriving at certainty and truth, there are some radical post-modernists who argue that the post-modern age is one of fragmentation, malaise and meaninglessness with no hope for change (Rosenau, 1992). However, more affirmative post-modernists believe that the negative impacts of modernism can be counteracted through social and political action.

Modern Biomedical Perspective on Somatization

From a modern perspective, the concept of somatization is based on a biomedical theory of disease which is characterized as both *functional* and *ontological* (Fabrega, 1990). From a functional point of view, the body is analogous to a machine and disease is explained in terms of dysfunction at the anatomical, physiological and/or biochemical level. The malfunctions caused by a disease are believed to produce predictable somatic and/or psychic responses depending upon the anatomical or physio-chemical processes which are affected. From an ontological perspective, diseases are held to exist as separate entities which unfold developmentally in a distinctive manner independent of the person. An epistemological distinction is made between objective evidence of disease (through physical signs and laboratory testing) and subjective reports of patients’ distress.

The biomedical theory of disease leads to a model of illness which allows doctors to specify that a person's responses to physiological or anatomic changes constitute deviations from predictable norms. It is when such responses deviate from the prevailing norms that the concept of somatization is brought into play. If an individual's somatic symptoms cannot be fully explained in pathophysiological terms, it is assumed that they must be caused by psychological or psychiatric factors. Symptoms have been frequently described as *functional* versus *organic*, reflecting the view that these patients are not suffering from a medical condition. In clinical usage, functional is typically assumed to mean *psychogenic*. However, the term more accurately implies a disturbance of physiological function, even if it is too subtle to be detected (Kirmayer & Robbins, 1991).

From a diagnostic point of view, a psychiatric referral may lead a patient to be diagnosed with one of the *somatoform disorders* listed in the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV, APA, 1994). The common feature of these disorders is the presence of physical symptoms that suggest, but are not fully explained by, a general medical condition. If there is a related general medical condition, the somatic complaints are in excess of what would be expected from the history, physical exam, or laboratory findings. The most important of these disorders include: somatization disorder, conversion disorder, pain disorder, and hypochondriasis. Somatization disorder is seen as a chronic, polysymptomatic disorder characterized by pain, gastrointestinal, sexual and pseudoneurological symptoms. Conversion disorder involves pseudoneurological sensory or motor deficits that are judged to be associated with psychological conflicts or stressors. In pain disorder, psychological factors are also judged to play a significant role in the onset, severity, exacerbation or maintenance of the pain. Hypochondriasis is diagnosed when one is preoccupied with the fear that one has, or will have, a serious physical disease. Other diagnostic codes are used to indicate somatoform symptoms which do not meet criteria for any of the specific disorders.

Somatoform disorders are distinguished from what used to be referred to in the DSM as *psychosomatic* or *psychophysiological* disorders and are now subsumed under the broader category of *psychological factors affecting medical condition*. While psychosocial factors are similarly assumed to play a significant role, the somatic symptoms in these conditions can be

partially or fully explained by objective signs of structural or physiological dysfunction. This category encompasses organic diseases (e.g., ulcerative colitis) as well as functional disturbances in which the organic etiology is not clearly established (e.g., irritable bowel syndrome).

Apparently, this categorization was aimed at increasing collaboration among specialists and avoiding etiologic inferences. However, according to Fava (1992), internists and surgeons still talk about (and often resent) psychosomatic disorders, and psychiatrists rarely use this category. In addition, biologically oriented clinicians are much less likely to diagnose a patient with one of the somatoform disorders.

Post-Modern Social Constructionist Perspective on Somatization

From a post-modern perspective, many factors outside the realm of science influence the conceptualization of somatization and its etiology. For example, some authors view the concept of somatization as a historical product of Western medicine and its changing conceptualizations of disease. Others have focused more on how social-cultural values and expectations play an important role in the construction of illness meanings. All of these authors agree that social-cultural and historical factors are far more influential in constructing the phenomenon of somatization than processes which reside within the individual.

Historical Antecedents of Somatization in Western Medicine

The concept of somatization is viewed by many authors as the historical product of Western medicine and its shifting conceptualizations of disease (e.g., Fabrega, 1990; Fink, 1996; van der Feltz-Cornelis & van Dyck, 1977). This is particularly true of those disease entities found at the interface between mind and body. Rather than representing a new phenomenon, the clinical features of somatization have been described throughout the history of Western medicine, through disorders such as conversion hysteria, neurasthenia, and hypochondria. The following is a brief summary of how the historical shifts in concepts of disease and disease entities have led to the current concept of somatization.

In pre-modern times, a unitary or holistic view of illness prevailed. Mind and body were viewed as “inseparable and mutually dependent aspects of man” (Lipowski, 1984, p. 159). According to the four-humor theory proposed by Hippocrates (400-300 BC) and elaborated on by Galen (130-200 AD), an excess or deficiency of four bodily fluids was believed to account for personality temperament, as well as physical or mental illness (Gatchel, 1993). It was also asserted that emotions, or “passions,” could influence bodily functions and cause disease (Lipowski, 1986).

However, two events had a detrimental impact on holistic conceptions of medicine. The first was the formulation of a mind-body dualism by Descartes in his “Discourse on Method” in 1637. The initial impact of Descartes’ work on medicine was minor, as many physicians did not grasp its implications (Lipowski, 1984). However, the ground-breaking works of Newton and Descartes led to the dawn of modern science and philosophy, which influenced the field of medicine to become more mechanistic and reductionistic. As a result, all illnesses in the 17th century came to be viewed as the result of various physical changes in the nervous system (e.g., irritations, spasms, reflexes), including illnesses such as hysteria or hypochondria.

The second major challenge to holistic conceptions of medicine came with the scientific and technological advances in anatomy, physiology, and cellular pathology that took place in the 18th and 19th centuries. These advances led to the view of multiple diseases each having separate origins, constituted by anatomical, physiological or psychological “lesions” (Fabrega, 1990). The notion of diseases having a bodily location led eventually to the conceptual separation of mind from body. Psychiatry also emerged as a medical discipline, specialized in describing and treating the psychopathology of psychoses, and later, of the neuroses. By the end of the 19th century, “nervous diseases” or neuroses such as conversion hysteria, hypochondria and neurasthenia were viewed as increasingly psychological phenomena. As a result, persons treated by psychiatrists began to suffer increasing stigmatization. The mind-body dualism proposed by Descartes more than two and half centuries earlier had become the predominant philosophical basis for medicine.

The disease entity of conversion hysteria is often used to exemplify the changes in theories of disease and disease entities which have taken place. This illness has apparently

existed in various forms since antiquity, marked primarily by pseudoneurological sensory and/or motor disturbances (e.g., blindness, deafness, paralysis, convulsions) as well as emotional excitability or indifference (Shorter, 1992). Proposed physical causes have ranged from a “wandering womb,” to a “reflex neurosis,” to an organic neurological brain disorder (Fink, 1996). Psychogenic explanations became predominant in the late 19th and early 20th century, with Freud’s theory proposing that hysterical neurosis was caused by a conversion mechanism against knowledge of an internal conflict. Freud’s thoughts were carried forward by psychoanalytic doctors who began the psychosomatic medicine movement in the early 20th century. As the psychogenic theories of psychoanalysis fell out of fashion, the disease entity of hysteria was dropped from the DSM-III (1980), with its symptoms “split asunder” into the categories of dissociative disorders, somatoform disorders, and histrionic personality disorder (Kirmayer & Robbins, 1991). Although the disease entity as such disappeared from the DSM-III, the social stigma attached to the bodily symptoms of hysteria have continued under the concepts of somatization and somatoform disorders.

To summarize, post-modernists view the concept of somatization as being constituted by the developments in Western medicine that have shaped our contemporary thinking regarding the relations between mind and body in illness and disease. The phenomena pointed to by the term *somatization* have been described throughout Western history. They have been given different names and causal explanations, based upon the theory of disease which was predominant at the time (Fabrega, 1990; Fink, 1996; Shorter, 1992). The concept of somatization holds no meaning in non-Western traditions of medicine, such as those found in China or India, as these traditions are based on non-dualistic philosophies which view the experience of psychological and bodily symptoms as a unified whole (Fabrega, 1990). The notion of somatization is thus viewed as a cultural and historical “fallout product” or “artefact” of the unresolved debate in Western medicine regarding the nature of the relationship between mind and body (Malt, 1991; van der Feltz-Cornelis & van Dyck, 1977).

Role of Social-Cultural Values and Expectations

From a post-modern perspective, social-cultural values and expectations are believed to play a far greater role in the construction of somatization than individual processes which reside within the patient. Individuals from a variety of human science disciplines have put forward their views regarding the social construction of somatization.

Shorter (1992, 1994) is a medical historian who has written two volumes on the history of psychosomatic illness (which he views as equivalent to somatization). He proposes that psychosomatic symptoms are shaped by two processes: “socially correct” models of behaviour, and “medically correct” models of behaviour (Shorter, 1994). In the first case, symptoms develop when one perceives oneself as being unable to meet the cultural expectations associated with one’s social class, gender, ethnicity, and age. For example, the pressures experienced by North American women to be “superwomen” (i.e., to successfully manage the demands of career, children, and spouse), are believed by many to contribute to somatization (e.g., Kleinman & Kleinman, 1985; Shorter, 1994; Wessely, 1997). Under these pressures, Shorter (1994) believes that the unconscious mind attempts to produce physical symptoms which are considered legitimate by the medical theories that prevail at the time. He uses this hypothesis to explain the shift in psychosomatic symptoms from the pseudoseizures and paralyses of the past to the chronic pain and fatigue of the present. With the advancement of medicine, motor symptoms have become easy to disprove, but sensory symptoms are much more difficult to assess objectively. According to Shorter (1994), patients have always found an organic diagnosis more socially acceptable and have sought them throughout history. As Wessely (1997) describes, experiencing stress is acceptable in our culture, but succumbing to it is not. Therefore, a biological mechanism such as the immune system is necessary as a “narrative device, a cultural explanation, and a method of linking mind and body that preserves self-esteem” (p. 30).

Kleinman is a medical anthropologist who defines somatization as “the expression of personal and social distress in an idiom of bodily complaints and medical help seeking” (Kleinman & Kleinman, 1985, p. 430). He uses the term *sociosomatic* to refer to the dialectic relationship that exists between body and society. While psychosocial distress can increase bodily symptoms, these symptoms can also serve the purpose of changing distressing aspects of

one's social world. For example, in a study of individuals suffering from chronic fatigue syndrome (CFS), Ware and Kleinman (1992) found that many were leading a frenetic, overextended lifestyle before their illness began. For some, CFS gave them an opportunity to re-evaluate priorities and assert some much needed control over their lives. In other cultures where "psychologization" (i.e., talking openly about psychosocial problems) is discouraged, somatic symptoms may be used to mitigate oppressive social conditions or to challenge social structures (Kirmayer & Young, 1998). These authors interpret the experience of bodily symptoms as an indirect method of communicating individual and collective distress. As mentioned earlier, individual distress is never believed to reside entirely within the individual but to always be shaped by aspects of one's interpersonal world.

It is clear by now that post-modernists view the biomedical theory of disease as more of a cultural narrative than a theory that corresponds with "objective reality." As a result, physicians are viewed as making interpretations rather than discovering reality or truth (Kirmayer, 1986). In fact, one medical sociologist views somatization as "the result of a strong belief in the overidentification of western culture with the unequivocal truth of biomedicine" (Oderwald, 1994, p. 91). Another sociologist views medicine as an agent of society and somatization as a form of "conformity to culturally predominant value standards" rather than as a reflection of psychopathology (Greco, 1998, p. 238). These authors suggest that the resistance of patients to psychological explanations is driven more by a realistic fear of the legal, financial, and social ramifications of a psychiatric diagnosis, than by a pathological defensiveness about emotional problems. Many people feel compelled to express their distress somatically to legitimate their efforts to find help.

Post-modernists have contributed to the understanding of somatization by emphasizing the powerful role played by social-cultural values and expectations, with medicine playing a central role in the interplay between biology and culture. While offering little in terms of therapeutic advice, they have argued that researchers and clinicians need to adopt a social-cultural perspective before they can truly understand this phenomenon and devise effective therapeutic strategies. The influence of the biomedical and social constructionist perspectives will become more evident as we review the current models of somatization.

Case Conceptualization: Description of Mary's Case

Diagnosed with fibromyalgia three years ago, Mary⁸ is a 52 year-old Caucasian women who recently retired from a managerial position at a local university. She lives with her retired husband and their 22 year-old daughter who works full-time. She also has a 20 year-old son who lives out of town. To help contextualize Mary's experience as a fibromyalgia sufferer, a brief description of her childhood and family life will first be presented.

Mary lived through a difficult childhood. Both of her parents were alcoholics and were unable to provide financial or emotional stability for Mary and her older brother. She recalls experiencing a lot of shame and embarrassment related to the family's poverty that resulted from her parents' alcoholism. For example, she remembers feeling fearful when making purchases with her mother's credit card, as she never knew whether it would be accepted. She also avoided having friends come to visit.

Mary was closest to her father and described him as morose and sometimes irritable, but never violent. The intense conflict between her parents affected Mary far more than her father's drinking. Her mother tried to get him to change, but she eventually gave up and became a heavy drinker as well, withdrawing from the rest of the family. Mary never felt close to her mother. However, she does not remember feeling that either of her parents were overly critical or disapproving of her. Her grandmother was the only one whom she recalls as being intensely critical, and this criticism was aimed primarily at her father. This strained relationship contributed to the family tension when she came to live with them.

Mary had an older brother whom she looked up to. In fact, she remembers valuing his opinion over anyone else's, including her parents. She admired his intelligence and his intuitive, empathic nature. Mary struggled to feel accepted by her peers during high school, and was quite hurt when her brother ignored her during this time. However, she later came to view his behaviour as being normal for an older teenage brother. They reportedly developed a close relationship after high school. Unfortunately, he died of a brain tumour in his thirties. Mary

⁸ Mary (not her real name) was a client whom the author worked with for twelve sessions during her pre-doctoral internship. Fibromyalgia is a functional somatic syndrome characterized by pain amplification at numerous tender points throughout the body. Sleep disruption and fatigue are frequently experienced in addition to the pain.

believes that she has not fully grieved the loss of her brother. She describes him as exuding a sense of serenity and self-acceptance that she hopes to attain some day.

Mary continued to experience a difficult home life after she married and bore two children. She describes her 22-year old daughter as self-righteous, defiant, angry and “born with a temper.” Mary never felt a bond with her as an infant, and has always found it difficult to speak to her without triggering a defensive reaction. According to Mary, it has been like “walking on egg shells” for 22 years because her daughter is extremely sensitive to anything that may be perceived as a criticism. She believes that her daughter’s anger is partially related to the inordinate amount of attention that her brother received as a child. From an early age, he developed serious emotional and behavioural problems which became the family’s central focus for many years. By the age of eighteen, he had developed an addiction to cocaine. Mary recalls feeling intensely fearful, guilty, and helpless. However, she and her husband helped him obtain treatment, set strong boundaries with him (i.e., avoided the “enabling” role), and he is now in successful recovery. Mary describes having a close relationship with her son, particularly since his treatment. While she still worries about him, these feelings are much less intense and she is very proud of the progress he has made.

Mary states that she has always felt inadequate as a mother. She has come to acknowledge that she worked long hours and used her administrative job as an escape from the chaos at home, because her work seemed to be the only place where she felt competent and could exert some control. Although she describes loving her children dearly, she feels “jipped” that she was never able to really enjoy her kids. She also feels very guilty about inadvertently “teaching” her kids to deny or suppress their emotions, as she learned from her parents. She did not realize that there were other ways to deal with emotions until she participated in her son’s treatment program two years ago. Since that time, she has experienced a growing interest in becoming better able to identify and articulate her feelings, although she does not feel that she has made much progress. She describes herself as operating mostly at a rational, intellectual level and has always felt frustrated that her emotional, intuitive side is so “under-developed.” Her husband is apparently very similar to her, in that both of them are concrete, task-oriented individuals who came from alcoholic families. Mary would like to develop a closer relationship with her husband

but feels that he is content with how things are and would be unlikely to share her interest in learning to communicate more openly about feelings.

Mary describes herself as a “Type A” personality. With a strong work ethic and a perfectionistic nature, she has always had difficulty slowing down and relaxing. Mary sees one of her long-standing difficulties as being unable to set appropriate boundaries in family or work situations. She tends to feel overly responsible for negative outcomes and frequently “beats herself up” over what she could or should have done differently that may have led to a more positive outcome. She has always had difficulty determining what is reasonable to expect of herself, given the circumstances. She sees her perfectionism and worry over the opinions of others as being related to a need for acceptance and validation.

In terms of Mary’s fibromyalgia, she feels that her pain is related to chronic tension and stress. She became aware in 1994 that her forearm muscles were often quite tense. For a time she was able to relax her muscles when she caught herself tensing them. However, over the years she has gradually lost this ability and the tension has progressively spread to her entire body. As a result, Mary reports experiencing continuous pain in her arms (elbows, wrists), feet (heels, ankles) and knees, with variable intensity over the course of the day. While headaches have been a problem in the past, their frequency has recently decreased. Mary has also suffered from chronic lower back pain since the birth of her second child, but she has coped with this pain for a long time and does not consider it a primary concern. In terms of other medical issues, Mary was told that she had “rheumatoid arthritis” as a child but it resolved when she was 18 years old.⁹ She has no known allergies but occasionally has difficulty breathing from emphysema. Abdominal discomfort and indigestion are also experienced periodically. Her cardiovascular fitness, strength, and flexibility are reportedly good for her age, but she has high post-exercise blood pressure.

Mary came to the treatment centre because she was concerned that her levels of pain and fatigue had escalated significantly over the past eight months. Up until then, she had found the pain to be quite manageable. Contrary to most fibromyalgia sufferers, Mary’s pain is much worse when she is motionless (i.e., sitting, lying down, sleeping) so she keeps herself busy with gardening, cleaning, house-hold chores and exercise to keep her pain under control. While she

⁹ As this information was discovered in Mary’s file after we finished working together, I was not able to ask for further elaboration.

continues to remain active, she feels that the pain has been “controlling” her since her symptoms have worsened. She describes herself as feeling increasingly anxious, depressed, helpless and “pain-focused” and wants to be proactive in preventing any worsening of her condition.

In addition to increased levels of pain, Mary is very concerned about the non-restorative nature of her sleep. She sleeps eight hours with the help of medication, but it is not refreshing. In fact, she feels that she is “damaging” herself during sleep because her body remains very tense throughout the night. She is awakened by muscle spasms in her back or limbs, and is occasionally awakened by nightmares. She says that “frustration” has been a common theme in her dreams and nightmares over the past year. She describes clenching her jaw at night and feeling very tense when she awakes. She finds the pain to be much worse upon awakening, particularly in her feet, and must sit for 20 minutes before she is able to stand or walk. After a day of near-constant activity, Mary reports experiencing significant fatigue by early evening. She also notes that her memory is not as good at these times.

During therapy, Mary came to believe that her symptom escalation had been triggered by the firing of a vice-president in her workplace whom she had admired and respected. While she had always felt competent in her job, Mary found that the politics and “back-stabbing” in her final two years of employment had left her filled with self-doubt and worry. As a result, she feared that she may have inadvertently contributed to the vice-president’s departure and was unable to let go of feeling partially responsible. After many years of dedication and hard work, she also felt hurt and betrayed by a couple of supervisors who appeared to use her as a “scape-goat” to protect themselves and/or others who were responsible for some bad decisions by her department.

In addition to these unresolved feelings related to her workplace, Mary is facing a number of challenges that may be contributing to her level of distress. Her early retirement represents the loss of an important source of her identity and self-esteem, as well as a respite from the stresses of her home life. Referring to her “Type A” personality, Mary has also expressed concern over how she will keep herself occupied during retirement. Spending more time with her husband than ever before, she appears to be increasingly aware of the emotional distance between them and has expressed uncertainty about whether their relationship can improve. Mary is also struggling with

mixed emotions towards her daughter. Frustrated with their current relationship, she would like to make it clear that she expects her daughter to interact with her in a less defensive, more age-appropriate manner. However, feelings of worry, guilt, hurt and disappointment make it difficult for her to follow through on her intentions.

Neuropsychiatric Model of Somatization

Literature Review

Background Theory

An Act of Congress in the United States dubbed the 1990s “the Decade of the Brain,” symbolizing the tremendous impact of the neurosciences in medicine, psychology and particularly psychiatry (Bell, 1994). Neuroscience is a combination of related disciplines (e.g., neuroanatomy, neuropsychology, neurochemistry) that study the relationship between brain structure and function on the one hand, and human thoughts, feelings and behaviours on the other (Andreasen, 1984). State-of-the-art advances in brain imaging technology has led to an explosion of empirical research correlating structural, biochemical, neuroendocrine, and/or genetic abnormalities with psychiatric symptoms and syndromes. The brain is no longer viewed as static, but as a dynamic network of functional systems. It is believed that the *plasticity* of neurons enables the brain to change and develop over time (Hedaya, 1996).

From a “hard-nosed” neuropsychiatric perspective, psychiatric illnesses are viewed as diseases caused by biological factors which reside primarily in the brain (Andreasen, 1984). Intrapsychic factors such as “weakness of will” or interpersonal factors such as “bad parenting” are not considered to play an etiological role (Andreasen, 1984). In addition, the mind is viewed primarily as a by-product of brain activity in which thoughts or “meanings” have little to no role to play in correcting the changes that have led to the dysfunction (Gillett, 1990; Mender, 1994). For this reason, it is believed that psychiatric illness can only be treated effectively if biological methods are used to regulate disturbed brain function (e.g., medications, electroconvulsive therapy). While psychotherapy may help some patients cope better with their symptoms, it is not

believed to be helpful in ways that are etiologically relevant (Guze, 1989). The brain is viewed as the master organ which monitors and controls all mental and bodily functions (Andreasen, 1984).

More moderate neuropsychiatrists suggest that there is a mutually reciprocal interaction between one's genotype and environment such that genetics *and/or* experience can lead to dysregulated brain function (Mender, 1994). For example, no mental disorders have been found to be entirely inherited. While the genotype establishes a range of limits and possibilities, environmental factors determine whether an individual at increased risk eventually develops a psychiatric illness (Guze, 1989). In addition, it is believed that genetics contributes substantially to one's level of emotional reactivity, as well as to one's temperament, including characteristics such as harm avoidance, impulsivity, reward dependence, and novelty-seeking (Hedaya, 1996). Hence, one's reactions to anticipated harm, uncertainty, pleasure or risk may be "hard-wired" at birth, but can potentially be modified through interactions with one's environment. For example, when individuals have a temperamental tendency toward emotional over-reactivity and affective instability, they are more likely to react strongly to minor events, making it more difficult for them to cope. A moderate neuropsychiatrist would aim to normalize the dysregulation of their emotional system through psychotropic medications, but may also consider life-style changes and psychotherapy. Again, it is not believed that social or psychological factors alone can *cause* a mental illness, as all neuropsychiatrists agree that the psychological and somatic symptoms of psychiatric syndromes are the result of disturbed brain function. However, a respect for the plasticity of neurons has led many to believe that negative or positive environmental factors can cause changes to the brain and how it functions. Therefore, it is hoped that improving a client's environment via life-style changes and psychotherapy can provide an additive benefit to psychotropic medications by contributing to improved brain function.

In terms of psychosomatic symptoms, Hedaya (1996) suggests that the cortex and limbic system form the link between mind (psyche) and body (soma). He describes the cortex and limbic system as representing, in simplistic terms, the thinking and emotional areas of the brain. Input from these areas is sent to the hypothalamus and converted into hormonal output, causing changes in the body via the autonomic nervous system. These changes can affect virtually every system in the body, including the immune, respiratory, cardiovascular, gastrointestinal, urinary

and reproductive systems. Hence, Hedaya believes this pathway can explain how one's perceptions, meanings, and experiences can be converted into physical symptoms and disease states. In his words, "our new knowledge has allowed us to identify structures that prove that the mind and body are inseparable, that psyche equals soma, and vice-versa" (p. 37). He also points out that this mind-body connection is bi-directional, in that dysregulated hormones due to physical disease can reciprocally influence one's mental-emotional state. Thus, neural mechanisms provide the explanatory framework for somatic *and* psychological states and experiences.

In summary, a neuropsychiatric perspective holds that a combination of genetic and environmental factors can cause the sub-systems of the brain to become dysregulated through a variety of feedback mechanisms, leading to disturbed brain function. The specific symptoms produced by this dysregulation (either physical or emotional) will be a direct reflection of the particular circuits of the brain that are affected. To correct this biological imbalance, medications or other somatic approaches (e.g., electroconvulsive therapy) are used as the primary form of treatment. However, given the potential modifiability of neural structures via the environment, life-style changes and psychotherapy may also be considered. There is a limit to this modifiability, however, and in many cases of serious mental illness, medications are seen as the only viable form of treatment. Neuropsychiatric advocates hope that redefining mental illness as physical disease will reduce the shame and guilt associated with it.

Application to Somatization

Researchers have put forward a variety of hypotheses regarding the neurobiological mechanisms that may be involved in the production of symptoms associated with somatization¹⁰. Many have posited theories regarding dysfunctional mechanisms related to attention and/or arousal (e.g., Bell, 1994; Ludwig, 1972; Ursin, 1997). Others have proposed the involvement of hemispheric assymetry or damage (e.g., Bakan, 1990; Hoppe, 1976; Smokler & Shevrin, 1979).

¹⁰ As somatization is a more recent term, many of these studies refer to hysteria. Recall that the diagnostic entity of hysteria was split into Somatoform Disorders, Dissociative Disorders, and Hysterical Personality Disorder. Hence, these neurobiological mechanisms may apply to some, but not all, phenomena related to somatization.

Common characteristics of this approach will be discussed after the specific hypotheses are reviewed.

According to Miller (1984), some evidence and much “educated speculation” exists to implicate arousal and attentional mechanisms in the etiology of somatoform disorders, particularly conversion disorder and hypochondriasis. Miller refers to Ludwig (1972) as one of the first investigators to place attentional dysfunction at the core of conversion symptoms (e.g., paralysis, anesthetics). Ludwig proposed that intense emotional experiences could trigger a reactive inhibition of the *reticular activating system*, which is involved in attending to incoming sensory stimulation such as touch or pain. Instead, as Miller (1984) describes it, “the awareness of bodily function is...shouted down by the emotional cacophony that competes for reticular attentional mechanisms” (p. 83). An opposite mechanism is proposed by Ludwig to explain hypochondriasis, where excessive attention to bodily sensations leads to a vicious cycle of reduced corticofugal inhibition and greater awareness of the stimulus. Barsky and Klerman (1983) describe a similar process, and believe the term “hypochondriasis” should be replaced with “amplifying somatic style.”

More recently, a number of investigators have proposed limbic sensitization and kindling mechanisms as a basis for many symptoms, such as pain and fatigue, associated with somatization (e.g., Bell, 1994; Miller, 1991; Ursin, 1997). Sensitization and kindling are types of learning processes which can occur in certain parts of the nervous system (Hedaya, 1996). In sensitization, a stimulus that initially causes little or no response, will, after repeated and intermittent exposure, eventually produce a full response. If this exposure continues, kindling will occur, resulting in a relatively permanent increase in neural excitability (Miller, 1991). At this point, a full response can occur in the absence of a stimulus. Given the vulnerability of the limbic system to kindling, it is hypothesized that affective disorders can develop via intermittent and repetitive psychological stressors over an extended period of time (Post, 1992). Behaviourally, it might manifest as irritability, anxiety, mood lability or social withdrawal, with episodes of depression or anxiety appearing to occur “out of the blue.”

With respect to somatization, a cross-sensitization process is proposed to explain the high co-morbidity of affective disorders and post-traumatic stress disorder with somatization disorder,

chronic fatigue syndrome (CFS), multiple chemical sensitivity (MCS) and irritable bowel syndrome (IBS). Bell (1994) holds that CFS and MCS, “which skeptics are...trying hard to reduce to psychiatric diagnoses” (p. 82), could be better understood as referring to brains which are not only hyper-reactive to psychological stressors, but also to physical and chemical stimuli. Hence, these stimuli could act synergistically with the neurochemistry of depression or anxiety, leading to an over-amplification of somatic and psychological responses. The sensitization/kindling process is also offered as an explanation for the high correlation between somatization and physical, verbal or sexual abuse (Ursin, 1997).

Goldstein (1996) uses the term “neurosomatic” to refer to a wide range of disorders that he believes have been mistakenly perceived as “psychosomatic.” These include fibromyalgia, chronic pain, CFS, MCS, IBS, and many others. He views these disorders as neurological illnesses caused by a complex interaction of genetic, developmental and environmental factors. Genetics may predispose an individual to impaired sensory processing or to persistent viral infections of the central nervous system. Developmental factors, such as hypervigilance related to an unsafe environment in childhood, may also lead to disturbed brain function. Together, these factors can reduce the flexibility of the brain (i.e., neural plasticity), making it more difficult to respond effectively to environmental stressors. Symptoms are held to result from an impairment of the sensory information processing network, resulting in a misperception of sensory information (e.g., light touch producing pain, mild odours producing nausea). This dysregulation of sensory input is believed to be mediated by decreased levels of norepinephrine, increased levels of substance P (the “pain neurotransmitter”), and abnormal levels of approximately ten other neurochemicals.

Aside from attention and arousal, there are some researchers who believe that impairments in hemispheric functioning play a prominent role in the development of somatization. According to Miller (1984), these explanations are posited for two reasons. The first is that conversion and pain symptoms are more frequently experienced on the left side of the body, suggesting an involvement of the right hemisphere. Secondly, right hemisphere activity is believed by some to reflect the site of unconscious processes. These processes have long been purported by psychoanalytic theorists to play an important etiological role in psychosomatic

disorders (e.g., Grossman, 1992).

Hoppe (1976) is one of the few researchers to posit impaired communication between hemispheres as a factor. He proposes that a “functional commissurotomy” exists in hysterical patients with alexithymic traits¹¹. A commissurotomy is a surgical procedure used to treat individuals with severe epileptic seizures. It involves severing the *corpus callosum*, a structure of the brain which is responsible for communication between the right and left hemispheres of the brain. Hoppe proposes that alexithymic traits are the result of some form of impairment of inter-hemispheric communication via the corpus callosum. As a result, somatic expression of emotion is believed to occur directly through right hemisphere channels, without the “conscious” knowledge of the verbal left hemisphere. Hence, an insufficiently developed corpus callosum may constitute an early developmental basis for repression and alexithymia.

Smokler and Shevrin (1979) propose that the main features of hysteria, including repression, emotional lability, and concrete thinking, are consistent with a rigid preference for right hemisphere processing. In contrast, Flor-Henry, Fromm-Auch, Tapper and Shopflocher (1981) believe that these features are the result of a dysfunction in the *left* hemisphere which causes a secondary disorganization of the right hemisphere. The left hemisphere dysfunction is typically masked by the more visible alterations in right hemispheric activity. Flor-Henry et al. also believe that hysteria in females is the “syndromic equivalent” to antisocial personality in males, where a predominant left-hemisphere dysfunction is typically found.

With respect to research, it is important to note that these neuropsychiatric hypotheses regarding somatization are based primarily upon observation and speculation rather than direct research evidence. While a certain amount of data has been collected to support isolated aspects of these hypotheses, they have primarily been generated from the knowledge that has steadily accrued in neuropsychiatry regarding the organic correlates of thoughts, feelings and behaviours. That knowledge is drawn from a wide range of neuroscientific studies with animals and humans.

In summary, proponents of a neuropsychiatric model typically view somatization as a psychobiological phenomenon that should not be classified as a mental disorder. They disagree with the mind-body dualism inherent in the DSM classification system, and view the distinction

¹¹ Alexithymic traits include asymbolic and concrete thinking, and difficulty identifying and communicating feelings (Schumacher Finell, 1997).

between mental versus physical causation as meaningless and unnecessary. Instead, they hold that the bi-directional interaction between psyche and soma results in neurobiological changes which create the symptoms (somatic or psychic) that are experienced. Hence, diagnosis and treatment must be focused on identifying and countering the dysregulation taking place in various sub-systems of the brain. No “functional” or “organic” disease is believed to exist without neurochemical abnormalities, regardless of whether they can be identified by current diagnostic procedures (Lechin, van der Dijs & Lechin, 1996). The hope of these researchers is that somatization can eventually be treated by “pushing the right neurochemical button” (Goldstein, 1996, p. 179). Hence, psychopharmacology is viewed as the most promising and viable route for treatment.

Therapeutic Implications

As neurobiological research into somatization has barely begun, it comes as little surprise that current treatment implications are minimal. While the hope is to eventually create drugs to correct the specific abnormalities causing somatization, this dream is a long way from being realized. In the meantime, neuropsychiatrists are limited primarily to the use of anti-depressant or anti-anxiety drugs to treat co-existing affective disorders. Bell, Miller and Schwartz (1992) suggest that clinical trials of anti-kindling or anti-convulsant drugs should be conducted on patients suffering from multiple chemical sensitivity (MCS). However, they acknowledge that this may be difficult, as MCS patients are typically intolerant to medications. Given the intense speculation regarding the role of kindling in somatization, it seems surprising that none of the other investigators recommended anti-kindling drugs as a potentially fruitful area of research. With respect to affective disorders, Hedaya (1996) suggests that anti-kindling drugs can only be useful if a patient is treated early enough in the process. Once kindling has taken place, the changes to neural hypersensitivity are believed to be relatively resistant to modification.

Goldstein (1996) is atypical of this group of investigators. On the one hand, he is primarily a clinician rather than a researcher, and his publications in refereed journals are quite limited. On the other hand, his theory appears comprehensive and is the only one that has been

applied to clinical populations. He states that extensive study of the neurosciences and a dozen years of clinical experience with neurosomatic conditions (e.g., chronic fatigue syndrome, multiple chemical sensitivity) led him to develop a multi-drug treatment protocol. It is designed to target the twelve neurochemicals which he believes to be out of balance in neurosomatic patients. His protocol involves the administration of multiple, rapid-acting medications administered sequentially over a period of one or several days, until the right drug or combination of drugs results in a significant improvement of symptoms (e.g., pain, mental acuity, fatigue). At the time of publication, this protocol had been used with approximately 4,000 patients. Goldstein (1996) reports that 95% of his patients have significantly improved, frequently within one or two visits, and that these results are maintained as long as they continue to take the prescribed medications. While this approach appears promising, it needs to be validated by empirical research.

Regarding hemispheric asymmetry, Bakan (1990) suggests that treatments should be designed to decrease right hemisphere activity and/or increase left hemisphere activity. For example, left hemisphere activity could potentially be increased by turning the head or eyes to the right, breathing unilaterally through the right nostril, or listening unilaterally through the right ear. Biofeedback techniques could also be used. He emphasizes that these are only suggestions for research. Their efficacy has yet to be determined.

With respect to conversion symptoms, it has been suggested that hypnosis, sedatives, and other relaxation treatments can be effective in the first, acute phase of treatment (Cloninger, 1994). Rapid relief of symptoms is considered important to reduce the risk of their persistence by secondary gain. Secondary gain and other conditioned responses are also believed to play an important role in chronic pain. While psychological therapies may serve as a useful adjunct in such cases, the hope of neuropsychiatric proponents lies in the potential for neuroscientific and psychopharmacological research to provide biological solutions to the problem of somatization.

Conceptualization of Mary's Case

In applying the neuropsychiatric model to Mary's case, proponents would explain her

symptoms of pain and fatigue as reflecting a disturbance in the functioning of various sub-systems in her brain and central nervous system. This neurobiological disturbance would likely have developed over time through a complex interaction of genetic, developmental and environmental factors.

From a genetic perspective, Mary may have inherited a nervous system that is hyper-reactive to emotional stimuli and/or has difficulty registering and processing emotional experience. For example, she may have been born with (and/or developed) some impairment in communication between the left and right hemispheres of her cerebral cortex. This would help explain her difficulty in identifying and articulating (via the verbal left-hemisphere) her emotional (right-hemisphere) experience. If this hemispheric connection is poor, her emotional experience may be registering primarily on a physiological level (i.e., heightened arousal, muscle tension) without conscious awareness of the emotions being experienced. Repression of emotions is also suggestive of an overly rigid preference for right hemisphere processing. In support of a potential genetic component, Mary's parents and her children appear to have also had difficulty handling and processing intense emotions without either acting them out behaviourally (e.g., through aggressive behaviour) or repressing awareness of them (e.g., through withdrawal, alcohol, drugs, etc.). It is also possible that she may have inherited a predisposition to addictive behaviours which manifested in her workaholicism. Her son's cocaine addiction may have resulted from a similar genetic predisposition.

From a developmental perspective, a conflictual and stressful environment may have impeded normal brain development in Mary's first years of life. In terms of attention and arousal mechanisms, chronic levels of stress may have led to excessive stimulation of the sympathetic nervous system, thus sensitizing the limbic structures of the brain to become hyper-reactive to psychological stressors. When combined with a prolonged period of "intermittent and repetitive stressors" related to family and career, her limbic system may have become vulnerable to kindling processes such that arousal responses began to occur even in the absence of a stimulus. Together, these genetic, developmental and environmental factors may have reduced the flexibility (i.e., neural plasticity) of her brain, thus making it more difficult for her to respond to environmental stressors without experiencing symptoms of physiological arousal (i.e., muscle

tension, pain, fatigue, disturbed sleep) and/or emotional arousal (i.e., anxiety, depression). The gradual reduction in Mary's ability to perceive her body tensing and to relax may be an indication of this reduced flexibility. Abnormal levels of various neurochemicals may also be contributing to an over-amplification of somatic and psychological responses.

Critical Evaluation

Explication of Foundational Assumptions

The neuropsychiatric model of somatization is described by proponents as a non-dualistic approach. Aside from this assertion, no other references are made to the philosophical and methodological assumptions that ground their work. The absence of clearly articulated assumptions is a common criticism of experimental and biological approaches (Miller, 1992). To uncover these assumptions, the language used to describe the model's concepts and hypotheses will be scrutinized closely. This task will be assisted by our knowledge of the natural science paradigm (see page 52), as the neuropsychiatric researchers explicitly endorse this paradigm and the scientific method that follows from it.

Mind-Body Relations

Proponents of the neuropsychiatric model state that they reject the substance dualism implied in the medical model which views body and mind as made of material and immaterial substances respectively, which have no causal impact on each other. Instead, they put forward a psychobiological, multi-causal model which acknowledges the interaction of genetics, developmental and environmental factors in the development of somatization. They propose that a bi-directional interaction occurs between psyche and soma at the neurobiological level. Some of the proponents describe their model as fitting within a biopsychosocial framework (e.g., Ursin, 1997).

However, there are a number of indications to suggest that proponents of this model hold more materialistic assumptions than they claim. Psychosocial or environmental factors are not

considered etiologically relevant in themselves. Rather, it is the *neurobiological* component of a person's response to these stressors that is considered important. Thus, an apparent mind-body event becomes a brain-body event, limiting the interactionism to bodily systems. Moreover, the proposed synergistic effect of *cross-sensitization* can only be considered possible if one assumes that psychosocial "stress" (regardless of the context) has the same effects on brain chemistry as those produced by other physico-chemical stressors (e.g., household cleaners, airborne allergens). As Bell, Miller and Schwartz (1992) state, "the nature of sensitization means that a previous acute toxic chemical exposure *or* [italics added] an emotionally traumatic event could initiate or increase vulnerability to Multiple Chemical Sensitivity" (p. 232). These mind-body assumptions are quite similar to those held by *central state materialists* who view mental states as actual internal states with causal effects but who regard these mental states as contingently identical with states of the brain or central nervous system (Audi, 1995).

In a similar fashion, the purported rejection of Cartesian dualism by neuropsychiatric proponents can only be considered a partial one. They describe their model using dualistic language (e.g., "somatic" versus "psychological" responses, "organic" triggering stimuli) and focus their attention on the physiological processes occurring inside the body rather than the whole person who is experiencing the environmental "stress." Consistent with the dualist premises of biomedicine, proponents appear to agree that bodily symptoms are ultimately to be explained by bodily events.

Person-World Relations

While not explicitly stated, it can be inferred that proponents of the neuropsychiatric model hold to the subject-object, internal-external and experience-behaviour dualisms that are part of the natural science paradigm. People who suffer from somatization are viewed as biological organisms engaged in mechanistic, causal interactions with "exogenous" factors in their external environment (e.g., psychosocial stressors), and "endogenous" factors in their internal environment (e.g., excessive cortical arousal). While the person, as subject or observer, is viewed as separate from the external world, a mutually reciprocal interaction is purported to exist between one's genotype and one's environment or culture. As Guze (1989) states, "people

learn differently, perceive differently, and think differently, because their brains develop differently as the result of different genotypes interacting with different and constantly varying environments (both internal and external)” (p. 316). Thus, individual differences are explained by the impact of genetics and environmental factors on the development of our brains.

In terms of the experience-behaviour dualism, the existence of subjective experience (i.e., meanings, emotions, choices) is rarely referred to, making it clear that conscious motivational and emotional processes are not considered etiologically relevant to the development of somatization. Instead, subjective processes are translated into “objective,” measurable neurophysiological processes to which behavioural learning or information processing principles can be applied. For example, it is posited that “intermittent and repeated exposure” to psychosocial or physical “stressors” can condition our limbic systems to become sensitized and susceptible to kindling. Or alternatively, “the control of data input and output from processing centers” is purported to be dysfunctional (Goldstein, 1996, p. 14). Thus, humans are believed to respond internally or externally in a mechanistic, stimulus-response fashion, similar to biological organisms or computers, which notably lack the human ability to be consciously aware of inner, subjective experience.

Freedom-Determinism

Miller’s (1991) hypothesis regarding hysterical conversion provides a good illustration of the deterministic nature of the neuropsychiatric model: “An idea - that is, some psychical force...acts in a given person upon a pre-existing personality and cognitive style based, in turn, upon his/her particular intra- and interhemispheric functional pattern, which shapes and determines how that person processes information from within and without, including thoughts, feelings, perceptions, words and so on” (p. 100). He describes this “pre-existing” personality and cognitive style as largely determined by what a person is “constitutionally endowed with,” although he and others acknowledge that stressful or traumatic life events can interfere with normal brain development and functioning.

It seems clear from the above statements that proponents of this model view human behaviour (including one’s personality, thought processes, emotions, etc.) as primarily

determined by how well a person's brain and central nervous system are functioning. This, in turn, is determined by a person's genetic constitution and the impact of environmental "stressors" which, particularly in the case of early abuse or trauma, are beyond a person's control. As our cognitive and emotional functioning becomes conditioned by "internal" and "external" factors to respond in particular ways, the plasticity of our nervous system can become strengthened or diminished (sometimes permanently), thus having a direct impact on our ability to cope physically and emotionally with stressful life events. It seems reasonable to infer from this picture that humans are primarily viewed as reactive beings who have limited freedom to respond to their world in an autonomous manner.

Acquisition and Validation of Knowledge

As neuropsychiatric proponents operate within the natural science paradigm, it can be inferred that they view the acquisition of scientific knowledge as empirically grounded and as proceeding according to the principles of causality, determinism, and reductionism. Proponents of this model presuppose that there are determinant conditions for the development of somatization, and that these determinants exist on an objective, material level within the mechanistic processes of the brain and central nervous system. Their goal is to develop and test hypotheses regarding the causal chains and networks of events that lead to somatization, so that this phenomenon can be predicted or controlled in a way that will lead to effective treatments. It is through a reductionistic research strategy that breakthroughs are anticipated in attaining a mechanistic understanding of the etiopathogenic processes. Even though their hypotheses are regarded as highly speculative at this point, proponents of this model uniformly express a strong faith that effective interventions for somatization will develop from future neuroscientific advances.

Together, these principles of scientific inquiry dictate a certain stance between the researcher and the object of study. To be scientifically objective, the object of study must be observable, measurable and amenable to observation by independent observers. The inquiry must also be conducted in a detached, impersonal manner so as to avoid subjective biases or judgements. When this directive of objectivity is combined with a materialist ontology, it

becomes clear why the neuropsychiatric proponents have demonstrated no interest in studying the subjective experience of somatizers. Instead, they have reviewed the clinical literature for various disorders describing personal, social and cognitive functioning and have developed etiological hypotheses based upon knowledge of the brain's functioning arrived at through neuroscientific research. As Scadding (1990) states, "for biological function there exists a generally agreed upon corpus of knowledge of mechanisms and norms, so that the hypothesis that symptoms are due to a biological dysfunction can be tested objectively, without the need for subjective judgements" (p. 245). Thus, it is believed that objective, value-neutral facts can only be arrived at through the natural scientific method.

Evaluation of Strengths and Weaknesses

Following is a critical evaluation of the neuropsychiatric model's strengths and weaknesses, based upon its: a) comprehensiveness, b) consistency, c) research relevance, and d) its congruence with the foundations of a human science approach.

Comprehensiveness

The neuropsychiatric model of somatization draws upon a field which has contributed significantly to our understanding of "brain-behaviour" correlations in health and disease. By attempting to synthesize neuroscientific, clinical and psychiatric literature, the model presents some interesting and novel hypotheses to account for the development and co-morbidity of certain somatoform, functional and affective disorders. The neuropsychiatric model also provides a good counterpoint to those investigators or clinicians who assume that the cause of somatic symptoms must be psychological if standard testing reveals no pathophysiology. Patients in the early stages of a chronic illness can often be misdiagnosed by clinicians who are quick to assume a psychological cause.

The narrow scope of the neuropsychiatric model represents one of its clear weaknesses. It focuses only on certain somatoform disorders (i.e., conversion disorder, hypochondriasis and somatization disorder), functional somatic syndromes (chronic fatigue syndrome, fibromyalgia,

multiple chemical sensitivity, irritable bowel syndrome) and conversion hysteria, and attempts to account for the comorbidity of these disorders with post-traumatic stress disorder, early childhood abuse and mood disorders. Most somatizers fail to meet the criteria for somatoform disorders or functional somatic syndromes, thus limiting the potential generalizability of this model to the larger phenomenon of somatization.

Similarly, by restricting their focus to neuropathological mechanisms, other issues of potential relevance to somatization have been left very vague or have not been addressed at all. For example, while reference is made to psychosocial, developmental, or environmental factors, no attempt is made to provide a more detailed account of the specific *kinds* of factors that place individuals at greater risk for these disorders. Instead, general statements such as the following are made: “If a child feels unsafe for a period of time from birth through puberty, he may become hypervigilant and interpret the saliency of sensory input differently than a child who feels secure” (Goldstein, 1996, p. 15). In terms of individual differences, no attempt is made to explain why a person experiences paralysis in a hand rather than a foot, or develops pain as the primary symptom rather than fatigue, or suffers from back pain rather than headaches. These are just a few examples of questions that are not addressed by the neuropsychiatric model.

The neuropsychiatric model lacks comprehensiveness in a more serious way by presenting neurobiological hypotheses which lack detail and precision. Broad-based neural processes (e.g., sensitization/kindling, impaired sensory processing, hemispheric dysfunction) are purported to account for a wide array of possible affective and/or somatic symptoms. For example, disturbed inter-hemispheric processing is purported to result in a hysterical cognitive style that is used to explain almost all of the clinical features (personal and social problems, mental status, somatic complaints) of hysteria or somatization disorder (Cloninger, 1994; Miller, 1984). Similarly, a hypothetical cross-sensitization process is proposed to account for the comorbidity amongst functional somatic syndromes and affective disorders.

Consistency

Another weakness of this model is that some of the propositions made by proponents are illogical or inconsistent with their stated assumption of non-dualism. As previously elaborated,

proponents of this model appear to be operating from more materialist and dualist assumptions than those that they profess to hold. This leads to a number of difficulties. For example, proponents tend to infer causation from brain-behaviour correlations and assume that the direction of causality is always physical. Logically, it is impossible to infer direction of causality with correlations, or to rule out other mediating factors. In fact, they use this point to argue against the etiological relevance of psychotherapy: "Psychotherapy can never test and validate causal hypotheses regarding non-biological origins in a scientifically valid way, and it can't distinguish whether the particular phenomenon is the cause or the result of the illness" (Guze, 1989, p. 20). A similar argument can be used to challenge the validity of making physicalist assumptions of causality based upon brain-behaviour correlations.

The assumption of physical causation also reflects an inconsistency with their proposed "psychobiological," multi-causal interactionist model. If neuropsychiatric proponents acknowledge that psychosocial factors can contribute to the development of somatization via their impact on the central nervous system, it seems inconsistent to assume that improved psychosocial functioning (e.g., via psychotherapy) could not have a potentially positive neurobiological impact.¹² Miller (1992) suggests that this is a confusion frequently found in the neuropsychiatric literature. Proponents are ideologically committed to a reductionist program of biological determinism (i.e., materialism) and believe that real scientific explanations must always be at the biological level, yet they cannot quite bring themselves to dismiss psychological explanation.

Research Relevance

While the hypotheses raised by neuropsychiatric proponents are quite novel and interesting, they are based primarily upon a synthesis of neuropsychiatric and clinical literature and have yet to lead to any direct research. The imprecise nature of their hypotheses is indicative of the fact that the neuropsychiatric model is at an early, speculative stage of development. Of the literature reviewed, Bell, Miller and Schwartz (1992) are the only authors to provide suggestions

¹² Ursin (1997) is the only exception. Leaning more towards a biopsychosocial framework than the other proponents, he suggests that psychological therapies can influence the same neurochemical substrate as drugs and physical training.

for testing certain aspects of their model. However, their suggestions are limited primarily to animal research. The authors acknowledge that research with humans would be very challenging and would likely involve indirect measures of neurophysiological processes (e.g., PET and SPECT imaging) or clinical trials of anti-kindling drugs. While this kind of research may be fruitful, it would not be sufficient to confirm or refute their hypothesis that environmental chemicals act synergistically with the neurochemistry of strong emotional experiences to augment limbic kindling. Given the lack of precision in the hypotheses and concepts of the neuropsychiatric model, it is difficult to imagine how they could be tested and verified empirically. Goldstein's (1996) work clearly stands apart from the others. He has taken his hypotheses beyond the speculative stage and has developed and implemented a treatment protocol which has been used in his clinical work for many years. Despite the advanced stage of his model, Goldstein has identified some significant obstacles to empirically verifying his claims. Given that his treatment involves the administration of multiple short-acting drugs until the "right combination" is arrived at to reduce symptoms, Goldstein suggests that a double-blind, placebo-controlled trial would be very difficult to perform. His attempts to obtain funding for such research were reportedly refused as being "premature" (Goldstein, 1996).

Congruence with a Human Science Approach

All of the criticisms previously outlined in the phenomenological critique of the natural science paradigm (see page 52) are applicable to the neuropsychiatric model of somatization, and will therefore not be repeated here. Guided by natural scientific views regarding human nature, epistemology and methodology, it is not surprising that the *experience* of somatization is never put forward as a relevant issue to be studied. Driven by the presumption that somatization is ultimately caused by biological factors, experimental research and inferences are structured to support this reductionist ideology by searching for aberrant genetic or neurophysiological factors. The resultant data is then circularly used to validate the reductionist hypotheses. Goldstein's (1996) criticism of those who "psychologize" somatization can be equally applied to those who "biologize" somatization. In his words, "if the only tool you have is a hammer, everything looks like a nail" (p. 8).

By using animal and computer models to account for the symptoms of somatization, the intentionality of human consciousness is completely ignored as a relevant factor. As Kruger (1981) states, “If we go through the brain, we find no meanings, no words, no motives, no conscious contents, nothing of that which makes human existence meaningful” (p. 149). Yet paradoxically, huge inferential leaps are made regarding the causal influence of abstract, neurophysiological processes on conscious human experience (e.g., the personality and cognitive style of hysterics being reduced to disturbed inter-hemispheric processing). Human science proponents have made it clear that distinctly human experience and behaviour can never be fully understood by applying theories and methods that have been used to study biological organisms or physical systems. As Wallace (1997) implores, “if this is indeed the ‘Decade of the Brain,’ then let it be that of the whole brain, embodied in world” (p. 95).

Implications for the Problematic of Somatization

Given the bodily nature of the symptoms of somatization, it would certainly seem appropriate to investigate whether some form of pathophysiology is involved. The inability of current investigative procedures to detect such anomalies is no reason to categorically deny the possibility of their existence. Therefore, one of the positive implications of the neuropsychiatric model is that it may lead to the discovery of pathophysiological factors or mechanisms that are currently unknown. Whether this leads to effective treatment or not, it could potentially help reduce the tendency of physicians to jump to psychogenic conclusions that risk misdiagnosis and leave patients feeling stigmatized and misunderstood. Goldstein’s (1996) multi-drug treatment protocol could also hold some promise for somatizers if its efficacy can be confirmed empirically.

In terms of potential negative implications, a serious problem arises when a biological reductionist view is put forward as the *only* valid perspective. Physicians and somatizers are already struggling with the Cartesian delusion that the cause of the patient’s symptoms must be *either* physical *or* mental. In comparison with a true interactionist perspective which asserts that *both* mental and physical factors are involved, the neuropsychiatric model forces patients to

believe that, if the cause is physical, it *cannot* be mental as well. This belief can have serious consequences for somatizers. While many patients are resistant to psychological referrals, most will acknowledge that psychosocial factors may be contributing to their symptoms if the issue is raised by the physician. However, when somatizers are provided with scientific “ammunition” to support their contention that they are suffering from a real biological illness, they are much more resistant to considering that psychosocial factors may be playing an etiological role. For example, the Internet and support groups for chronic fatigue syndrome have put sufferers in touch with a vast array of scientific data regarding physiological anomalies that have been used by many to defend themselves against perceived intimations that “it’s all in their heads.” Unfortunately, it has been found that somatizers who refuse to explore other potential contributing factors put themselves at greater risk for developing persistent, disabling symptoms (Kirmayer et al., 1993).

The trade-off for “blaming the body” (versus the individual or society) is that control over one’s symptoms is taken completely out of the patient’s hands and left with scientists in the hopes that effective treatments will someday be discovered. Aside from attempting to learn better coping skills, neuropsychiatric proponents appear to suggest that patients are “at the mercy” of their dysfunctional central nervous system and have no choice but to endure their suffering until a doctor can fix them. In the meantime, familial and social-cultural factors that may be contributing to a patient’s symptoms are completely bypassed, leaving the socio-cultural status quo intact, and the patient with no effective ways to improve or recover from his or her condition.

Biopsychosocial Model of Somatization

Literature Review

Background Theory

The biopsychosocial model of health and illness came into being at a time when traditional boundaries between disciplines were loosening and new interdisciplinary fields, such as psychoneuroimmunology and behavioural medicine, were being formed (Engel, 1977, 1982;

Schwartz, 1982). These fields came together out of a belief that the focus of the biomedical model on biological factors was too narrow to fully explain the complexities of illness and disease. It was not until Engel's seminal article in 1977 that a biopsychosocial model was put forward to challenge the hegemony of the biomedical model and the "crisis" which Engel believed it had created. A further elaboration of this model was published in 1982. Engel criticizes the biomedical model for being mechanistic, reductionistic, dualistic, and scientifically inadequate in explaining the disease process. He charges that the somatogenic-psychogenic dichotomy is too narrow in scope to accommodate the complexity of many chronic conditions. By failing to provide physicians with a model that takes psychosocial factors into account, he argues that physicians are unable to account for individual differences in vulnerability or response to illness, as well as the discrepancies between patient's complaints and the degree of observable pathology. In summary, Engel (1982) states that the biomedical model is flawed because it "does not include the patient" (p. 150).

To address the limitations of the biomedical model, Engel (1977, 1982) proposes a patient-oriented model which views health and illness as resulting from a dynamic interplay of biological, psychological, and social-cultural factors. The biopsychosocial model takes into account, not only the patient and his/her social context, but also the impact of the physician's role and the health care system on the patient. By taking these factors into consideration, Engel claims that his biopsychosocial model is much better able to explain the heterogeneity in behavioral and psychological manifestations of a dysfunction, both across persons with comparable symptoms and within the same individual over time.

To explain how biopsychosocial variables interact, Engel (1977, 1982) adopts a *systems theory* approach to health and illness. Systems theory is concerned with general principles, derived from a diverse array of disciplines, that are believed to be applicable to all aspects of nature (Schwartz, 1982). It was initially conceived by von Bertalanffy (1968), a biologist, who saw the need for a more holistic approach to studying life processes in molecular biology. Systems theory holds that all levels of organization in any entity are linked to each other hierarchically, so that change in any one level has an impact on the other levels (Schwartz, 1982). The levels of organization pertinent to health and disease range, in order of complexity, from

“subatomic particles through molecules, cells, tissues, organs, organ systems, the person, the family, the community, the culture, and ultimately the biosphere” (Engel, 1982, p. 152). Each system is interconnected with every other system by the reciprocal flow of information through feedback loops. Hence, disturbances at any system level can affect other system levels, particularly those in closest functional relationship to it.

From a systems perspective, health and illness are conceptualized in terms of the relative intactness and functioning of each component system. Whether a disturbance has an impact on one level versus many levels depends upon the capacity of the system to adjust to change. For example, if one is able to adjust psychologically to the impact of a job loss, it is unlikely to have a disruptive impact on the physiological systems of the body. However, the same experience for another individual could result in profound disruptions involving many systems in the hierarchy. Hence, one’s overall health is believed to reflect the level of harmony within and between systems. As these systems are dynamically related, the weighting of each factor is expected to change over the course of an illness. Thus, for Engel, a systems approach to health and illness provides physicians with reciprocal, multi-factorial causal explanations that are much better able to account for a patient’s symptoms than the linear-causal explanations of the biomedical model.

Engel (1977) put forward his biopsychosocial model as “a blueprint for research, a framework for teaching, and a design for action in the real world of health care” (p. 135). Biopsychosocial proponents have emphasized the importance of using more complex multivariate approaches to research design, so that multiple variables can be assessed, integrated and interpreted (e.g., Schwartz, 1982). From an educational perspective, it is argued that medical education must be broadened to include information and training in all three domains - biological, psychological and social. In terms of clinical practice, it is proposed that medical diagnosis should *always* consider the interaction of biopsychosocial factors in order to assess a person’s health and to make recommendations for treatment. If the physician does not have sufficient knowledge or skills to assess these factors, an interdisciplinary team approach should be adopted (Schwartz, 1982).

While the biopsychosocial model has had a significant impact in fields such as behavioural medicine and health psychology, Engel (1992) has expressed disappointment with its

limited impact within the medical community. In his initial response to critics, Engel (1982) emphasized that he never intended his biopsychosocial model to *replace* the biomedical model. Rather, it was meant to be an *extension* of the biomedical model, by applying scientific methods to areas that have otherwise been neglected. In his view, progress can only be made when scientific methods are applied. Despite its limited impact on the practice of medicine, it has had a strong impact on a new generation of researchers, providing them with a model for conceptualizing and investigating the potential factors involved in a variety of health conditions. One of the outcomes of this research is the biopsychosocial model of somatization which follows.

Application to Somatization

Many researchers have investigated the influence of different isolated factors on somatization. A few authors have summarized these factors and categorized them according to whether they *predispose*, *precipitate* and/or *maintain* somatization (e.g., Barsky, 1998; Kellner, 1990; Lipowski, 1988). These multi-factorial models summarize a variety of factors that have been found to statistically correlate with somatization, or at least with those somatizers who seek medical help. According to Carlsson and Jern (1982), multi-factorial models must be distinguished from genuine multi-causality models in which the researcher attempts to not only identify the potential causal factors, but also to explain the relationships between these factors.

Mayou, Bass and Sharpe (1995) have attempted to move beyond a simple multi-factorial model by describing how some of the biological, psychological and social factors interact with each other to create and maintain functional somatic symptoms. Central to their “multi-causal interactive etiological model” is the view that somatizers misinterpret their bodily sensations as being more threatening than is warranted. The following discussion will use their model as an organizational framework for presenting and describing the relationships among the predisposing, precipitating and maintaining factors that are believed by many biopsychosocial researchers to contribute to the development of somatization. This will involve an initial examination of the sources of common bodily symptoms and sensations. Factors which

predispose or precipitate the misinterpretation of bodily symptoms as threatening will then be presented. Finally, the factors believed to maintain or reinforce somatization will be reviewed. The works of other researchers will be drawn upon where further clarification or elaboration of particular factors is deemed necessary.

According to Mayou, Bass and Sharpe (1995), there are three potential causes for the bodily symptoms or sensations that somatizers misperceive as threatening. The most common source of symptoms are the body's physiological responses to emotional or physical stressors. For example, emotional stress can cause some individuals to experience a tension headache following excessive contraction of scalp muscles, or abdominal discomfort following contraction of smooth muscles in the digestive tract. The body can also have physiological responses to chemical stimuli, such as the ingestion of caffeine, nicotine, drugs or alcohol. These substances can produce a wide range of symptoms including palpitations, dizziness, tremors, and abdominal distress. Bodily symptoms are also commonly experienced by people who suffer from psychiatric disorders such as anxiety, depression or the somatoform disorders. In addition, individuals with hypochondriacal concerns can significantly amplify somatic sensations by selectively focusing their attention on normal bodily processes (Barskey & Klerman, 1983). Whether somatic symptoms are caused by stress, psychiatric disorders, or excessive awareness of normal bodily processes, they are held to be the result of minor pathophysiological activity rather than serious pathology.

Many factors have been identified as *predisposing* or *precipitating* individuals to misinterpret their bodily symptoms as threatening. Mayou, Bass, and Sharpe (1995) organize these factors into two categories: a) illness knowledge and experience, and b) emotional arousal. The knowledge and beliefs that one acquires about illness is influenced not only by one's family but by the illness-related beliefs and practices of the social class and culture to which the family belongs. Somatization has been found to be particularly prevalent in families or cultures in which the verbal expression of emotional distress is frowned upon (Lipowski, 1988). Similarly, cultural belief systems that view mind-body relations in dualistic terms encourage patients and their physicians to focus exclusively on the somatic aspects of an individual's problem (McDaniel, Hepworth & Doherty, 1987).

Individuals who experience illness as a child or adult, or who are exposed to excessive illness or somatic complaints in their family, may be predisposed to develop somatization as a coping strategy. Through identification and modelling, they can learn that physical complaints result in increased parental care and attention, or avoidance of conflicts or obligations (Kellner, 1990). Children who experience illness or hospitalization are believed to be more at risk to somatize as an adult if they lacked adequate parental care (Craig & Boardman, 1992). In addition, people who have experienced major physical illnesses are frequently more alert to bodily sensations and may be more likely to perceive them as threatening.

“Emotional arousal” refers to the group of predisposing and precipitating factors which result from an interaction between *personality* and *stress* (Mayou, Bass & Sharpe, 1995). Personality refers to the various personality traits that have been found to correlate with somatization. From surveying the literature, it appears that the biopsychosocial perspective encompasses two psychopathological models of somatization: an *amplification model* and a *defense model* (Bakal, 1990; Simon, 1991). The amplification model attempts to explain somatizers who amplify their somatic symptoms as a result of psychological distress. This model is based upon research findings which demonstrate a strong correlation between emotional distress (e.g., anxiety, depression) and somatic symptoms (Simon, 1991). It is also the model that is most widely held and accepted by biopsychosocial proponents (e.g., Bakal, 1990; Kellner, 1990; Simon, 1991). The defense model is based upon psychoanalytic notions of conversion and the use of somatic symptoms to mask unconscious intrapsychic conflicts.¹³ It attempts to explain the “minimizers,” i.e., those who experience somatic symptoms but who deny the existence of psychological distress. Each of these models will be discussed in turn.

The amplification model assumes that psychological distress is experienced consciously and is reported along with somatic symptoms. Individuals with certain personality traits and psychiatric disorders are believed to be at increased risk for misinterpreting their somatic symptoms as threatening. Costa and McRae (1987) postulate that this correlation is due to *neuroticism*, a chronic condition of irritability and proneness to distress. Pennebaker and Watson (1991) use the term *negative affectivity* to refer to a similar dispositional trait, characterized by

¹³ The defense model will be elaborated more fully when the psychoanalytic model of somatization is presented.

negativity, introspection, vulnerability to stress, and higher than average levels of anxiety, hostility, depression and dissatisfaction. It is also associated with a perceptual-cognitive style of sensitization or hypervigilance to bodily sensations. Barsky and Klerman (1983) describe this perceptual bias as an *amplifying somatic style* frequently found in anxious individuals who exaggerate or amplify sensations that are non-threatening. In summary, the amplification model views somatization as the result of a positive feedback loop in which emotional distress and somatic distress intensify and perpetuate each other.

However, as Bakal (1990) points out, not all somatizers engage in thinking characterized by amplification of their symptoms. There are many individuals who experience somatic symptoms yet who minimize or deny the existence of psychological distress. The defense model holds that somatic symptoms serve a defensive function which allows a person to express mental distress without having to acknowledge such underlying emotions as depression, anxiety, guilt, aggression or resentment. From this perspective, somatic symptoms are viewed as occurring *in place of* (rather than alongside) personal or social problems via defense mechanisms such as denial, displacement or rationalization. In the extreme form, individuals who present with physical symptoms in complete absence of psychological complaints are referred to by some as manifesting “alexithymia,” characterized by difficulties in awareness and verbalization of affect (Sifneos, 1973). Numerous case reports and clinical anecdotes suggest that the defense model has some merit. However, most biopsychosocial researchers argue that there is not enough empirical support to indicate that defensive processes play more than a minor role in somatization (e.g., Kellner, 1990; Mayou, Bass & Sharpe, 1995; Simon, 1991).

From the perspective of Mayou, Bass and Sharpe (1995), somatization is even more likely to occur when individuals with predisposing personality traits are exposed to stressful life events. It is not uncommon in somatization cases of recent, acute onset to identify a precipitating event experienced by the individual as a loss or perceived threat of loss (e.g., bereavement, physical illness or injury, potential breakup of a relationship, loss of a job) (Lipowski, 1988). Frequently, these stressful events result in increased anxiety and/or depression, heightened awareness of bodily sensations and medical help-seeking for somatic symptoms. These events are often more difficult to identify in chronic cases of somatization. However, somatic symptoms in

adulthood can more reliably be associated with previous stressful experiences if they were traumatic and/or recurrent in nature, especially if there were physical sensations at the time of the stressor (e.g., combat, physical abuse, sexual abuse) (Ford, 1997). If the trauma occurred early enough, the developmental capacity to communicate psychological experiences may also have been impaired.

Factors associated with the *persistence* of somatization include some of the dispositional traits or psychiatric disorders already discussed, as well as the complex interactions that take place between somatizers and their families, the medical health system and society at large (Lipowski, 1988). For example, the reactions of friends or family members can reinforce a patient's worries or somatizing tendencies and help to maintain them indefinitely. In the case of chronic pain, the importance of family reactions has been particularly emphasized (e.g., Turk, Flor & Rudy, 1987). Lack of confidants and social support can also contribute to the persistence of somatization.

Some authors view somatization as a condition that is maintained and reinforced by personal and social gains (e.g., Mechanic, 1986; Pilowsky, 1990). From this perspective, somatic complaints may represent an attempt to attain certain personal objectives, whether the individual is aware of them or not. These reinforcements can include gaining attention and emotional or financial support, as well as avoiding social or family obligations and demands. These authors tend to view somatization as the outcome of socially and culturally regulated patterns of illness behaviour rather than as a result of psychological disturbance. While other biopsychosocial researchers agree that secondary gains can be a contributing factor, most appear to accord it a lesser role than Mechanic and Pilowsky. It is generally held that the suffering experienced by somatizing patients is much greater than the gains that they may realize by adopting the sick role, and that the psychopathological models of somatization provide a more powerful explanatory model (e.g., Mayou, Bass & Sharpe, 1995; Kirmayer & Robbins, 1991).

Finally, the biopsychosocial model of somatization acknowledges that there are many social, legal and financial aspects of the health care system that can lead to a reinforcement of somatized communications of distress. Wickramasekera (1998) speaks of the "tacit conspiracy of silence" between doctor, patient, and the health insurance industry to resist psychosocial

explanations for somatic disorders. For patients, a medical diagnosis avoids the stigma associated with mental illness. As well, medical legitimization may be required to alleviate the skepticism of family members, employers, compensation boards or insurance companies. For physicians, the fear of having “missed something,” the difficulty in acknowledging uncertainty and feelings of therapeutic impotence, and the lack of training in assessing psychosocial aspects of disease, lead many to participate in endless investigations, specialist consultations and invasive or unnecessary treatments. These processes can lead to “somatic fixation” where the doctor and health care system collude with the patient to focus exclusively on the somatic aspects of their distress (van Eijk et al., 1983). However, somatization can also be reinforced if physicians or mental health practitioners *discount* the somatic symptoms of these patients and insist that they use emotional language to express their distress. Clearly, there are many aspects of the health care system that can contribute to the maintenance or reinforcement of somatization.

In summary, the biopsychosocial model put forward by Mayou, Bass and Sharpe (1995) views somatization as a disorder of appraisal in which certain characteristics of a person’s illness knowledge and experience interact with his/her level of emotional arousal in ways that increase the risk that bodily perceptions will be misinterpreted as being more threatening than is warranted. These bodily perceptions may be due to minor physical pathology, the somatic consequences of psychiatric disorders, or excessive awareness of normal bodily processes. Factors which predispose or precipitate the onset of somatization can interact with the reactions of others (e.g., friends, family, society, health care systems) to reinforce and maintain the patient’s misinterpretation of their symptoms, resulting in physical and psychological distress and disability. A review of the somatization literature suggests that Mayou, Bass & Sharpe’s model accurately reflects the etiological factors that have been put forward by other biopsychosocial researchers as contributing to the phenomenon of somatization. The etiology of somatization is thus viewed as multi-factorial and complex, with the relative influence of etiological factors varying across individuals and over time. The hope is that knowledge of these factors can point to ways in which distress and disability can be reduced.

Therapeutic Implications

Proponents of the biopsychosocial model note that only a minority of patients with functional somatic symptoms seek medical treatment. In the general population, these symptoms are very common and usually transient. Individuals typically ignore their symptoms or treat them with folklore remedies, over-the-counter medications, or alternative health care products and services (Sharpe, Bass & Mayou, 1995). If symptoms persist, medical treatment is typically sought from the primary care physician. Biopsychosocial proponents suggest that the somatic symptoms experienced by most somatizers can be successfully managed by primary care physicians if they receive proper psychosocial training. Therefore, this discussion will begin with a review of the general principles that primary care physicians are recommended to follow (Lipowski, 1988; Kellner, 1990; Sharpe, Bass & Mayou, 1995; Simon, 1998). Other therapeutic strategies will then be presented.

Numerous authors have highlighted the importance of establishing a collaborative versus authoritarian relationship with the somatizing patient (e.g., McDaniel, Hepworth & Doherty, 1987; Sharpe, Bass & Mayou, 1995). It is considered especially important to avoid conducting a psychosocial evaluation after a medical investigation yields negative results. Rather, it is recommended that *all* patients be assessed to determine the biological, psychological and social factors that may be contributing to their symptoms. These factors, in turn, should be differentiated according to their predisposing, precipitating or perpetuating nature (Sharpe, Bass & Mayou, 1995). This helps the physician determine which perpetuating factors should be the focus of treatment.

As part of the assessment, a patient's beliefs regarding their symptoms should be elicited so that misconceptions can be corrected, particularly those regarding fear of serious pathology. Aside from providing reassurance, it is important that patients are given a positive explanation for their symptoms and are not simply told that there is nothing physically wrong with them (Kellner, 1990). Knowledge of the patient's illness beliefs can make it easier to provide an explanation that is understandable to the patient. If family issues are believed to be relevant, it would also be important to include the spouse or relevant family member in these discussions.

Compliance will be more likely if the doctor, patient, and family member negotiate a shared explanation of the symptoms and develop a treatment plan based upon this explanation (McDaniel, Hepworth & Doherty, 1987).

For chronic somatizers, it is recommended that the patient be seen at regular intervals (e.g., every few weeks) and not just when symptoms occur or intensify (Simon, 1998). Excessive diagnostic investigations or treatments should be avoided and visits to other health-care providers discouraged, unless the physician requires reassurance from a specialist that there is no underlying organic pathology (Sharpe, Bass & Mayou, 1995). Visits should focus on symptomatic relief and reassurance. Given that many somatic symptoms are believed to be the consequences of anxiety and depression, it is recommended that the physician identify and treat these symptoms with psychotropic medications. Data also support the efficacy of some antidepressant drugs for reducing hypochondriacal beliefs, pain intensity and improving sleep in patients with irritable bowel syndrome, fibromyalgia and some chronic pain syndromes (Simon, 1998). Physicians can also provide advice regarding behavioural and life-style changes to improve the patient's coping strategies.

If these basic measures are insufficient, it is recommended that physicians refer their patients to a mental health care provider (e.g., psychiatrist, psychologist or family therapist) for consultation and/or treatment (Sharpe, Bass & Mayou, 1995). These therapists can offer a diverse array of orientations, modalities and strategies. To make this referral more acceptable to the patient, it is suggested that the first meeting occur jointly with the therapist, physician, patient and relevant family member(s) (McDaniel, Campbell & Seaburn, 1989). It is particularly important that patients receive a clear message that their somatic symptoms are accepted as "real" and not simply "in their heads." When the somatic reality of their suffering is acknowledged, many patients are able to consider the possible impact of emotional and interpersonal dimensions as well (Kirmayer & Robbins, 1991).

As a biopsychosocial clinician, Simon (1998) has put forward some general principles for providing psychological treatment with somatizers, regardless of the therapeutic modality. Overall, the role of the therapist is to shift the focus of patients from diagnosis and cure to symptom management and rehabilitation. This may involve helping them to develop more

realistic goals, such as improved functioning and well-being (versus complete pain relief or cure), and a greater tolerance for uncertainty regarding the cause of their symptoms. Over the course of therapy, there is also a gradual shift in attention from the somatic symptoms themselves to life stressors or affective states that may be exacerbating the symptoms. The hope is that patients will gradually come to attribute some of their somatic symptoms to psychosocial causes (Goldberg, Gask & O'Dowd, 1989).

A variety of therapeutic strategies have been recommended to assist therapists in attaining these goals. Many of these are similar to those used in the treatment of anxiety and depression. Cognitive-behavioural techniques such as relaxation and stress management training, cognitive restructuring, and enhancement of self-efficacy may provide patients with more adaptive coping skills (Kirmayer & Robbins, 1991). Psychophysiological monitoring of autonomic responses may help demonstrate to skeptical patients the connection between their cognitive-emotional functioning and physiological changes in their body. If autonomic arousal increases when particular topics are discussed, the patient may also be helped to identify sources of distress that they were not previously aware of (Wickramasekera, 1998). Cognitive techniques can be used to challenge hypochondriacal beliefs and to encourage reattribution of common somatic symptoms to benign sources (Kirmayer & Robbins, 1991). Family members can also be encouraged to support increased activity and to withhold reinforcement for symptomatic behaviour. All of these strategies can be utilized in individual or group therapy.

Brief psychodynamic psychotherapy has also been considered as a possible modality for treatment. While it is less commonly practiced among biopsychosocial proponents, at least one author has empirically demonstrated the benefits of this approach with irritable bowel syndrome (Guthrie, 1995). Guthrie describes focusing on the historical origins of symptoms and helping patients make a link between symptom development and difficulties they have experienced in current and past relationships.

If family issues are believed to be relevant, consultation or treatment by a family psychologist may be indicated. With the growth of the specialty of family medicine, some practitioners have combined Goolishian and Anderson's (1987) collaborative language systems approach with Engel's biopsychosocial model to develop a therapeutic approach referred to as

“medical family therapy” (e.g., Doherty & Baird, 1983; McDaniel, Hepworth & Doherty, 1987, 1992). According to McDaniel et al. (1987), this form of therapy involves “collaborative negotiation and co-creation of therapeutic stories that are mutually acceptable to the patient, the family, the therapist, and the medical provider” (p. 378). In addition to those principles of treatment already discussed, this approach uses family therapy strategies to identify changes in family roles, recent stressful events, unresolved family issues, and other family members who may have experienced similar symptoms. Strengths of the patient and family members are also identified and reinforced.

In summary, the biopsychosocial model recommends a “stepped-care” approach to the treatment of somatization, beginning with simple, cost-effective measures and utilizing more complex therapies when the basic measures have proven insufficient (Sharpe, Bass & Mayou, 1995). Ideally, psychosocially trained primary care physicians would treat the majority of somatizers with reassurance, medications, regularly scheduled visits and a mutually agreed upon explanation and treatment plan. The goal would be to improve the patients’ functioning and increase their tolerance for uncertainty, resulting in decreased distress and disability. Those who require further help would be referred to a mental health provider, preferably in a specialist clinic run jointly by physicians and psychiatrists or psychologists. For a few severely disabled patients, in-patient treatment may be required (Lipowski, 1988). The primary goal of these therapies is to help shift the patients’ focus from the somatic symptoms themselves to psychological or social issues that may be perpetuating or exacerbating the symptoms. Interventions can then be designed more specifically to address these issues. However, as Sharpe, Bass & Mayou acknowledge, the services today fall far short of this ideal.

Conceptualization of Mary’s Case

In applying the biopsychosocial model to Mary’s case, proponents would likely attempt to identify the predisposing, precipitating and maintaining factors that have led her to misinterpret muscle tension as being more “damaging” and threatening than it actually is. They would suggest that a recent increase in Mary’s stress level has intensified her muscle tension to the point of

causing increased pain and emotional distress, thus creating a self-perpetuating cycle.

The biopsychosocial model groups predisposing and/or precipitating factors into two categories. The first is a person's knowledge and experience of illness as a child or adult. In terms of Mary's childhood, she describes having "rheumatoid arthritis" but the nature of this condition is unclear. However, biopsychosocial proponents may hypothesize that she is predisposed to somatize as an adult because children who experience illness and who lack adequate parental care are believed to be more at risk.

The second category of predisposing and/or precipitating factors is "emotional arousal" which results from an interaction between personality and stress. In terms of Mary's pre-morbid personality, she seems to share more of the characteristics of a "minimizer" than an "amplifier." The amplification model assumes that emotional distress is experienced *consciously* and that emotional and somatic distress intensify and perpetuate each other. However, she describes herself as someone who learned from her parents to deal with difficult emotions by denial and suppression. She also describes herself as operating primarily from a rational, intellectual level and having difficulty identifying and articulating her emotions. These characteristics are more congruent with "minimizers" who are believed by defense model proponents to defend against awareness of their emotional distress by expressing them through somatic symptoms. Mary's workaholic tendencies enabled her to deflect attention away from her family stresses, as well as the tense state of her body until she began to experience pain. Hence, her tendency to deny or suppress awareness of her emotions and bodily sensations would likely preclude her from being identified as an amplifier with "neurotic" personality traits.

However, when one looks at the *interaction* between Mary's pre-morbid personality and her recent and on-going stressors (i.e., what the biopsychosocial model refers to as "emotional arousal"), the amplification model may be helpful in explaining the recent escalation in her symptoms of pain and fatigue. Her recent stressors include fears that she may have contributed to her vice-president's involuntary departure, the loss of her identity as a competent, valued employee, the uncertainty of what her retirement will entail, and the inability to control her symptom escalation. On-going stressors include a challenging relationship with her daughter and an emotionally distant relationship with her husband. In a positive feedback loop, the

amplification model would suggest that these stressors have led to elevated levels of emotional distress, which have increased Mary's muscle tension to the point of increased pain and fatigue. Other than Mary's increased level of emotional arousal, insufficient information is provided in the case illustration to identify other factors (e.g., reactions of others, iatrogenic effects of health care system) that may be maintaining her self-perpetuating cycle of symptom escalation and worry.

Critical Evaluation

Explication of Foundational Assumptions

Mind-Body Relations

Similar to the neuropsychiatric model of somatization, few foundational assumptions are made explicit by proponents of the biopsychosocial model. However, it is clearly stated that the mind-body dualism of the biomedical model must be rejected. Instead, a reciprocal interactionism is proposed, not only among the micro-level systems that relate to "mind" and "body," but also among the macro-level systems, such as family, community and culture. With respect to somatization, it is asserted that biological factors can initiate, maintain, and modulate bodily sensations, psychological factors can influence the appraisal and perception of internal physiological signs, and socio-cultural factors can shape a person's perception and response to illness (Turk, 1996). Specific examples are provided for each of these factors and their possible interactions.

Some biopsychosocial proponents agree with the neuropsychiatric view that functional somatic syndromes (such as chronic fatigue and fibromyalgia) involve physiological disruptions that are too complex or subtle to be reflected in clear structural defects. As Kirmayer and Robbins (1991) explain, "the hierarchical systems view suggests that the distinction between functional and organic is really one between levels of process and structure: functional disorders may involve abnormal processes occurring in structurally intact organ systems" (p. 79). However, in contrast with the neuropsychiatric model, biopsychosocial proponents insist that

these physiological disruptions are not indicative of anything serious or problematic. Instead, somatization is viewed as a “disorder of appraisal” where a number of factors lead individuals to misinterpret their bodily perceptions as being more threatening than is warranted.

It is clear that mind-body interactionism is quite different from a dualistic perspective which dismisses any causal link between the two realms. However, there are a number of indications that proponents of the biopsychosocial model have only been able to partially let go of dualist assumptions. As long as *mind* and *body* are interpreted from a natural science point of view, some form of dualism is impossible to avoid. As one proponent acknowledges, “regardless of our ultimate conviction that mind and body constitute a true functional unity, the fact remains that as observers, investigators, and theorists, we are obliged (whether we like it or not) to deal with data from two separate realms, one pertaining to mind and the other to body” (Reiser, 1975, p. 479). Thus, working at a level of scientific abstraction, proponents such as Reiser claim that they are forced to *behave* as if they are dealing with a mind-body duality, even though they *believe* conceptually in a more holistic view of the total organism. Brown (1989) refers to this as an operational dualism rather than a conceptual or ontological dualism.

The biopsychosocial model also appears to work from the biomedical premise that some form of pathology or lesion must exist for somatic symptoms to be considered a medical problem. As Engel (1977) states, “It is the doctor’s, not the patient’s, responsibility to establish the nature of the problem and to decide whether or not it is best handled in a medical framework” (p. 133). While illness is explained in broader terms than simply a biological malfunction, it is still assumed that somatic symptoms which are not supported by “objective medical findings” are the result of psychosocial factors (interacting with benign biological factors) and are not reflective of serious pathology. Thus, proponents of the biopsychosocial model appear to operate from more dualistic, biomedical assumptions than those that they profess to hold.

Person-World Relations

Biopsychosocial proponents argue that their model of somatization replaces the dualistic, reductionistic, linear-causal explanations of the biomedical model with reciprocal, interactionist, multi-causal explanations. Thus, illness expression is accounted for by the circular causal

interrelationships among biological changes, psychological status, and the social and cultural contexts that shape the patient's perception and response to illness. These biopsychosocial factors are construed as reflecting multi-level systems that are linked hierarchically by the reciprocal flow of information through feedback loops. This helps to explain how disturbances in one level can effect change in other levels. The movement towards multi-causal, systemic explanations represents a significant advance over the simplified, linear-causal framework of the biomedical model.

Given that the biopsychosocial model has developed from efforts to summarize and categorize the results of empirical research into somatization, the model still holds to the subject-object, internal-external and experience-behaviour dualisms that are part of the natural science paradigm. As the subject of study, it is assumed that somatization must be studied objectively by utilizing natural scientific methods and procedures. Humans are viewed as biological organisms engaged in multi-level interactions that connect "internal" (i.e., biological and mental-emotional) processes with familial and social-cultural processes that are "external" to the organism. In terms of subjective experience, the biopsychosocial model refers primarily to the role that cognitions can play in misinterpreting bodily symptoms. It also makes reference to psychiatric disorders and/or personality traits that can predispose a person to somatize. Behaviours referred to include modelling of family illness patterns, medical help-seeking, adoption of the "sick role," and secondary gain. Compared to the neuropsychiatric model, the biopsychosocial model provides greater elaboration on the factors associated with the each dichotomous polarity.

Freedom-Determinism

The biopsychosocial model attempts to explain which biological, psychological and social factors are most likely to determine whether an individual develops somatization. As a multi-causal model, it clearly considers certain factors to be determinants of health and illness. However, when one looks at the therapeutic implications of this model, it is apparent that proponents do not consider these determinants to be absolute. By changing one's interpretation of the seriousness of one's bodily symptoms, shifting one's focus to relevant psychosocial issues, or changing one's behaviours (e.g., increasing physical activity, practicing relaxation/stress

management), it is expected that somatic symptoms will improve. Such suggestions are geared toward the perpetuating factors that are considered to be primarily under a patient's control. Given the interactive nature of the model, it is also suggested that doctors, therapists and family members can assist the patient by correcting misinformation and reinforcing more adaptive thoughts, emotional responses and behaviours.

One can infer from these treatment recommendations that patients are considered to have a certain degree of freedom and control over their symptoms if they are willing to adopt more adaptive ways of thinking and behaving. However, it appears that only a certain amount of change is considered possible. For example, beyond improving doctor-patient relations, there are no suggestions made regarding how one can counteract the powerful effects of the health care system (including insurance companies, employers, etc.) which tends to reinforce somatized communications of distress by stigmatizing psychiatric illness. Similarly, no recommendations are put forward to address the impact of predisposing or precipitating factors, such as illness knowledge and/or experience gained from childhood, personality disposition, psychiatric disorders or stressful life events. Finally, the recommendation that patients shift their expectations from "diagnosis and cure" to "symptom management and rehabilitation" makes it clear that only a limited amount of change is considered possible (Simon, 1998).

Acquisition and Validation of Knowledge

Proponents of the biopsychosocial model are guided in their empirical research by principles of the natural science paradigm, including causality, reductionism and determinism. It is pre-supposed that somatization is determined by a reciprocal interaction of biological, psychological and social factors, and that scientific knowledge of these multi-causal interactions can be acquired through the objective methods and measures of the natural sciences. The ultimate goal is to explain the phenomenon of somatization as accurately as possible so that it can be predicted or controlled in some way. The use of multivariate statistics and research designs are particularly encouraged, so that multiple variables can be assessed, integrated and interpreted.

In their quest for comprehensiveness, biopsychosocial proponents appear willing to consider hypotheses based upon clinical anecdotes or other methods viewed as less rigorous than

natural scientific methods. However, the value of these hypotheses is typically qualified by statements referring to their lack of supportive empirical evidence. For example, the defense model of psychopathology is based upon psychoanalytic assumptions and is supported by case reports and clinical anecdotes. While the model is not rejected outright, biopsychosocial proponents suggest that defensive processes only play a minor etiological role given the “paucity of empirical evidence” (e.g., Kellner, 1990). Clearly, there are no hypotheses that would be accepted by biopsychosocial proponents as valid without submitting them to natural scientific methods of analysis.

Evaluation of Strengths and Weaknesses

Following is a critical evaluation of the biopsychosocial model’s strengths and weaknesses, based upon its: a) comprehensiveness, b) consistency, c) research relevance, and d) its congruence with the foundations of a human science approach.

Comprehensiveness

The primary strength of the biopsychosocial model is its comprehensiveness. It recognizes the multi-factorial nature of somatization and attempts to portray these factors in a hierarchy of biological, psychological and social systems that are interconnected. The biopsychosocial model also provides an account for the considerable heterogeneity in behavioural and psychological manifestations of somatization, both across persons with comparable symptoms and within the same individual over time. At different times during the course of an illness or impairment, the weighting of these biological, psychological and social factors is considered likely to change. By viewing somatization as an ongoing, dynamic, multi-factorial process, biopsychosocial proponents are better able to explain the discrepancies between “objective” and “subjective” reports of illness that physicians are presented with on a regular basis. For these reasons, the biopsychosocial model represents a significant advance over the neuropsychiatric model.

Although there is an attempt to account for two types of somatizers, i.e., *amplifiers* and *minimizers*, the study of minimizers is mostly neglected within the biopsychosocial model. As the empirical findings are believed to be much more supportive of the amplification model versus the defense model, no empirically grounded explanation is put forward to account for somatizers who deny or minimize their emotional distress. It is possible that minimizers have been studied less because the biopsychosocial model refers primarily to somatizers who seek medical help. Thus, a large portion of the somatizing population who ignore symptoms or treat them with folklore, over-the-counter or alternative health care remedies are not accounted for by this model. A few authors argue that somatizers with “under-emotional” coping styles should be investigated much more thoroughly, as they respond differently than amplifiers (both psychologically *and* physiologically) and they are equally at risk for developing somatization and other psychophysiological disorders (e.g., Bakal, 1990; Sivik, 1998; Wickramasekera, 1998).

Another weakness of the biopsychosocial model is that it is not well grounded from a theoretical perspective. Systems theory holds that disciplines at different levels of the hierarchy are connected through hierarchical dependence. Yet it is unclear how one is supposed to integrate different explanations of the same phenomenon (e.g., biological versus psychological) when there is no shared conceptual framework or common unifying language. Proponents of the biopsychosocial model are left to present findings from different disciplines alongside each other, with no guidelines to reconcile differing explanations that are based upon different theoretical assumptions. For example, the amplification and defense models are based upon very different foundational assumptions regarding human nature and psychopathology. Without an over-arching theory, proponents are left to judge the value of these explanatory models by their amount of supportive empirical (i.e., natural scientific) evidence. The biopsychosocial model may be viewed as empirically strong, but its value is weakened by being unable to offer a unified theory that deals with the hierarchy of systems as a *whole*.

One of the consequences of lacking a detailed, over-arching theory is that the biopsychosocial model has been criticized for not providing physicians with specific guidelines for treating *individual* patients (e.g., Harms, 1985; Herman, 1989; Schwartz & Wiggins, 1985). Based upon correlational data, the model describes general risk factors for somatization but it

does not provide guidelines for determining how and why somatization develops in a particular individual at a particular time. In the words of one physician, “In spite of having read much of the requisite literature, I do not always know ‘how to be’ biopsychosocial” (Herman, 1989, p. 107). Physicians can list the biological, psychological and social factors¹⁴ alongside each other that may be predisposing, precipitating and/or perpetuating the patient’s symptoms, but there is no indication regarding how to combine these factors *dynamically* so that different pathogenic (and non-pathogenic) factors can be related to the patient’s life as a *whole* (Harms, 1985). According to these critics, the lack of specific guidelines for implementing the biopsychosocial model is one of the reasons that it has had limited impact on the practice of medicine.

Consistency

With the difficulties already discussed in applying theory to practice, it is not surprising that the biopsychosocial model of somatization presents a number of inconsistencies. These are particularly notable when reflecting on the model’s treatment recommendations. For example, the model presents numerous predisposing, precipitating and maintaining factors that are frequently of a long-standing, dispositional and/or socio-cultural nature. These include negative affectivity, psychiatric disorders, illness knowledge/experience, abuse/trauma, the health care system, and the reactions of others. Given the complex and multi-faceted nature of the problem, it seems overly optimistic or simplistic to assume that the majority of somatizers can be successfully treated by psychosocially trained physicians. According to Sharpe, Bass and Mayou (1995), these physicians would relate empathically to the patient, correct misinformation and exaggerated beliefs, provide an explanation that includes physiological and psychological factors, modify unrealistic expectations regarding diagnostic certainty and cure, and provide advice regarding behavioural and life-style changes. Psychological therapies are believed to be necessary for only a minority of patients and are designed to support the same cognitive and behavioural goals described for physicians.

In terms of practical application, the heart of the biopsychosocial model appears no longer

¹⁴ Harms (1985) also makes the point that the biological, psychological and social systems are not the only possible ones to have an influence on health. For example, *spirituality* would be considered equally as important by many non-Western cultures, as well as advocates of the holistic health movement.

to be systems theory, as this would require consideration of *all* the biological, psychological and social factors involved. Instead, as Antonovsky (1989) describes, “The emphasis is on communication skills and the psychology of the patient. The broader systems of family, community, social class, etc. (i.e., the “social” part of the model) are ignored. Moreover, the psychology of the physician and the social structures within which health care is carried out is rarely related to the clinical problems” (p. 252). Even the work of medical family therapy seems restricted to achieving pre-set goals that would improve doctor-patient relations and decrease health care utilization (e.g., McDaniel, Hepworth & Doherty, 1987).

In summary, the therapeutic implications of the biopsychosocial model do not seem consistent with the biopsychosocial conceptualization of somatization or with the systems theory from which it is purportedly derived. It seems reasonable to consider that these inconsistencies may be related to the dualistic, biomedical assumptions that are implicit in the biopsychosocial model and are fueled by the reality of working in dualistic, biomedical institutions. By failing to challenge a number of assumptions that are central to the biomedical model, some authors argue that Engel’s biopsychosocial model has only strengthened biomedicine by ensuring that the patient is “successfully managed” through improved communication skills (e.g., Armstrong, 1987; Salmon & May, 1995). Rather than truly taking the patient’s illness story and experience into account, the treatment recommendations seem more driven by the biomedical assumption that somatic symptoms without objective medical findings are psychosocial in origin, and by the pragmatic goal of decreasing the impact of somatization on an over-burdened health care system. It was not likely Engel’s intention to have psychosocial considerations relegated to the position of being “just another tool in the doctor’s bag” when he developed his biopsychosocial model. However, the problems faced by the biopsychosocial model attest to the difficulties inherent in attempting to work within, yet move beyond, the scientific reductionism of the biomedical model. Not infrequently, this reductionistic tendency can lead to over-simplified solutions for complicated and multi-faceted problems (Sivik, 1998).

Research Relevance

The amount of empirical research generated by the biopsychosocial model is clearly one

of its greatest strengths. In fact, the majority of contributors to the literature on somatization subscribe to this model. Much of this literature consists of correlational research designed to determine the relationship of various isolated factors to somatization. A few authors have begun to utilize multivariate research strategies to generate more complex hypotheses regarding the interaction of multiple variables, as well as the comorbidity of certain symptoms and syndromes (e.g., Kirmayer & Robbins, 1991). Biopsychosocial proponents have also made a significant contribution by highlighting the conceptual confusion that surrounds somatization, functional somatic syndromes and somatoform disorders. The attention brought to somatization by biopsychosocial proponents has likely helped increase awareness of the problem within the broader medical community.

Congruence with a Human Science Approach

The criticisms previously outlined in the phenomenological critique of the natural science paradigm are applicable to the biopsychosocial model of somatization and will not be repeated here. The biopsychosocial model has attempted to move beyond the individualistic notions of illness that are central to the biomedical model. From a therapeutic perspective, it has made some positive suggestions toward improving relations between health care professionals and somatizing patients. These include establishing a collaborative therapeutic relationship, eliciting the patient's and/or family's illness story, making inquiries into other aspects of the patient's world, and arriving at a shared, mutually acceptable explanation of the symptoms and course of treatment. Importance is also placed on accepting the validity of a patient's somatic symptoms and empathizing with the distress that the patient is experiencing.

From a human science perspective, both the biomedical and biopsychosocial models overlook a fundamental aspect of the physician-patient relationship. Without considering the *being* or life-world of the patient, the patient's experience will always be misconstrued. The biopsychosocial model fails to notice that the human sciences prove relevant to medicine because the physician must *understand* patients, not simply *explain* symptoms from a scientific perspective. This is because it does not recognize the reliance of medicine on the pre-scientific world of lived experience. Instead, it subsumes the concrete reality of the patient's life-world

under the abstract concepts of the sciences (Schwartz & Wiggins, 1985). Rather than attempting to understand the effects of various factors on the *specific patient's being*, they are related to the *patient in general* (Harms, 1985). As Schwartz and Wiggins (1985) emphasize, "the many scientific abstractions through which we understand the person and his or her social moorings achieve integration only if we relocate that person within the more concrete setting of the pre-scientific lifeworld" (p. 338). The patient's life-world provides the "supra-system" necessary to combine the biological, psychological and social systems in a structured, meaningful way. Without it, a patient is represented by the *sum total* of a collection of different systems that can never become a whole.

Implications for the Problematic of Somatization

There are a number of positive implications that arise from the biopsychosocial model of somatization. Given its focus on improving doctor-patient communication, it could potentially lead to a reduction in the strain between somatizing patients and their physicians. By arguing for the etiological relevance of biological, psychological and social factors, physicians may be less likely to communicate the impression that "it's all in your head" or that the patient is malingering. Patients may be more likely to consider the role of psychosocial factors if the issue is raised by their physician in a respectful way, particularly if they are linked to biological factors as well. If patients receive assistance from a physician or therapist in exploring and addressing these psychosocial issues, they may be less likely to develop persistent, disabling symptoms. In providing suggestions regarding behavioural and life-style changes, patients may also benefit from a greater sense of control over their symptoms. On a practical level, physicians could reduce the iatrogenic health risk of somatizers by avoiding risky or unnecessary medical investigations, surgical procedures or medications.

One of the challenges of the biopsychosocial model is that the positive implications are entirely dependent upon whether the patient is willing to *accept* the physician's (bio)psychosocial explanation for their symptoms. Most somatizers arrive at their doctor's offices with dualistic assumptions of their own, that are not easily swayed by "rational," scientific arguments. In fact,

the biopsychosocial model describes quite clearly how the social, legal and financial aspects of the health care system put tremendous pressure upon patients to somatize their distress and to resist psychosocial explanations. Other contributing factors include traumatic life events, psychiatric disorders or neurotic personality traits, and the reactions of others. In effect, the biopsychosocial model puts forward many reasons why a patient would *not* be likely to accept a physician's (bio)psychosocial explanation. Yet it provides no guidelines for what a physician should do if the patient disagrees. Even with the best efforts of the physician, the patient can easily be left feeling stigmatized, misunderstood and angry if s/he does not accept the physician's explanation. This is an example of how the treatment recommendations are not consistent with the model's conceptualization of somatization, and reflect an over-simplification of the problem.

A similar type of simplification follows from assuming that the reality of the patient can be represented by the abstract concepts of the sciences. For example, it is assumed that the model's treatment recommendations would be helpful to all somatizing patients, regardless of their particular illness story or experience. These include "respectfully" persuading patients that they are misinterpreting the nature and seriousness of their symptoms and gradually shifting their focus to psychosocial factors that may be involved. While the goal is to arrive at a mutually acceptable explanation and course of treatment, it is difficult to see how this can occur without being based on a mutual, shared understanding of the patient's lived experience. If a patient feels that their beliefs and concerns are not being understood or addressed, they are much less likely to accept the physician's explanation or to follow through on their recommendations.

From a research perspective, the natural science paradigm restricts the biopsychosocial model to exploring potential contributing factors to somatization that are observable and measurable. The danger of this restriction is that important "subjective" or hidden factors may be dismissed or ignored. As an example, the population of "under-emotional" or "minimizing" somatizers have rarely been studied by proponents of this model because the research has typically been restricted to somatizers who seek medical help and are therefore easier to access. Similarly, by subscribing to the biomedical assumption that somatic symptoms without objective medical findings are of a benign nature, biopsychosocial proponents are much less likely to explore subtle pathophysiological factors that may be involved and could possibly be treated

medically. From a clinical perspective, patients in the early stage of an organic illness may be at increased risk of being misdiagnosed as somatizers.

In summary, the biopsychosocial model represents a significant advance over the neuropsychiatric model. To the extent that it leads to improved doctor-patient relations, reduced iatrogenic health risks, and assistance for patients in exploring and addressing psychosocial issues, this model can have a positive impact on the problematic of somatization. However, without designing research strategies and providing treatment recommendations that address the complexities of somatization as it is *experienced* by individual patients, it is unclear how much positive impact will be realized.

Psychoanalytic Model of Somatization

Literature Review

Background Theory

Trained as a neurologist in Vienna, Freud (1896, 1900, 1923) developed the first “talking cure” for what he referred to as the *psychoneuroses* (e.g., hysteria, obsessions, phobias) based upon the revolutionary idea that neurotic symptoms were the product of unconscious drives and conflicts. Freud’s theory came to dramatically alter our perceptions of the human psyche. It also sparked great controversy and has undergone many revisions since its inception. While some of Freud’s original followers broke away to develop their own theories, others have continued to revise and expand psychoanalytic theory, making substantial changes but continuing to maintain some of Freud’s key concepts and principles. Since the 1920s, the emphasis has shifted from the id to the ego, and later to the self. This has resulted in the emergence of various schools within the psychoanalytic movement, including ego psychology, object relations theory, and self psychology. These schools have not only made modifications to the theory and practice of psychoanalytic therapy, they have also broadened the scope of treatment to include more serious forms of psychopathology than the neuroses. To distinguish this broader movement from

classical psychoanalysis, it is generally referred to as *psychodynamic* theory.

The purpose of this section is to provide a brief description of Freud's psychoanalytic theory and the distinctive contributions of three psychodynamic schools which have evolved out of his work. A detailed overview of these theories would naturally be beyond the scope of this thesis. Rather, the intent is to restrict this review to the concepts and principles which are central to the psychoanalytic model of somatization.¹⁵

Freud's Psychoanalytic Theory

Freud's theory of personality is based upon the notion that humans are powerfully motivated by unconscious sexual and aggressive instincts or drives. A drive is neither psychological nor biological but rather a combination of both (St. Clair, 1986). It is a bodily urge that takes the form of unconscious wishes and impulses that seek gratification. Using the metaphor of a hydraulic system, Freud imagined the drives as consisting of a form of energy he called *libido* (Engler, 1991). Viewing the sexual drive as primary, Freud redefined sexuality by arguing that procreation was not its sole purpose. Rather, he insisted that sexual behaviour was motivated by pleasure and that it included the autoerotic activities of young children who derive pleasure from thumb sucking and exploring their own bodies. In fact, Freud viewed personality development in terms of a gradual progression from the autoerotic sexuality of infants to the genital sexuality of adults. As the child proceeds through the various psychosexual stages of development, the child's libido is increasingly *repressed* by parental figures who train the child to delay gratification and to channel the libido in more socially appropriate ways. Adult personality and psychopathology is believed to be determined by how successful we are at obtaining optimal gratification as we pass through these stages of development. If too little or too much gratification takes place, a person may become *fixated* at that stage, resulting in the development of certain character traits postulated by Freud to be associated with each stage (Ryckman, 1997). In addition, a fixated person can *regress* and display infantile behaviour as a means of alleviating stress.

¹⁵ The model of somatization is referred to as "psychoanalytic" with the understanding that it draws from traditional psychoanalysis as well as contemporary psychodynamic theory. Similarly, "psychoanalytic therapy" will refer broadly to treatment by both psychoanalysts and psychodynamic therapists. Distinctions will be made between psychoanalytic and psychodynamic approaches when it is contextually relevant.

In Freud's structural model of the mind, he described personality in terms of three psychic structures: the *id*, *ego* and *superego* (Engler, 1991). He proposed that the unconscious mind is dominated by the *id*, which is present at birth and governed by the "pleasure principle," pursuing gratification of instinctual needs with no regard for the consequences. The conscious mind is dominated by the *ego* by using various psychological defense mechanisms to control or transform the *id*'s instinctual drives. The *ego* is governed by the "reality principle," and provides a person's connection with the outside world, mediating between the *id*'s libidinal drives and the demands of the environment. The *superego* develops during the phallic stage of development when the child resolves the oedipal conflict¹⁶ by identifying with the parent of the same sex and internalizing the parent's authority. The *superego* represents one's conscience, using guilt and anxiety to influence the *ego* to behave according to parental and societal standards.

Psychological disturbance is believed to result when there are unresolved conflicts between the different structures of the personality (i.e., *id*, *ego*, and *superego*) or between the instinctual demands and the demands of reality. The unresolved conflicts of childhood, especially oedipal conflicts, are believed to result in adult neuroses (St. Clair, 1986). These conflicts are held to produce internal signals of potential anxiety or depression, eliciting the *ego* to respond with a variety of unconscious defense mechanisms to keep the disturbing affects and conflicts out of awareness. The most common defense mechanism is *repression* which blocks a wish or drive from being experienced or expressed (Ryckman, 1997). These defense mechanisms attempt to arrive at a compromise by keeping the most disturbing themes unconscious while partially gratifying or accommodating the wishes and fears. However, these compromise solutions are not always successful, and can result in some symbolic expression of the instinct or wish in the form of a neurotic symptom. The Freudian analyst will attempt to uncover the conflicts and seek the unconscious causes of the neurotic symptoms.

The primary method used by Freud to study the human psyche and uncover repressed conflicts was *free association* (Engler, 1991). Patients were asked to verbalize and reflect upon

¹⁶ According to Freud, 4 to 5 year old boys develop a desire for sexual contact with the mother but feel anxious that their rival, the father, will castrate them in punishment for their desires. To alleviate their anxiety, they identify with the father. A different conflictual process was postulated for females, but concepts such as "penis envy" led many female psychoanalysts (and later, feminists) to severely criticize this aspect of Freud's theory (Ryckman, 1997).

whatever came to mind, no matter how trivial or unpleasant. Special attention was paid to dreams or “slips” of the tongue in which a person says something which they did not consciously intend to say. Freud assumed that nothing in our psychic life is arbitrary or insignificant. Instead, he believed that these “free” associations were not free at all but determined by unconscious forces, and that following a chain of associations would ultimately lead back to the source of the problem. By interpreting the underlying motives for dream images or slips of the tongue, Freud hoped to weaken the patient’s defenses and ultimately bring the repressed conflicts out into the open. He viewed the subsequent behaviour of his patients as confirmation or disproof of his interpretations. Freud theorized that patients resisted remembering the repressed conflicts, and this resistance was evident in disruptions in the free association process. Thus, the theory and practice of psychoanalysis was built upon the empirical observations made by Freud of his patients’ free associations, dreams, and responses to his interpretations as their treatment unfolded.

Besides free association and dream analysis, Freud relied heavily on *transference* to understand and treat his patients (Ryckman, 1997). He found that patients inevitably began to relive old conflicts and ambivalent feelings towards past (usually parental) authority figures in their relationship with him. In the initial phase of treatment, a *positive transference* typically developed, in which feelings of affection, trust and sometimes love or lust were expressed towards Freud. During this time, patients were quite receptive to his interpretations and generally made progress. However, this positive phase was typically followed by a *negative transference* in which the patient’s anger, hostility and distrust from past relationships came to be transferred onto Freud. As Freud interpreted the relevance of the patient’s feelings and conflicts toward him, the patient was helped to understand and work through the past conflictual situations to a more satisfactory conclusion.

In summary, psychoanalysis consists of a theory of personality based upon instinctual drives and an approach to psychological treatment that focuses on uncovering the repressed intrapsychic conflicts that underly neurotic symptoms. This form of treatment utilizes free association, interpretation and analysis of the transference as its primary means of conducting therapy. Ultimately, it is based on the view that human beings experience a perpetual state of

conflict between their animal nature and the ideals of their culture.

Ego Psychology

While Freud emphasized the influence and power of the id, subsequent practitioners came to focus on the importance and independent functioning of the ego, including Anna Freud, Heinz Hartmann, and Ernst Kris (Loevinger, 1976). Anna Freud was one of the first child psychoanalysts and the first to extend psychoanalysis to the exploration of the ego. In “The Ego and the Mechanisms of Defense,” she emphasized the value of focusing on the ego’s defense mechanisms that are interfering with the emergence of unconscious material in the analytic situation (Freud, 1936).

Heinz Hartmann became known as the “father” of ego psychology after his publication of “Ego Psychology and the Problem of Adaptation” in 1939 (Engler, 1991). He was the first to propose that the ego was an important autonomous force that was not inescapably bound to the id. He also argued that the ego’s functions were not limited to the avoidance of pain and the gratification of instincts. Instead, he posited that ego defenses can develop, with psychological maturity, into “conflict-free ego capacities” which are well-adapted to the environment (Loevinger, 1976). He broadened the scope of psychoanalysis from psychopathology to a more general psychology by focusing on the synthesizing and integrative functions of the ego (e.g., perception, attention, memory, rational thought) and the ego’s capacity to adapt to an “average expectable environment” by regulating instinct tensions (Engler, 1991).

While the ego psychologists focused more on analyzing the ego’s capacities and defensive strategies than on uncovering unconscious wishes, they still subscribed to Freud’s drive theory (with minor modifications)¹⁷ and emphasized the central role of intrapsychic conflict and the compromise formations that result. Hartmann’s notion of an average expectable environment led others to emphasize the importance of a nurturing environment in the development of adaptive capacities, and the *ego defects* (e.g., affect intolerance, poor impulse control) which can result from a lack of nurturance (Grotstein, 1996). This recognition of the importance of nurturance corresponded with a growing interest within the psychoanalytic

¹⁷ For example, Hartmann, Kris and Lowenstein put forward the notion that the ego operates with *neutralized* energy as well as the energy from sexual and aggressive drives (Loevinger, 1976).

community to explore the psychopathological consequences of early deficits in child-caregiver relations.

Object Relations Theory

A number of writers may be loosely grouped together as object relations theorists, although they reflect a diverse array of suppositions, concepts and orientations with varied uses in terminology. Grotstein (1996) divides the primary contributors to object relations theory into the Hungarian school (e.g., Ferenczi, Balint), the American school (e.g., Mahler, Jacobson, and Kernberg, who were strongly influenced by ego psychology) and two British schools. These consisted of Melanie Klein and her followers, as well as an Independent group (e.g., Fairbairn, Winnicott) which occupied a middle ground between the Kleinians and the Anna Freud group. Although the term *object relations* has been defined in different ways, it essentially refers to the inner traces of past relationships that shape an individual's current interactions with people (St. Clair, 1986).

While acknowledging the differences in this group, there are a number of general statements that can be made about object relations theory. Firstly, it proposes that early child-caregiver relationships are more primary than innate instinctual drives in the shaping of personality. While some analysts have attempted to integrate Freud's drive theory (e.g., Kernberg, Jacobson), others have proposed radical revisions (e.g., Fairbairn) (Grotstein, 1996). Secondly, it accounts for the development of internal psychic structures by the influence of external objects in the child's environment (i.e., parents or significant others). In fact, structure formation is understood as a process of internalizing a *relationship with an object* rather than the drive-derivative formation of an id, ego or superego (St. Clair, 1986).

In contrast with the Freudian focus on the oedipal conflicts which arise during the phallic phase of development (i.e., three to five years), object relations theorists have focused more on the developmental processes and relationships in the first three years of life. Since the work of Mahler (1968), the crucial developmental issue in this pre-oedipal phase has been viewed as the child's move from a state of symbiotic fusion and dependence on the mother to a state of separation and increased independence and self-differentiation. In terms of psychopathology,

early developmental deficits are believed to hinder or prevent the integration of psychic structures, resulting in more serious psychopathology than the classical neuroses. Object relations theorists have been particularly interested in psychopathology involving disturbed relationships, and have contributed significantly to the study of borderline and schizoid personality disorders (Michels, 1995).

Another common theme is that object relations theorists view the individual in terms of an “internal drama” formed out of experiences with the primary objects, or significant persons, of childhood (Pine, 1988). The *internal object* refers to a child’s mental representation of how it experiences its relationship with its primary caregiver (St. Clair, 1986). As the internal object is influenced by the affects and wishes of the child, it typically reflects a distorted or inaccurate perception of the relationship. The *external object* refers to the actual caregiver or significant other who exists in the external world. Similarly, a child’s inner psychic world will include a mental representation of its own *self*, as it is experienced in relationship with significant others in its environment. This self representation is frequently linked by theorists to other mental processes, such as projection¹⁸ and different forms of internalization and identification (St. Clair, 1986). Object relations theorists believe that there is a strong tendency for significant early experiences and “family dramas” to be repeated in future relationships, either out of efforts to repeat familiar experiences or to master traumatic ones (Pine, 1988). Hence, the goal of therapy is to free the person from continuing to act out the old patterns.

Self Psychology

Heinz Kohut (1971, 1977) and his followers have developed a third school of psychodynamics which places the need to develop and maintain a cohesive self at the center of personality development and psychopathology. The self is viewed as the broader organization that underlies the id, ego and superego and provides us with our basic sense of who we are (St. Clair, 1986). Kohut’s work with narcissistic personality disorders¹⁹ led him to disagree with Freud, who believed that narcissistic individuals had too much libidinal investment in themselves

¹⁸ Projection is a defense mechanism in which a person attributes his or her own undesirable characteristics to others (Ryckman, 1997).

¹⁹ Narcissistic personality disorders are characterized by an exaggerated sense of self-importance and self-involvement, masking a fragile sense of self worth (Ryckman, 1997).

to establish a therapeutic relationship. In contrast, Kohut believes that these individuals can have therapeutic relationships, but that they are narcissistic ones in which the therapist is dealt with as if he or she were a part of the self (St. Clair, 1986). Accordingly, a different form of treatment is required from that designed for the neuroses. In addition, he believes that the prevalence of narcissistic and borderline personality disorders have increased significantly since Freud's time, which he attributes to changes that have taken place in family relationships and society (Leider, 1996).

Self psychologists are similar to object relations theorists in that they view psychopathology in terms of psychic deficits that result from disturbed object relations in the early pre-oedipal years of life. However, self psychologists focus much of their attention on *selfobjects*, which are described as "mental representations of other people, who function as tension-regulating structures of the self and who are experienced as if they are a part of the self" (Ryckman, 1997, p. 266). The term *selfobject* is meant to reflect this lack of differentiation between self and object. Parents or caregivers are initially considered to serve as selfobjects, helping their children regulate the tensions and stresses which they are unable to do on their own. Selfobjects also serve to meet three other basic needs: a) an exhibitionistic need for approval via mirroring responses, b) a need for closeness and support from an omnipotent idealized other, and c) a need for the presence of another being who is felt to be similar to oneself (St. Clair, 1986). These needs are viewed as basic constitutional givens. Gradually, as these needs are met, it is proposed that the self withdraws narcissistic investment from its early selfobjects and learns to perform psychic functions (such as affect and self-esteem regulation) on its own. However, some selfobject needs do not fade and are considered a normal part of development, with potential selfobjects broadening to include spouses, children, and other significant individuals or groups in one's life (Leider, 1996).

In terms of narcissistic pathology, it is believed that disorders of the self arise from the failure of caregivers to empathically respond to the child's selfobject needs. A *nuclear self*, consisting of a *grandiose self* and an *idealized parental imago*, is believed to be formed through the empathic responsiveness of the selfobjects (St. Clair, 1986). If this nuclear self is not formed, it is proposed that the grandiose self and idealized object remain isolated from the rest of the

psyche, demanding that their archaic needs be met.²⁰ Chronic nonresponsiveness prevents the child from merging and eventually withdrawing from the selfobject, depriving the child of the opportunity to build up his/her own regulatory psychic structures. Lacking a sense of cohesion, individuals with self disorders frequently experience the fear of fragmentation and disintegration. According to Leider (1996), this disintegration anxiety is viewed by Kohut as the deepest anxiety that man can experience. Originating in the pre-verbal stages of development, it is experienced as a vague and diffuse sense of terror that cannot be easily described. To combat this anxiety, these individuals seek out narcissistic object relations to meet their selfobject needs. Therapy is thus viewed as an opportunity to provide the empathic relationship that the individual was originally deprived of, in order to repair some of the deficits that took place. Interpretation is still used, but its role is conceptualized differently than in psychoanalysis, occurring later in the therapy after an empathic, "corrective" relationship has had time to strengthen the low self-esteem and shaky boundaries of the patient.

Summary

Significant revision and expansion of psychoanalysis has taken place since Freud's time, although many of his key concepts and principles remain. For example, psychodynamic schools tend to hold that unconscious forces have a determining influence on behaviour, that dreams are psychologically meaningful, and that the analysis of transference is critical to therapy. However, the role and significance of instinctual drives and structural conflict is no longer universally agreed upon. Furthermore, serious character pathologies are believed by many to be the result of psychic deficits caused by early disturbances in object relations rather than maladaptive defense mechanisms. While it may appear that these psychodynamic schools have replaced psychoanalysis, they continue to be based upon psychoanalytic theory which they have updated and expanded to include a broader range of disturbances.

²⁰

Archaic refers to pre-oedipal or pre-verbal needs that persist in an adult (St. Clair, 1986).

Application to Somatization

More than a century ago, Freud (1896) described a mysterious “leap” from the mind to the body in his studies on hysteria and conversion symptoms. He postulated that conversion hysteria reflected a sharp conflict between the ego’s struggle to gratify forbidden impulses of the id while also attempting to defend against the condemnation of the superego. As a compromise, the conflict is converted into a somatic symptom (e.g., paralysis, blindness, etc.) to prevent the forbidden impulse from being acted upon. For example, an unconscious desire to strangle one’s husband could result in the paralysis of one’s hand. The symptoms were viewed as symbolic of the forbidden impulses that had been repressed from consciousness.

In 1895, Freud made a distinction between *psychoneuroses* (e.g., hysteria, phobias, obsessions) and *actual neuroses* (anxiety neurosis²¹, neurasthenia and hypochondriasis) (Taylor, 1992). As the psychoneuroses were viewed as resulting from unconscious intrapsychic conflicts, Freud believed they were amenable to psychoanalysis. In contrast, the vague, diffuse somatic symptoms of the actual neuroses were not held to be symbolic. Instead, Freud proposed that an excess or depletion of sexual energy transformed subjective distress directly into somatic symptoms. As these symptoms were produced primarily by physiological processes, he did not believe that psychoanalysis could ameliorate these symptoms.

Significant time passed before psychoanalytic theorists paid serious attention to Freud’s distinction between psychoneuroses and actual neuroses. However, a strong psychoanalytic interest in psychosomatic disease emerged in the first half of the 20th century. The seven traditional psychosomatic diseases included duodenal ulcer, bronchial asthma, rheumatoid arthritis, ulcerative colitis, essential hypertension, neurodermatitis, and thyrotoxicosis (Schumacher Finell, 1997). *Specificity* theorists, such as Alexander (1950), attempted to link specific psychodynamic conflicts with specific illnesses, although biological and environmental factors were also believed to be involved. While agreeing with Freud that psychosomatic symptoms were not symbolic in the manner of hysterical symptoms, specificity theorists believed that psychoanalysis could ameliorate psychosomatic symptoms by uncovering and working

²¹ The symptoms of anxiety neurosis are similar to contemporary descriptions of panic disorder (Wolman & Thompson, 1996).

through the repressed emotions and conflicts. As a result, psychosomatic patients came to be treated analytically in a very similar fashion to psychoneurotic patients.

However, subsequent research failed to validate the specificity theories and the therapeutic results did not live up to the high hopes of the psychoanalytic community (Taylor, 1992). At the same time, advances in the biological sciences strengthened the allegiance of physicians to the biomedical model of disease. As a result, psychoanalytic interest in psychosomatic illness dropped off significantly. It was not until the 1970s that a resurgence of interest in psychosomatic illness took place under the concept of *alexithymia* (meaning “no words for feelings”) (Kooiman, 1998). The term was coined by Sifneos (1973) to reflect a series of cognitive, affective, and object-relations disturbances that he observed in many of his psychosomatic patients. These patients displayed a thinking style described as concrete, operational, and detail-oriented, with significant deficits in symbolic or imaginative thinking. They had great difficulty identifying and describing emotions, or being aware of bodily sensations associated with affective responses. They experienced occasional brief outbursts of emotion (e.g., anger), but with minimal insight as to the cause. Their object relationships were described as significantly lacking in affect, with the other person experienced as an extension of themselves. Interestingly, these deficits did not prevent many of these patients from succeeding in work or professional life.

The excitement generated by this new construct has led some psychoanalysts to view it as central to a potential new paradigm for explaining psychosomatic symptoms (e.g., Taylor, 1992). Similar to Freud’s description of the actual neuroses, subjective distress is held to be transformed directly into somatic symptoms because of deficits in one’s capacity to psychologically “work over” the distressing material. However, not all psychosomatic patients are alexithymic, nor do all alexithymic patients suffer from psychosomatic symptoms (Lolas & von Rad, 1989). In fact, aside from the association found between alexithymia and psychosomatic illness, alexithymia has also been shown to correlate with post-traumatic stress disorder, substance abuse, sexual perversions, pathological mourning, and narcissistic personality disorders (Lesser, 1981; Warnes, 1988; Weinryb, 1995). Although there are some authors who question the relationship between alexithymia and psychosomatic disturbances (e.g., McDougall, 1980; Weinryb, 1995), it is rare to

find a contemporary psychoanalytic account of psychosomatic illness that does not attempt to explain alexithymic deficits at the same time. Hence, the following accounts of psychosomatic illness²² will necessarily be intertwined with an etiological discussion of alexithymia.

The psychoanalytic model of somatization consists of two different perspectives on the etiology of psychosomatic illness: a *defense model* put forward by proponents of Freud's drive theory, and a *deficit model* put forward by object relations and self psychology theorists (Lolas & von Rad, 1989). These models are based upon clinical observations of early childhood development and extensive case histories of psychosomatic patients who have undergone psychoanalytic treatment. While both models move away from Freud in focusing on pre-oedipal versus oedipal factors, they offer different explanations for the development of psychosomatic symptoms and alexithymic disturbances based upon their view of the importance of defense mechanisms versus psychic deficits.

Defense Model

Contemporary proponents of the defense model believe that unconscious intrapsychic conflicts are at the root of psychosomatic disorders (e.g., Hogan, 1989; Sperling, 1978; Wilson, 1989). In contrast to earlier theorists (e.g., Alexander, 1950), it is asserted that psychosomatic symptoms carry primary symbolic meaning. According to Knapp (1989), proponents have extended Freud's conversion theory beyond the sensorimotor symptoms of conversion hysteria to include all organ systems and bodily functions - even those thought to be autonomous and not under voluntary control. The only difference is that the conflicts underlying psychosomatic conditions are believed to be pre-oedipal (corresponding with the oral and anal stages of development), in contrast with the oedipal conflicts predominant in hysteria.

Proponents of the defense model describe psychosomatic patients as having "primarily oral and anal fixations, with an inability to tolerate frustrations and a need for immediate gratification of aggressive, sexual, and dependency needs" (Mintz, 1995, p. 313). At the same time, a primitive and punitive superego is believed to exist which demands perfection and

²² In modern usage, psychoanalytic writers use the term "psychosomatic" to include all physical illness in which there appears to be a strong emotional component, with or without tissue damage. Given the popularity of this term in psychoanalytic writings, I will continue to use it in this section with the awareness that it encompasses the phenomena of somatization.

requires punishment through suffering. To ward off the guilt and fear associated with giving in to these forbidden impulses, the desires are expressed or discharged in symbolic, somatic symptoms. For example, Mintz (1995) suggests that spastic colitis can symbolize the release of aggressive impulses through diarrhea or the control of aggressive impulses through constipation. Similarly, asthma can symbolize the guilt associated with an aggressive impulse to choke another person.

Schur (1955) and other theorists view adult psychosomatic symptoms as representative of a defensive regression to a more primitive stage of psychic functioning (i.e., pre-verbal, pre-ego) where responses to emotional distress could only be expressed through the body. This regression is believed to account for the alexithymic disturbances noted in many patients, as well as the frequent presence of narcissistic, borderline, and dependent personality features (Grossman, 1992).

A seminal article by Engel (1959/94) provides an excellent example of how chronic pain has been conceptualized from this model. Through comprehensive interviews with a large number of patients, he attempted to identify the early developmental determinants of “pain-proneness” in patients who were either unresponsive to treatment, or had no identifiable organic pathology to account for their pain. The main common feature he found was that aggression, suffering, pain and guilt played a significant role in early family relationships. In fact, Engel believes that guilt was an invariable factor in the “choice” of pain versus other types of bodily symptoms. According to Engel, “pain becomes par excellence a means of assuaging guilt” (p. 216). He found that pain and relief became intermixed with concepts of good and bad, reward and punishment, success and failure. For example, children who were comforted by a remorseful parent after inflicting pain learned that pain and suffering gain love. Engel believed that these individuals had an unconscious propensity to solicit pain and suffering²³, as any form of success or good fortune mobilized intolerable feelings of guilt and frequently triggered a pain episode. Pain episodes were also triggered by guilt for aggressive or sexual feelings, as well as the threat or actual loss of a significant person, particularly if they had experienced ambivalent or

²³ Many patients described histories of extraordinary emotional and physical suffering, including a large number of painful investigative procedures, operations, and treatments. These procedures were frequently undergone at the insistence of the patient, in a similar fashion to the “doctor-shopping” practices characteristic of the chronic somatizer of today.

aggressive feelings toward that person. The location of pain also appeared to have symbolic meaning for these patients.

Grzesiak, Ury, and Dworkin (1996) agree with Engel that in clinical work with chronic pain patients, “it is often suffering, not pain, that poses the primary problem” (p. 155). They argue that psychogenic pain is rare, but that chronic pain occurs frequently after tissues have healed and can often reflect “the superimposition of psychodynamic issues on sensory memories” to prolong the clinical symptom (p. 162). They describe a recent study by Gamson (1990) which found that two variables were consistently associated with chronic pain: emotional repression and *ergomania*. Ergomania is defined by Blumer and Heilbronn (1989) as a conflicted work ethic characterized by “excessive work performance, relentless activity, self-sacrifice, and the precocious assumption of adult responsibilities” (cited in Grzesiak et al., p. 152). As this pattern frequently leads to a worsening of symptoms, it reflects one of the ways in which pain-prone individuals are believed to unconsciously solicit pain and suffering as a form of self-punishment. In fact, Grzesiak et al. suggest that pain patients develop “transferential” responses to their pain in the same way that they reacted to past authority figures. Responses can range from patients’ feeling oppressed (i.e., pain as punishment), abandoned (pain as loss), victimized and helpless, or berated for letting the pain inhibit them.

In summary, psychoanalysts who support the defense model view psychosomatic symptoms as a reflection of intrapsychic conflicts related to oral and anal fixations and an excessively punitive superego. Psychosomatic and hysterical conversion symptoms result from the same defensive processes and are therefore both symbolic. Defense mechanisms keep these conflicts out of awareness and regression to a more primitive stage of psychic functioning leads the forbidden impulses to be discharged somatically. Alexithymic disturbances are viewed as the result of this defensive regression. Contemporary proponents of this defense model appear to represent a minority view, given the purported consensus among most psychoanalysts that psychosomatic symptoms are not symbolic (Wolman & Thompson, 1996).

Deficit Model

A shift in interest from neurotic states to more primitive mental states has led object

relations and self psychology theorists to arrive at a different conceptualization of the development of psychosomatic conditions. Basically, it is proposed that disturbances in early object relations, or traumatic experiences at any age, can cause psychic deficits or impairments which lead individuals to express distress somatically. In contrast with the defense model, psychosomatic symptoms are not viewed as symbolic in nature as they are created by very different processes than hysterical conversion symptoms. The following section will present the deficit model by first looking at how children are believed to develop the capacities for symbol formation and verbalization of affect in the first years of life. This will be followed by a description of how trauma or a disturbed child-caregiver relationship can lead to alexithymic deficits. It is argued that these psychic deficits strongly predispose a child to somatize distress as an adult.

After a newborn leaves the safety of the mother's womb, it is believed that the infant desperately wishes to recreate this "one body fantasy" with the mother to regain the safety of the lost intrauterine paradise (McDougall, 1980). However, the infant also has a need to differentiate and learn that s/he can feel safe even when the mother is not physically present. At this early stage, Winnicott (1958) refers to the infant as a *psyche-soma* who expresses all distress somatically as s/he has no ability to differentiate between physical discomfort and psychic pain. The "good enough" mother attunes to the child's needs and acts as a psychic regulator of affect, providing a "holding environment" to protect the child from neglect or overstimulation (Winnicott, 1960). Some analysts believe that caregivers function as biological regulators as well (e.g., Taylor, 1992). Repeated experiences of the mother's warmth and closeness recreate the illusion of a merger with the mother. This, in turn, enables the infant to form an internal picture of the soothing maternal image so that s/he can fall asleep peacefully when separate from the mother. When the infant is seven to eight months of age, this process of internalization is facilitated by the use of *transitional objects* (e.g., blankets, stuffed animals) which come gradually to represent the mother symbolically and to provide soothing and regulating functions that previously required her presence (Winnicott, 1958). As the caregiver helps the child differentiate and name what he or she is experiencing, the healthy child eventually learns to symbolize and verbalize affect, as well as to differentiate between physical and emotional

responses.

This process of development can be severely disrupted if the caregiver is not properly attuned to the child's needs, particularly during the process of separation and individuation in the first three years of life. This lack of attunement can take various forms, including emotional unavailability, inconsistent responses to a child's affective needs, or an overly strong focus on the child's physical versus emotional needs (Winnicott, 1958). For example, if the parent is only attentive when the child is ill, health may come to symbolize loss, abandonment, and annihilation. From a self psychology perspective, the parents fail to respond empathically to the child's needs to be mirrored and to accept his or her idealized projections (Rickles, 1985). In addition, it has been observed that the mother frequently insists on maintaining the symbiotic merger with the child, and interferes with or feels threatened by the child's use of transitional objects (McDougall, 1980). This is believed to serve the mother's own unconscious narcissistic and libidinal longings, which are viewed by some as a sign of self pathology in the mother (Rickles, 1985; Schottler, 1998).

Severe trauma in childhood or adult life has also been shown to contribute to somatization. Although repression is still believed to play a role in keeping prior traumas out of conscious awareness, dissociation has come to be seen as central in the process of somatization in response to trauma (Miliori, 1998). According to Ross (1994), "psychosomatic symptoms from all bodily systems are often dissociative in nature and related to chronic severe childhood trauma" (cited in Miliori, p. 277). Using concepts from self psychology, Miliori defines dissociation as a vertical split in the psyche between the body-self and the mental-self. A child who learns to cope with overwhelming emotional and physical distress by dissociating is considered much more likely to react somatically to distressing events in adult life.

Disruptions in the child's early development are believed to cause the psychic deficits encompassed by the construct of alexithymia. These include deficits in the capacity for fantasy formation, symbolization, awareness of emotions, and the capacity to distinguish somatic from psychological experience (Lolas & von Rad, 1989). Impairments in the ability to regulate affect and provide self-care and self-soothing functions are believed to be the result of faulty internal representations of self and object (Taylor, 1992). Lacking a cohesive self, many individuals seek

out symbiotic selfobject relationships where the boundaries between self and other are blurred. They frequently turn to “pathological transitional objects” - such as alcohol or sexual activity - to self-soothe and regulate their impulses and emotions (Schumacher Finell, 1997). The need for constant, frenetic activity (similar to ergomania) can also reflect a method of warding off painful, primitive affects (Blaustein & Tuber, 1998). For these reasons, some view alexithymia as a sub-category of self or narcissistic disorders (e.g., Rickles, 1985; Schottler, 1998) or as the most conspicuous expression of an underlying personality disorder (Weinryb, 1995). Krystal (1979) points out, however, that the severity, consistency and reversibility of alexithymic characteristics is quite variable and should not be viewed as an “all-or-nothing” phenomenon.

Given that these developmental arrests occur during the separation-individuation phase, it is believed that psychosomatic symptoms are triggered in adulthood in response to archaic, primitive anxieties over fragmentation and disintegration (McDougall, 1980; Rodin, 1991). Unconscious fears of annihilation such as loss of body integrity, loss of identity, fear of merging with the selfobject (i.e., being unable to differentiate one’s thoughts, emotions from the other person), as well as fears of being overwhelmed or unable to cope, are believed to underly the affects of anxiety, panic²⁴ and depression which are most commonly associated with psychosomatic conditions (Hurvich & Simha-Alpern, 1997). Psychosomatic symptoms are considered to be a revival of the infantile psychosomatic state, where emotional pain can only be responded to somatically, in a pre-symbolic manner that circumvents the use of words (McDougall, 1989). The primary triggers for psychosomatic symptoms are believed to be disruptions in selfobject relationships, leading to psychological and physiological dysregulation (Schumacher Finell, 1997; Taylor, 1992). For example, Taerk and Gnam (1994) describe two cases where the onset of chronic fatigue syndrome was believed to be initiated by disruptions in selfobject relationships.

According to the deficit model, somatic symptoms serve the primary purpose of expressing affect, and protecting the person from experiencing overwhelming anxieties. For example, fears of merging with the selfobject can be alleviated by defining one’s body limits through physical suffering. The suffering body can also represent a way of attacking the body of

²⁴ For example, panic attack sufferers often experience fears of losing bodily control or of dying (DSM-IV; APA, 1994).

the internalized mother (Hurvich & Simha-Alpern, 1997). Observers of somatizers have also pointed to the secondary benefit of gaining access to caretaking people. Blaustein and Tuber (1998) view these help-seeking behaviours as indirect strivings for relatedness. By focusing on physical symptoms, the patient is able to tolerate a certain amount of relational proximity without finding it too overwhelming. According to these authors, “the human contact (and often, the ensuing disappointments) enacted via the help-seeking behaviors may represent, therefore, not a secondary gain, but rather a central dynamic of the psychology of chronic somatizers” (p. 362).

In summary, the deficit model of somatization represents an integration of contributions primarily from object relations theory and self psychology. Proponents of this model view the somatic expression of emotional distress as the result of alexithymic deficits caused by trauma or disturbed object relations in the first few years of life. Somatic symptoms are believed to help protect the individual from being overwhelmed by annihilation anxieties due to the lack of a cohesive self. As psychosomatic and hysterical conversion symptoms are believed to be created by very different processes, psychosomatic symptoms are not viewed as symbolic in nature.

Therapeutic Implications

Defense and deficit model proponents agree that there are obstacles and risks involved in working with psychosomatic patients. Alexithymic characteristics present the most significant difficulty as the psychoanalytic therapist typically relies on the client to provide dreams, fantasies and emotions to work with. There are also concerns that the therapeutic process can exacerbate psychosomatic symptoms or lead to near-psychotic regressions, putting the patient’s life at risk (McDougall, 1980; Sifneos, 1975). While some analysts believe that psychoanalytic therapies are contraindicated for these reasons (e.g., Sifneos, 1975), others believe that psychosomatic patients can benefit from psychoanalytic therapy if modifications are made and therapy proceeds slowly (e.g., Krystal, 1979; Rodin, 1991). As an example, some psychoanalysts (particularly in Germany) suggest that various forms of body work (e.g., bioenergetics, concentrative kinetherapy, analytical body therapy, functional relaxation, authentic movement) can be helpful in gaining access to unconscious pre-verbal material (Müller-Braunschweig, 1998; Wyman-

McGinty, 1998). Beyond these considerations in working with psychosomatic patients, there are significant differences in treatment recommendations between the two models. These are outlined below.

Defense Model

Proponents of the defense model view the alexithymic characteristics in psychosomatic patients as defensive in nature, where the appearance of being “emotionless” is due to repression rather than an incapacity to experience emotion (Grossman, 1992). As a result, the therapist uses clarification and interpretation of dreams and transference material to uncover the unconscious conflicts at the root of the psychosomatic symptom. The general aim of psychoanalysis is to foster regression so that the repressed infantile wishes can re-emerge in the transference (St. Clair, 1986). However, to decrease the risk of serious symptom exacerbations, Hogan (1989) believes that certain issues should be addressed right away. The therapist must make the client aware that the symptoms are self-destructive and indicative of an unconscious need for self-punishment which could ultimately lead to death. The therapist should also help the client recognize that their conscience is excessively strict and punitive in nature. He cautions that premature interpretation of unconscious feelings, such as hatred or aggression, could lead to intense guilt and increased psychosomatic symptoms.

According to the defense model, the goal of therapy is to eventually transform the physical symptoms into psychological ones which are more amenable to psychoanalytic treatment, without severe regression or decompensation (Mintz, 1995). However, before the form of conflict shifts to the psychological realm, the patient may experience a shift to less serious forms of psychosomatic conditions, indicating decreased levels of aggression and a less rigid and punitive conscience.

In terms of the therapist-patient relationship, it is believed that the absence of condemnation and rejection or retaliation gradually leads to a modification of the patient's conscience and a greater acceptance of formerly taboo wishes (Pine, 1988). However, Wilson (1968) cautions against gratifying the “excessively dependent and demanding needs” of psychosomatic patients (cited in Mintz, 1995, p. 316). Instead, he emphasizes the importance of

using interpretation to advise patients that indulging in such demands would hinder their development of a healthy self-esteem. The therapist-patient relationship is used to model healthy interpersonal interactions and to contribute to the patient's maturation. Grzesiak et al. (1996) suggest that the "transferential relationship" which chronic pain patients develop with their pain can be transformed through the altering of the transferential relationship with their therapist.

Deficit Model

Proponents of the deficit model view the role of interpretation differently. Interpretations alone are considered rarely sufficient to promote change, as they are cognitive rather than affective interventions (Lolas & von Rad, 1989). However, the prime concern is that one risks "rubbing salt into wounds" by interpreting ego deficits in patients who have low self-esteem and shaky boundaries. This can cause increased pain and hopelessness rather than useful insight²⁵ (Pine, 1988). Therefore, the main focus of the deficit model is to provide a new "corrective" object relationship, where the therapist functions as a "holding mother" who responds adequately to the patient's bodily and emotional needs in order to make up for what the original mother was unable to provide (Taylor, 1992). The patient's experience of feeling mirrored by the analyst and/or idealizing the analyst can, in part, compensate for the patient's deficient experiences in childhood. Interpretation is still believed to have its place, but care is taken to avoid interpreting the transference prematurely. According to McDougall (1989) and Winnicott (1960), the psychosomatic symptom needs to be transformed into a hysterical symptom before interpretation and more traditional methods can be used. The content of interpretations is also much more focused on the therapeutic relationship and internalized object relations rather than unconscious conflicts and wishes.

Kohut (1977) considers the interpretative process as consisting of a long phase of empathic understanding, and a later phase of explanation and interpretation (cited in Leider, 1996). In the first phase, the therapist meets various selfobject needs by helping patients identify and label their emotional experience, improve their affect tolerance, and increase awareness of

²⁵ In fact, some self psychologists attribute the historically limited analytic success with psychosomatic patients to the inappropriate use of interpretation with a narcissistically vulnerable population (Rickles, 1985; Schöttler, 1998).

themselves as a distinct entity from the therapist (Krystal, 1979; Lolas & von Rad, 1989; Rodin, 1991). The therapist must use the countertransference to ascertain, through projective identification, what feelings the patient may be experiencing. When a breach in the transference relationship takes place, the therapist empathically recognizes the disruption and helps the patient understand what precipitated it. Over a period of time, working through these disruptions is held to increase the patient's trust that the therapist is basically well-intentioned and concerned. With increased trust, it becomes possible to explain and interpret these transference disruptions by making analogies to similar disruptions which occurred during childhood. Repeating this process is believed to help repair deficits by fostering the re-emergence and integration of split-off, primitive internal objects so that the patient can move from symbiosis to separation and individuation (Rodin, 1991).

Conceptualization of Mary's Case

The defense model of somatization seems better suited to explaining Mary's case than the deficit model because she shares some of the characteristics of chronic pain sufferers elaborated upon by defense model proponents. For this reason, only a defense model conceptualization will be provided.

Proponents of the defense model would likely begin by suggesting that Mary did not receive optimal gratification of unconscious libidinal (i.e., sexual and aggressive) impulses in her first few years of life, leaving her personality to become fixated at the oral or anal stage of psychosexual development. From Mary's description of her childhood, it would seem likely that she endured some level of emotional and/or physical neglect or deprivation that may account for her "fixated development." Proponents would assume that unconscious aggressive impulses are being repressed by Mary's ego to protect her from being overwhelmed by guilt and anxiety. However, there are signs that her ego has been unable to completely repress these drives. Her perfectionistic nature suggests that she has an excessively punitive superego. At some point in her childhood, these aggressive impulses came into contact with her superego and caused a regression to her previously fixated (oral or anal) stage of psychic functioning. This defensive

regression would account for Mary's longstanding "alexithymic" traits, including her difficulty in identifying and articulating emotions, and her reliance on linear, rational thought processes. It would also account for her "ergomaniac" traits (i.e., excessive work performance, relentless activity) which have assisted her ego in keeping emotions repressed. At certain times in Mary's life, this conflict between her aggressive impulses and her punitive superego has been strong enough to demand symbolic expression in the form of pain. She suffered from some form of "rheumatoid arthritis" which resolved at 18 years of age, perhaps coinciding with a move away from home. She has also suffered from chronic back pain, headaches, and fibromyalgia.

Defense model proponents would suggest that Mary's pain represents an unconscious need for self-punishment to atone for feelings of guilt. A number of facts from her case would be used to support this conceptualization. Mary describes a life-long pattern of feeling overly responsible for negative outcomes and "beating herself up" over what she could or should have done differently. She reports feeling guilty for being an inadequate mother, for teaching her children to deny and suppress their emotions, and for contributing inadvertently to negative outcomes in her workplace. If she held any ambivalent feelings towards her brother at the time of his death, his loss could reflect a powerful source of unacknowledged guilt. He appears to have represented a significant person for her, in that his opinion mattered to her more than anyone else's, and he represented all the qualities that she felt she lacked and therefore desired. As "object loss" is considered a very common trigger for psychosomatic symptoms, it would be interesting to know whether his death coincided with the beginning of her chronic back pain.

Mary's recent escalation of pain and fatigue coincided with the firing of her V.P., which was reported to stimulate much guilt, self-doubt and worry regarding how she may have inadvertently contributed to his departure. An increase in guilt feelings may also be related to Mary's relationship with her daughter, who has frustrated her to the point that she does not want to "walk on eggshells" anymore but is unsure what to do about it. Proponents would suggest that the "damage" being done to her body (via muscle tension and pain during sleep) is symbolic of an unconscious need to be punished for aggressive impulses that are demanding some form of expression.

Defense model proponents would put forward a number of reasons for Mary's tension

and pain being worse at night. During the day, her pain is significantly lessened when she keeps herself engaged in some form of physical activity. At night time, she has no recourse to this manner of keeping her emotions and unconscious impulses at bay. As they pose a greater threat of breaking through into conscious awareness, there is increased psychic pressure to express and discharge the emotions somatically through tension and pain. Her recent feelings of anxiety, depression and helplessness may be directly related to unconscious fears that the ego is losing control and may soon be unable to keep these unacceptable wishes out of awareness.

Interestingly, Mary's pain appears to be experienced primarily in her arms, knees and feet. These parts of the body are intimately involved in being ambulatory and doing whatever activities are required to take care of one's needs, as well as the needs of others. Mary's pain is definitely worst in her feet in the first hour upon awakening. Psychoanalytic proponents may interpret the location and timing of Mary's pain as being symbolic of unconscious "dependency needs" that were never met as a child. Rather than having to get out of bed to take care of everyone else's needs, including her own, her foot pain may represent an archaic longing to stay in bed and have her needs taken care of by a caring, soothing, dependable caregiver.

Critical Evaluation

Explication of Foundational Assumptions

Mind-Body Relations

The psychoanalytic model describes a causal relationship between intrapsychic processes and psychosomatic symptoms. This interaction occurs at an *unconscious* level and is directed from the psyche to the soma. While defense model proponents view the psyche and soma as connected via libidinal drives that seek gratification, deficit model proponents tie psyche-soma relations to the inner psychic representations of self and other that develop from early child-caregiver relationships. Proponents of both models view psychosomatic symptoms as serving unconscious affect-regulating functions to *protect* the psyche from being overwhelmed and to

express or provide a discharge for emotional pain and distress. Similar to other dualistic models, the mechanisms of this causal interaction are not made clear.

Person-World Relations

Psychoanalytic theory and practice reflect a mixture of explicit and implicit assumptions from both the natural science and human science paradigms. The subject-object, internal-external and experience-behaviour dualisms are still maintained, but the boundaries are a little more fluid than in the two previous models of somatization. Compared to traditional psychoanalysis where the analyst is viewed as an objective, neutral observer of the subject of study (i.e., the patient), a self psychological approach acknowledges that a patient cannot be understood without the subjective involvement of the therapist. However, this relationship is still conceptualized in terms of transference and countertransference, rather than a true dialogical encounter (cf. Gadamer, 1975). With regard to the experience-behaviour dualism, “internal” mental representations (conscious and unconscious) are believed to mediate between a person’s subjective experience and the actions s/he takes in the world. For example, the internal representation of a person’s object relationships is held to have a powerful influence on that person’s interpersonal functioning in intimate relationships.

Based upon these assumptions, the psychoanalytic model of somatization portrays person-world relations as linear causal chains of events, with unconscious intrapsychic mechanisms and processes playing a key role. In particular, the model draws causal connections between early child-caregiver relationships, psychic defenses or deficits, and patterns of affect regulation, interpersonal functioning and somatization as an adult. The defense model would be considered more mechanistic and materialistic than the deficit model, as Kohut’s (1977) concept of the self was put forward to challenge the notion that the psyche is an “apparatus” constituted by mechanistic processes.

Freedom-Determinism

The defense model of somatization holds to the classical psychoanalytic view that humans are motivated by unconscious sexual and aggressive instincts that are in a perpetual state

of conflict with the ideals of society. Thus, psychosomatic and hysterical symptoms are believed to be determined by the ego's failure to mediate between the id's libidinal drives and an excessively punitive superego. In contrast, the deficit model views "objects" as psychic representations of real people rather than repositories of drives, and portrays humans as motivated by the need for relatedness to others, the need for self-esteem and the need for a sense of cohesion. If a person's ability to meet these needs is impeded by disturbances in early child-caregiver relationships during the separation-individuation phase of development, psychosomatic symptoms or other forms of pathology are believed to result.

Both of these models point to determining factors which are unconscious and which result from the inadequacy of parental care in early childhood. Humans are thus portrayed as having little to no freedom to escape their past or the impact of these unconscious forces without the aid of a psychoanalytic therapist. Even then, proponents appear cautious in suggesting that significant change is possible, given the risks and obstacles that are highlighted in working psychoanalytically with psychosomatic patients. It seems fair to suggest that the deficit model leans more toward an active agent conception of human freedom than traditional psychoanalysis. However, this understanding of human agency is still far from what an existential-humanistic thinker would regard as a truly active agent.

Acquisition and Validation of Knowledge

The explanatory framework of the psychoanalytic model is guided by principles of the natural science paradigm, including causality, determinism and reductionism. Freud's intention was to create a scientific theory of personality that was generalizable to all humans. According to Miller (1992), Freud insisted that "psychic reality was determined by causal forces and that laws of psychic functioning could be formulated and tested on the couch in a manner exactly parallel to the laws and methods of physical science" (p. 343). Most practitioners remain committed to the view that psychoanalysis is a science which seeks general laws and attempts to establish causal connections among psychic events.

However, the methods developed by Freud and other psychodynamic therapists are different from those used by the natural sciences. To arrive at an *explanation* for psychosomatic

symptomatology, therapists attempt to *understand* and/or *interpret* the meanings of complex unconscious intrapsychic processes that underly the symptoms of each psychosomatic patient who undergoes treatment. While not explicitly stated, the goals of understanding and interpreting meanings are consistent with the human science paradigm. Psychoanalytic methods include empathizing (e.g., Kohut), interpreting free associations and dream material, and analyzing the transference and countertransference as it manifests in the therapeutic relationship. The accuracy of the therapist's interpretation or empathic reflection is considered to be confirmed or disproved by the subsequent behaviour of the patient. Hypotheses and theories are then built upon extensive case histories of psychosomatic patients who have undergone treatment. Along with clinical observations of childhood development, these case histories are viewed as constituting the evidence for the psychoanalytic model of somatization.

Evaluation of Strengths and Weaknesses

Following is a critical evaluation of the psychoanalytic model's strengths and weaknesses, based upon its: a) comprehensiveness, b) consistency, c) research relevance, and d) its congruence with the foundations of a human science approach.

Comprehensiveness

The idiographic focus of the psychoanalytic model is its primary strength. It provides a clinical theory and method for intensively studying the subjective experience of somatizers and determining why a specific patient is manifesting particular symptoms at a particular time. By identifying subjective, intrapsychic issues that may predispose or precipitate a person to somatize, the model provides an important addition to the primarily "objective" empirical literature on somatization. The psychoanalytic model proposes a complex array of core developmental, intrapsychic and interpersonal issues that may underly chronic somatization, particularly among patients who suffer from characterological disturbances. These disturbances are suggested to account for somatizers who minimize their emotional distress. Unique to the psychoanalytic model is an intensive effort to uncover the psychological meanings or purposes of

psychosomatic symptoms for each patient. This enables the treatment approach to be highly individualized.

The idiographic strength of the psychoanalytic model is also a source of its weakness. By focusing primarily on subjective intrapsychic processes that contribute to somatization, little attention is paid to genetic, physiological or social-environmental factors that may also be involved. Without a systemic focus, there is no attempt to account for how the expectations and interactions with family members, health care professionals, and/or employers may be contributing to somatization. The only environmental factor identified as a possible precipitant is the real, threatened or fantasied loss of a significant "object."

Focusing on unconscious dynamics rather than observable behaviours, the model also suffers from a lack of clarity and precision. What transpires in the mind of a baby or in the unconscious of an adult can only ever be an inference. The psychoanalytic model puts forward two theoretical explanations for somatization that are quite different from each other in terms of the etiology and therapeutic modifiability of alexithymic characteristics that are believed to underly somatization. Yet, without testable hypotheses, it is difficult to determine which of these theories is more valid.

Since the concept of alexithymia was introduced by Sifneos in 1973, it appears that psychoanalytic proponents have latched onto alexithymia as *the* primary explanation for psychosomatic symptoms. While acknowledging the existence of psychosomatic patients without alexithymic traits, these individuals do not appear to be addressed by the current psychoanalytic model, making it unclear how their psychosomatic symptoms are accounted for. Even if they represent a small proportion of the psychosomatic patients treated by psychoanalytic therapists, the comprehensiveness of the model is diminished by not accounting for this segment of the somatizing population.

Consistency

Overall, the two psychoanalytic models of somatization (i.e., defense and deficit) demonstrate strong internal consistency. The conceptualizations of somatization and its treatment seem to logically flow from the stated assumptions, theoretical principles and clinical data of

each model. It would not make sense to look for consistency across both models, as they are based upon quite different theoretical principles. However, it is important to keep in mind that there are significant discrepancies within the psychoanalytic community regarding how psychosomatic symptoms should be conceptualized and treated.

The primary source of inconsistency in the psychoanalytic model is the tension that exists between its “natural science” aspirations and its “human science” practices. Each practitioner is caught to a greater or lesser extent between the natural science desire to *explain* somatization in causal, deterministic language, and the human science or clinical desire to *understand* and/or *interpret* each patient’s unique meanings, motivations, symptoms and experiences. Unfortunately, theoretical abstractions can get in the way of understanding a patient’s experience, even when the therapist has the best of intentions.

Kohut’s (1977, 1984) therapeutic approach provides an illustration of this point. Kohut became aware that patients who lacked a cohesive sense of self responded negatively to premature interpretations of their problems. These breaches in the therapeutic relationship made it more difficult to develop an empathic bond with the patient. As a result, Kohut came to argue that one should empathize with the patient and avoid imposing theoretical preconceptions during the earlier “understanding” phase of therapy. However, once the patient’s sense of self is stronger and an understanding of their problems has been reached, the therapist is to provide explanatory interpretations based upon self psychological theory. According to Masek (1989), this reflects an inconsistency with Kohut’s stated commitment to be faithful to the patient’s experience. He sees Kohut as abandoning direct experience in the explanatory phase by going “outside it” to explain it. In Masek’s words, “explanation abandons its therapeutic role - to expand understanding - and, instead, takes on a role indigenous to the early natural sciences: to explain causally the existence of something” (p. 188). A current debate regarding the scientific versus hermeneutic nature of psychoanalysis reflects this state of tension between the goals of explanation and understanding (e.g., Schafer, 1976; Strenger, 1991).

Research Relevance

Clearly, one of the major weaknesses of psychoanalytic theory is the relatively untestable

nature of its propositions and constructs. Unconscious processes cannot be easily translated into measurable variables. A frequent criticism of Freudian theory is that it is difficult to find evidence that would support it, and especially *fail* to support it (e.g., Pervin & John, 1997). This leaves psychoanalytic proponents in the awkward position of putting forward two different models of somatization that are very difficult to empirically evaluate. It is also problematic to rely on case study data for confirmation of one's theory, as the clinical observations are clearly subject to the interpretation and influence of the therapist. Finally, Freud has been criticized for generating a theory of "normal" personality from clinical work with "abnormal" patient populations. This criticism could equally apply to Kohut's theory of self development.

While acknowledging these weaknesses, few theories can compete with the tremendous heuristic value of psychoanalysis. Freudian theory has stimulated much interest and research by experimental psychologists and scholars from other disciplines who have attempted to corroborate or refine basic psychoanalytic hypotheses. It has also led to the revision and expansion of psychoanalytic theory and practice by psychoanalytic therapists. As Westen and Gabbard (1999) summarize, certain testable propositions have stood the test of time (e.g., that unconscious states exist and influence behaviour), while others are better conceived as guiding assumptions that are theoretically or methodologically useful. Clinical observations may be inadequate for verifying theoretical propositions, but they are important sources of data for theory building, particularly when dealing with complex phenomena such as somatization. Despite its methodological weaknesses, few people appear willing to reject the insights of psychoanalysis completely. In this vein, it is interesting to note that both the biopsychosocial and neuropsychiatric models make reference to psychoanalytic conceptualizations of somatization (cf. Mayou, Bass & Sharpe, 1995; Miller, 1991).

Congruence with a Human Science Approach

Freud pioneered the exploration of the meaningfulness of all human experience, including psychological symptoms. One of his most important legacies is the recognition that the meaning of experience is often not apparent in the surface actions or communications of people, and hence requires interpretation. Self psychology has advanced beyond traditional psychoanalysis in

emphasizing the importance of setting aside theoretical preconceptions when attempting to understand a patient's experience in the first phase of analysis. Proponents of the deficit model have also come to recognize that transferences and resistances are more frequently related to the immediate therapeutic relationship rather than solely to past relationships. These insights reflect aspects of the psychoanalytic model that are congruent with a human science approach.

However, the understanding of patients is hindered when therapists go beyond the immediate experience of their patients and postulate abstract, theoretical processes to account for their difficulties. One can discuss how a particular way of being-in-the-world may embody certain childhood experiences without postulating a causal influence of unresolved intrapsychic conflicts. Similarly, one can agree that a person's self-relationship emerges out of their relationships with others, without "dichotomizing human existence into two realms of inner and outer, of 'psychic representations' of people on the one hand, and 'actual' people on the other" (Halling & Dearborn Nill, 1989, p. 185). Caught up in the idealist language of representational thought, psychoanalytic theory is unable to provide a metapsychological foundation that is faithful to many of their insightful discoveries drawn from clinical practice.

The psychoanalytic model can also be criticized for tending to have a linear notion of time, wherein current experiences are portrayed as products of past events. Knowledge of past events may provide a deeper awareness of what is happening in the present, but it does not mean that the past *causes* the present, or that the future has no significance. Rather, as van den Berg (1972) points out, "the past is what was, as it is appearing now" (p. 82), and it shapes our forward movement. The psychoanalytic model also fails to consider that people's recollections of the past can be significantly altered by their present attitudes and circumstances.

As a result of this linear, deterministic perspective, humans are portrayed as predominantly passive beings with little freedom or ability to change the impact of their life circumstances. In reference to the child's relations with others, Merleau-Ponty (1964) states, "it is never simply the outside which molds him; it is he himself who takes a position in the face of external circumstances" (p. 108). From a human science perspective, people are viewed as having the freedom to take hold of the possibilities open to them and to make responsible choices within the factual constraints of their situation.

Implications for the Problematic of Somatization

There are a number of positive implications that follow from the psychoanalytic model of somatization. Just as Engel (1977) warns physicians against an excessive preoccupation with the body, proponents of this model (e.g., Krystal, 1979; McDougall, 1980) encourage psychoanalytic practitioners to take psychosomatic symptoms seriously and to avoid excessive preoccupation with mental functioning, particularly in the early phases of treatment. There are many mental health practitioners, including psychoanalysts, who alienate somatizers by psychologizing their symptoms too quickly and failing to take their somatic concerns seriously (Wolman & Thompson, 1996).

Secondly, the psychoanalytic model presents a theory and method of treatment that focuses on exploring and understanding the issues, conflicts, meanings and experiences that are unique to each individual patient. Somatizers are much less likely to feel misunderstood if they sense that their beliefs and experiences are being respected and taken seriously. This model may be particularly helpful for somatizers whose symptoms occur in the context of personality disturbances and alexithymic traits. These individuals are less likely to benefit from more conventional treatments (i.e., behavioural, cognitive-behavioural, psychopharmacological) as they fail to target the psychodynamic processes that may underly their somatic symptoms. With a patient and skilled therapist, these individuals may be helped to repair “psychic deficits,” resolve intrapsychic and interpersonal conflicts, and in the words of Grzesiak et al. (1996), “replace suffering with meaning” (p. 173).

On the negative side, relevant systemic factors could be overlooked if a therapist focuses only on the individual’s intrapsychic world. These could include the attitudes, expectations and behaviours of family members, health care professionals, employers, co-workers, insurance companies, members of one’s ethnic group, and society at large. Proponents of this model also acknowledge the potential risk of psychotic decompensation and/or life-threatening symptom exacerbations when working psychoanalytically with psychosomatic patients. Given the highly specialized expertise required, it is possible that insufficiently trained therapists could do more harm than good with these patients. Somatizers may also find that abstract, psychoanalytic

interpretations fail to resonate with their personal experience. Practitioners who hold rigid theoretical views are more likely to use notions of *resistance* and *transference* to conceptualize a patient's negative response to their interpretation, rather than to seriously question its validity. Without following through on the expressed intent of practitioners to understand (and hence remain faithful to) the patient's experience, the insights gained from these interpretations may fail to produce the desired results.

Narrative Model of Somatization

Literature Review

Background Theory

The narrative model of somatization (Griffith & Griffith, 1993, 1994) did not arise from a broader, established tradition of theoretical and therapeutic principles, as did the neuropsychiatric, biopsychosocial and psychoanalytic models. Rather, it arose specifically from the attempts of James Griffith, a doctor trained in neurology and psychiatry, and Melissa Griffith, a nurse trained in family therapy, to develop an effective therapeutic strategy for treating "mind-body problems." The Griffiths use the latter term to refer to somatoform, psychophysiological, and factitious disorders, as well as the psychosocial problems that frequently develop around medical illnesses. In their 1994 book, "The Body Speaks: Therapeutic Dialogues for Mind-Body Problems," they focus primarily on somatoform and factitious problems, providing an extensive description of their conceptual framework and therapeutic approach to understanding and treating somatization. As the narrative model is relatively new, the literature to be reviewed is derived solely from the works of its originators.

The term *narrative* is used to describe the Griffiths' model because it draws significantly from the narrative therapeutic approach developed by White and Epston (1990). However, the Griffiths' narrative model combines elements from a broad range of clinical and theoretical approaches and is not restricted to the theory and methods developed by White and Epston. The authors characterize their narrative model as a post-modern, language-based approach that

challenges the largely modernist assumptions of the dominant models of somatization. In particular, they criticize other approaches for not questioning the impact of their hidden philosophical assumptions and the language of their preferred illness model on the “truths” they construct regarding somatization and the patients they treat.

As an alternative, the Griffiths offer a model which is based upon different conceptions of language, mind, body and emotion than those traditionally held by the medical and mental health disciplines. Some of these ideas have been drawn from hermeneutic philosophy. For example, Griffith and Griffith (1994) agree with Heidegger (1962, 1971) that we are created by language and that language is a way of being rather than a tool of communication. Gadamer (1976) has also asserted the profound impact of language in shaping our thoughts and actions. Following Heidegger and Gadamer, the authors hold that we possess a *pre-knowledge* of how to interpret our experience that fits with the particular culture we have been born into. This pre-knowledge is based upon the idioms, teachings, and customs that have been transmitted to us through language.

Drawing on Merleau-Ponty’s (1962) work, the authors hold that we perceive complete forms or sensory *gestalts*, rather than formless sense-data, as proposed by most neuroscientists. However, Griffith and Griffith (1994) add their own interpretation of *form*, by suggesting that it is similar to “a ‘story’ so compelling it cannot be doubted by the mind or ignored by the body” (p. 33). According to the Griffiths, if sensory *gestalts* are the most basic forms of such stories, “it is only a small step to argue that stories, not isolated events, are the basic units of human experience” and are, thus, irreducible (p. 33-34). It is their view that these stories provide us with a pre-knowledge of how to perceive and respond in situations that require immediate action (e.g., a person whirls around to ward off a possible mugger when a shadow crosses his path; a child stops yelling and crying as soon as his abusive father enters the front door). Absorbed unwittingly from the language of our surrounding culture, it is proposed that these stories combine to form narratives which constitute our selfhood. The stories enacted by our bodies are viewed by the authors as most important in terms of constituting our bodily experience.

According to Griffith and Griffith (1994), they arrived at some comparable insights from cognitive science when they came across the works of Maturana and Varela (1987). In the 1970s

and 80s, these neurobiologists from Chile were attempting to understand the biology of cognition and human language. They sought to describe the causal structural mechanisms that would explain how physical and mental events exist in relationship via language. They ultimately came to describe language as “the generation of consensual behaviors by two beings who are structurally coupled, that is, the behavior by one prompts behavior by the other in a recursive pattern that keeps the two in a stable interaction” (Griffith & Griffith, 1994, p. 36). From this perspective, the social organization of humans is believed to be maintained through the mutual interchange of language.

Griffith and Griffith (1994) also formulated a biological view of emotion as part of their conceptual framework. In agreement with Maturana (1988), they view emotion as an interpersonal event involving a readiness for action or expression, rather than an internal event involving feelings that are experienced. For example, fear reflects a readiness to flee, while anger reflects a readiness to attack. An *emotional posture* describes the mental and physical components that occur during a specific emotion to prepare the body for a specific action (Griffith & Griffith, 1994). According to the Griffiths, all mammals (including humans) show two broad groups of emotional postures. The first are emotional postures of *mobilization* in which physiological changes (e.g., heart rate, muscle tension) prepare the body to defend or to attack. At the same time, attention is focused outwardly to detect potential threats in one’s environment. In contrast, emotional postures of *tranquility* involve a bodily readiness to take care of oneself or another person. Attention is focused inwardly on one’s self or on one’s understanding of another person, and vigilance to threat is low. Alarm will be triggered in animals if an intruder comes too close. However, for humans with language, it is our social practices which are believed to give us a sense of “safe and unsafe territories of discourse” (Griffith & Griffith, 1994, p. 68).

Combining the views of hermeneutic philosophy and the cognitive science of Maturana and Varela (1987), Griffith and Griffith (1994) base their narrative model of somatization on the following theoretical framework. Stories are posited as the fundamental units of human experience, providing the “joints that couple mind and body” (p. 36). A story or narrative is further described as “a linguistic unit of coordinated bodily states as they extend from start to end

of a human experience” (p. 37). In the broader social context, language is viewed as “a coordination of bodily states among members of a social group that preserves both the structural integrity of the social group and that of each group member” (p. 36). This coordination of bodily states is believed to occur through the “back-and-forth telling and listening to personal stories” (p. 37). With the proposition that stories exist within the bodily interactions between persons, the authors hold that language, as “a complex form of gesturing, a way of touching the body from a distance...can reconfigure the physiological state of the body, and vice versa” (p. 184). People experience emotional postures of mobilization or tranquility depending upon the sense of safety they experience in conversation with others.

Application to Somatization

To understand mind-body problems, the Griffiths believe it is most important to understand a person’s pre-knowledge of bodily experience. This is done by searching for the critical stories or narratives that call for a person’s body to experience suffering. In particular, the Griffiths have repeatedly found that somatoform symptoms appear (and medical symptoms exacerbate) when the patient is experiencing an *unspeakable dilemma*. This is described as a type of double-bind situation in which family, social, religious, or political circumstances force a person to stay in a distressing situation, because escaping the situation or discussing the person’s distress would create even greater distress or risk of physical harm. Since the dilemma cannot be expressed verbally, it can only be expressed through the body. When the dominant emotional posture is that of mobilization (i.e., readiness to defend or attack), the person attempts to keep the distress hidden by silencing the body’s expression of distress (e.g., altering one’s facial expression or tone of voice to appear calm). At some point, however, the person is no longer able to suppress their distress and a somatic symptom appears.

The authors have published one research study to support their clinical observations (Griffith, Polles & Griffith, 1998). After studying 14 videotaped family interviews of patients with pseudoseizures (13 of whom were diagnosed with conversion disorder; 1 with somatization disorder), an unspeakable dilemma was uncovered in 13 of the 14 interviews. The patient was

found to be the most silent family member. In six cases, a realistic threat of physical or sexual assault was revealed, although the threat was not always directed toward the patient. In nine cases, there was a prior awareness of the dilemma by either the patient or other family members. However, the patient's distress was typically minimized by family members. Alternatively, no one appeared to have associated the dilemma with the onset of symptoms.

According to Griffith and Griffith (1994), people find themselves in this type of dilemma because they feel bound or constrained by familial or social-cultural narratives (regarding gender, race, age, religion, ethnicity, etc.) which prescribe how they should think, feel and behave. The authors describe some of these dilemmas as unique to the post-modern age. In particular, they suggest that the social networks arising from neighborhood, extended family and religious communities have declined, leading people to become more estranged from one another. In addition, with people moving and changing jobs more frequently than ever before, the Griffiths consider it much less common for people to feel known and understood in all their complexity. Instead, the authors assert that most of our relationships are based upon showing only those parts of ourselves that will help us to compete or to be accepted in a variety of different relationships or social groups. Many people feel that revealing certain aspects of themselves may put a relationship or job at risk. The authors propose that people attempt to minimize such a risk by holding certain stories from their life experience in silence.

In summary, the narrative model of somatization proposes that a somatized symptom represents "the public performance of an unspeakable dilemma" in which the body receives two conflicting directives: that of mobilizing the body for action (e.g., to flee or to attack), while being forced to express a contradictory emotional posture (e.g., a warm, welcoming smile) (Griffith & Griffith, 1994, p. 65). It is not the intensity of an emotion that is believed to trigger a somatic symptom, but rather the intensity of the effort to silence its bodily expression. Using a drama analogy, the Griffiths describe a somatizer as "a deposed director, now become a mere actor in a play not of his or her choosing, performing a drama that tortures the body" (p. 135). The authors hold a view of emotion that describes mind-body problems in both linguistic, psychological terms (i.e., binding self-narratives) and non-linguistic, physiological terms (e.g., the body's "fight-or-flight" response). From this perspective, mind-body problems are perceived

as existing *between* persons in language rather than in the mind or body of the individual who is suffering.

Therapeutic Implications

The Griffiths reportedly experimented with various forms of family therapy before arriving at a combination of approaches that they found most effective. These include the constructivist, collaborative language systems, solution-focused and narrative approaches espoused by such authors as Andersen (1991), Anderson and Goolishian (1988), de Shazer (1985) and White and Epston (1990). Drawing upon these approaches, the Griffiths describe two options for intervention that follow from their conceptualization of mind-body problems: 1) language-based therapies which help the patient or family to uncover and escape the unspeakable dilemma, and 2) physiological-based therapies which use psychoactive medications to reduce the level of threat and vigilance experienced by the body. As mind-body problems are assumed to exist between persons in language, it is considered best to meet with the entire group of people (usually family members) who are “engaged in language” around the problem (Anderson & Goolishian, 1988).

The therapeutic process is divided roughly into two phases (Griffith & Griffith, 1994). In the first phase, the Griffiths draw primarily from Goolishian and Anderson’s (1987) collaborative language systems approach to help the patient and family members shift from emotional postures of mobilization to emotional postures of tranquility so that they can feel safe to tell their stories and dilemmas. In the second phase, the Griffiths rely heavily on narrative therapy methods developed by White and Epston (1990) to help therapy participants co-construct ways to undercut the power of the self-narratives tied to the somatic symptoms.

The primary goal of the first phase is to create a *conversational domain* of language within which the therapist, patient and family members feel mutually understood (cf. Braten, 1987). Questions are asked from a position of curiosity, openness and respect, and body language is monitored for signs of alarm to set the pace of therapy. The therapist facilitates a respectful, reflective inquiry into the unique meanings, language and stories of the therapy

participants. Interpretations are to be strongly avoided, as the Griffiths state: “there is no interpretation to be made when one authentically accepts the patient’s right to authorship of his or her story” (1994, p. 194). A reflecting team consultation²⁶ is reported to be especially helpful when approaching somatizing clients who are likely to be resistant to psychosocial inquiries (Griffith & Griffith, 1992).

Self-narratives tied to the somatic symptoms are also uncovered in the first phase. To identify the emotional posture, detailed questions are asked about the state of the patient’s body when the symptom occurs (e.g., “what do you imagine your body would say if it could speak?”).²⁷ The patient is then asked to recall critical life experiences that are connected to this emotional posture. The following illustration from a therapy session provides an insight into how these self-narratives can be accessed. Griffith and Griffith (1994) describe a patient who suffered severe headaches of unknown origin. The pain had been unremitting since the prior therapy session in which there was some discussion of the patient’s father. In the current session, the patient reported feelings of sadness, humiliation and anger related to her father but was unsure why. After describing how her head felt, she was asked to follow her body’s lead, and soon curled up on the couch, covering herself with pillows. When asked what story she connected to this position, she recalled curling up in a closet after her father would beat her. As she experienced more intense feelings of sadness and anger, she remembered struggling frequently as a teenager with the impulse to “blow his head off” with a shotgun. Imagining the scenario if she followed through with this impulse, she described feeling “peace” and said that her head pain was gone. According to the authors, the state of the patient’s body was governed by its place in a narrative about her father. The only way she could express the rage towards him was through her body. “For the story to endure, the body must ache” (p. 38).

When speaking about the dilemma is insufficient to resolve the mind-body problem, the

²⁶ This type of consultation involves observers who listen and make comments mid-way through the therapy session. These types of comments can be responded to or ignored without affecting the therapeutic relationship.

²⁷ According to Griffith and Griffith (1994), working with the body’s emotional posture is particularly helpful with patients who have difficulty accessing or describing their feelings. Viewing emotion as a readiness for action enables the therapist to work directly with the body’s emotional state, without requiring discussion of feelings. In addition, the therapist can attempt to match the breathing, posture or bodily movements of the patient to get a sense of what they may be experiencing.

second phase of therapy begins. The therapist use *deconstruction* and *externalization* questions developed by White and Epston (1990) to identify, explore, and challenge the validity of personal and cultural assumptions that underly the patient's binding self-narratives. Therapy participants are then helped collaboratively to change those narratives which are contributing to the patient's double bind. In some cases, the patient learns to block symptom occurrence by vividly recollecting life experiences and self-narratives that evoke protective, soothing emotional postures rather than fearful ones. In other cases, narrative methods are used to highlight gaps or inconsistencies in the dominant narrative, as well as the existence of "unique outcomes" (i.e., life events that contradict the dominant narrative). This process enables the patient and family to grasp previously unseen choices and create new meanings, thereby discarding, displacing or reauthoring the narrative that has had a hold on the patient's body.

This language-based therapy may be used in combination with pharmacotherapy to support the therapeutic process. For some patients with highly active noradrenergic systems, reflective listening and open, respectful conversation may not be possible without the help of some form of psychoactive medication. Therefore, the Griffiths propose that an *ethological* approach to pharmacology be used to reduce the body's level of sympathetic arousal so that open and reflective conversation can become possible (Griffith & Griffith, 1994). This approach is contrasted with the traditional psychopharmacological approach of using medication to treat a patient's disorder. According to the authors, the integration of conversational and pharmacological therapy is justified by the dual definition which is ascribed to an emotional posture. It is presented as both "an embodied self-narrative" and "a physiological state of the body," representing "the juncture between language and physiology" (p. 198). From this perspective, conversational therapy and medications are used together to facilitate emotional postures that are conducive to therapy.

In summary, the narrative model for treating mind-body problems has evolved out of a novel conceptual framework regarding the interactions between mind, body, language, and emotion. It holds that bodily symptoms arise when a dilemma is experienced but the kind of conversation needed for its resolution cannot occur. Drawing on a range of post-modern family therapy approaches, the Griffiths have developed a collaborative, language-based, narratively-

oriented therapy to help the persons “engage in language” around the mind-body problem and co-construct a solution to the patient’s dilemma. Hence, language skills are used to craft therapeutic questions and psychoactive medications are used to create a “biological context” that is favourable for telling, listening to, and reflecting upon the patient’s and family members’ stories about the problem. As the therapy participants engage in open, reflective conversation, the meanings of particular words, stories, life events, and bodily states are explored until the dilemma and associated stories are identified. Narrative methods are then used to deconstruct, externalize, and ultimately discard or reauthor those self-narratives that lie at the root of the dilemma, thus ending the patient’s bodily suffering.

The Griffiths use the Native American healer as a metaphor to describe their approach to therapy: “Through a rhythmic dance of words that joins the body of the one who is ill, the therapist and therapy participants search for a story that will bring healing. Like the shaman who may offer peyote, the therapist may offer the pharmacological fruits of biomedical science to change the body so it can tell a better story with which to live” (Griffith & Griffith, 1993, p. 323).

Conceptualization of Mary’s Case

In general, proponents of the narrative model would propose that the onset of Mary’s fibromyalgia symptoms coincided with a time when she was experiencing an “unspeakable dilemma.” They would assume that Mary was experiencing an excessive degree of distress at the time, but felt that leaving the stressful situation would have caused even *greater* distress. In addition, binding self-narratives or external constraints would have led her to feel that she had no option but to keep her distress hidden from those people involved. Hence, the type of conversation needed to resolve her dilemma would not have been able to occur. In terms of positing the specific nature of Mary’s dilemma, narrative proponents would suggest that this could only be arrived at through a collaborative therapeutic dialogue with her and her family. Hence, the following conceptualization will describe the types of questions that a narrative therapist might ask, and some *potential* responses that may be considered possible from the case

description.

Initially, the therapist may ask Mary to elaborate on the specific meanings of certain phrases that seem connected to her bodily state. For example, what does it mean to Mary when she says that she is “damaging” herself during sleep, or that the pain is “controlling” her, or that “chronic tension and stress” are at the root of her symptoms? In addition, the therapist would attempt to identify the characteristic emotional posture associated with her Mary’s pain through detailed questioning about the state of her body when her tension and pain begins to build.

The therapist would then attempt to identify the specific self-narratives that are bound to this emotional posture, as well as critical life experiences or relationships that seem most tightly connected to this self-narrative. For example, it could be hypothesized that Mary is influenced by a narrative where she tells herself, “I should have known better. I should have been able to do *something* to prevent this (negative outcome) from happening. It must be *my* fault.” Mary states that she “beats herself up” when she feels this way, suggesting a possible link between this self-narrative and her bodily symptoms. If her distress triggers a self-narrative that induces shame or guilt, her resistance to discussing it could be considered understandable. Alternatively, she may have constructed a self-narrative drawn from witnessing her parent’s attempts at communication. For example, “Discussing my distress can only lead to conflict or withdrawal. Therefore, it’s best to not say anything.” These are some potential self-narratives that may be preventing Mary from considering it acceptable to discuss her distress. There are many others that are possible.

If Mary’s dilemma revolved around particular stresses associated with her children, one could easily imagine that leaving the situation may not have been considered a viable option. This may also be true of her work environment, although perhaps to a lesser degree. If Mary’s actions are being guided by some of the self-narratives noted above, she may feel compelled to keep her distress hidden. This would be even more likely if she did not have a close, emotionally communicative relationship with any of the people involved (e.g., her husband or daughter). As Mary is continuing to experience symptoms of pain, it would be assumed that her body is still being held within a double-bind that is requiring her body to suffer. Recent exacerbations in her pain levels would suggest that she is perceiving an increased need to suppress indications of her distress.

Critical Evaluation

Explication of Foundational Assumptions

Mind-Body and Person-World Relations

Griffith and Griffith (1994) characterize their narrative model as a post-modern, language-based approach that challenges the largely modernist assumptions of the dominant models of somatization. They consider the biomedical model's conceptualization of mind-body dualism to be a "socially negotiated interpretation" rather than a reflection of objective reality. They also reject the traditional distinction between mind-body and person-world relations by proposing that they are strongly interconnected through the medium of language and narrative.

The narrative model of somatization is strongly influenced by social constructionism, a perspective that views all knowledge as socially constructed through the specific language, history and culture of each community. As one's thoughts, feelings, actions and identity are believed to be constructed by stories and conversations with members of one's culture, "language-oriented social interactions" are considered the important focus of interest rather than the individual. From this perspective, emotions are not viewed as internal events but as interpersonal phenomena directed toward others. Similarly, language and stories are held to exist in the social space *between* persons, rather than as "entities" inside either person's mind. The stories or narratives that constitute one's self-identity are transmitted in language through the idioms, teachings and customs of one's culture. Stories and self-narratives are also believed to constitute one's *bodily* experience, by impacting upon the physiological state of individuals as they engage in (or avoid) conversation.

Griffith and Griffith (1994) suggest that language and physiology are related through "structural selection," where events in each domain can indirectly limit or expand the possibilities of certain physiological states or conversations to occur. Their definition of an emotional posture (i.e., an embodied self-narrative *and* a physiological state) is put forward to avoid reducing one domain to the other and to justify their integration of conversational and pharmacological therapy. The Griffiths argue that structural selection offers an alternative way of

understanding mind-body relationships that “avoids the traps of...idealism, materialism, dualism, or interactionism” (p. 199).

Freedom-Determinism

The Griffiths’ views regarding freedom and determinism are heavily influenced by ideas related to critical theory and social constructionism that have been adopted by the narrative movement in family therapy. Aside from overtly oppressive environments, the narrative model suggests that the covert influence of culture-wide social practices potentially pose the greatest threat to individual freedom. Narratives regarding how one should think, feel and behave are held to be absorbed from the social, political and religious beliefs of one’s family and culture, as well as from one’s personal experiences (e.g., abuse, illness, loss). Conformist pressures are considered to be even stronger in the fast-paced, competitive society of the current post-modern era. These covert narratives are viewed not only as “structures of meaning” but as “structures of *power*” that restrict the ability of individuals to be the “author” of their own self-narratives. Griffith and Griffith (1994) state that “patients who have lived with destructive self-narratives...often have lost sight of their ability to identify, to interrogate, and to challenge the authority of the stories that guide their lives” (p. 121). The state of a person’s body can also come under the control of these binding self-narratives, as is the case with somatization.

At this point, it may appear that the narrative model paints a deterministic picture of humans as being passively shaped by these social-cultural influences. However, the Griffiths believe strongly that people can be helped to “loosen the binds” of these powerful narratives by questioning their validity and by separating them from the patient’s sense of self. Questions that deconstruct and externalize the dominant narrative are held to assist the patient and family in co-creating a *new meaning* or preferred self-narrative that disempowers the old one. Change is always considered possible when the clinician is able to work collaboratively with the patient and family in ways that enhance their sense of personal agency. Thus, humans are seen as having the ability to grasp previously unseen choices and to shape their lives in a more preferred manner if they can learn to question and challenge the authority of the stories that influence their lives.

Acquisition and Validation of Knowledge

The narrative model adheres to a number of post-modern assumptions that are in direct opposition to those put forward by the natural scientific paradigm. Viewing all knowledge as socially constructed, the model holds that “objective” facts do not exist, only “subjective” truths. In fact, it is believed that any truths held to be objective or absolute must be deconstructed and challenged to reduce their potential power to subjugate and oppress. For this reason, approaches that purport to offer a scientific, objective account of somatization are criticized for not questioning how the “implicit assumptions and the language of their preferred illness model participate in constructing what they perceive” (Griffith & Griffith, 1994, p. 14). In particular, these approaches are criticized for favouring professional and scientific explanations of a person’s problem over a person’s own illness stories and experiences. The narrative model outlines a way of “acquiring knowledge” about somatization that is based upon very different assumptions.

The epistemological approach of Griffith and Griffith (1994) is characterized as drawing upon the specific language, meanings, and experiences of the patient and family to understand the narratives and circumstances underlying the patient’s “unspeakable dilemma.” This approach is referred to as an “emic” approach and is described as similar to an anthropological “folk perspective.” Once the dilemma and binding self-narratives become clear, the therapist asks further questions to uncover and challenge the specific personal and cultural assumptions that have given power to the patient’s self-narratives. The focus is on facilitating exploration rather than providing explanations, instructions, or interpretations.

Instead of trying to discover the “true” causes of the patient’s somatization, new narratives are “co-constructed” by all therapy participants to undercut the power of the old ones which required the body to suffer. The patient and family members are viewed as the “bona fide” authors of their new story, with the clinician serving only as a consultant. No mention is made as to whether these new stories are considered any more “true” than the old ones. They are simply portrayed as more preferred or adaptive from the patient’s and/or family’s point of view. In fact, the patient is considered the ultimate judge of the value of potential insights and solutions that emerge in the therapeutic dialogue.

Evaluation of Strengths and Weaknesses

Following is a critical evaluation of the narrative model's strengths and weaknesses, based upon its: a) comprehensiveness, b) consistency, c) research relevance, and d) its congruence with the foundations of a human science approach.

Comprehensiveness

The narrative model's focus on the meanings and experiences of self and others is one of its greatest strengths. The Griffiths broaden their focus on the individual to include the patient's interpersonal and social environment by eliciting the participation of family members. Keeping the therapeutic dialogue grounded in the language, meanings, and experiences of the therapy participants, the clinician attempts to identify the self-narratives, emotional postures and life circumstances that are specific to each patient's unspeakable dilemma. In contrast with other natural scientific models, the patient's meanings and interpretations are not translated into abstract, theoretical constructs and processes. Solutions are individualized, with the patient and family members playing a leading role in their construction.

The narrative model is also impressive in its breadth. It attempts to account for all "mind-body problems," including somatoform, psychophysiological and factitious disorders, as well as psychosocial problems that develop around medical illnesses. It discusses personal and social-cultural factors that may contribute to somatization, including the interactions of patients with health professionals who may appear, at times, to speak a "foreign language" to patients regarding their problems.

The narrative model's comprehensiveness, however, is hindered by the lack of precision and clarity in some of their theoretical principles and constructs. At times, it is their definitions that are unclear. For example, in reference to "story" and "language," it is hard to grasp what Griffith and Griffith (1994) mean by such expressions as "a linguistic unit of coordinated bodily states," or "the generation of consensual behaviours by two beings who are structurally coupled" (p. 36-37). In other instances, greater elaboration and specificity is needed to clarify the theoretical statements they are making. For example, it is unclear how they consider a "form" or

“sensory gestalt” to be the same as a “story,” or how a story is deemed to represent the fundamentally irreducible unit of human experience that “couples” mind and body. “Pre-knowledge of bodily experience” is purported to play an important role but it is unclear what “pre-knowledge” refers to. Overall, the relationship between experience, narrative and the self is not clearly delineated. Further elaboration is also required of their concept of “structural selection.” What kind of structures are they referring to? What does this process of selection involve? It also needs to be shown more clearly how structural selection “avoids the traps of...idealism, materialism, dualism, or interactionism” in conceptualizing mind-body relationships (p. 199).

Finally, by focusing primarily on the “social space *between* persons,” the narrative model appears less able to provide a clear understanding of what the somatizing patient may be subjectively experiencing. This is particularly true for emotions. By viewing emotions *only* as interpersonal phenomena, it is unclear where emotions that one may be feeling toward one’s self or toward non-human aspects of one’s environments (e.g., a beautiful sunset) would fit within this model. Similarly, by restricting the focus to emotions related to safety (i.e., emotional postures of tranquility and mobilization), the richness of the patient’s emotional world appears to be minimized.

Consistency

The narrative model draws from a wide range of theoretical and therapeutic approaches. The Griffiths refer to hermeneutic philosophy and cognitive science as informing their theoretical framework, and constructivist, collaborative language systems, solution-focused and narrative approaches as shaping their approach to therapy. From a pragmatic perspective, it can sometimes be quite helpful to draw from a variety of orientations in clinical practice. However, doing so can be problematic in terms of reducing the coherence and consistency of a model’s theoretical foundation. The Griffiths tend to focus on what appear to be commonalities between theoretical approaches without taking into consideration how they may differ, particularly in terms of their foundational assumptions. For example, their description of “language” is based upon Maturana and Varela’s (1987) attempt to describe the *causal structural mechanisms* that relate “mental

events” and “physical events.” As cognitive neurobiologists, the natural scientific assumptions of their approach clearly differ from the human scientific assumptions held by the phenomenological hermeneutic philosophers referred to by the Griffiths (i.e., Heidegger, Merleau-Ponty, Gadamer). Yet somehow cognitive science and hermeneutic philosophy are interpreted by Griffith and Griffith (1994) as saying the same thing about language: that it is “located in the consensual behavioural interactions between persons, not inside ‘the mind’ of either” (p. 36). A closer look at the foundations of hermeneutic philosophy would reveal that this statement is *not* an accurate reflection of a hermeneutic view of language.

From a therapeutic perspective, the Griffiths appear to be guided more prominently by a Goolishian and Anderson’s (1987) collaborative language systems (CLS) approach in the first stages of therapy, and White and Epston’s (1990) narrative therapy approach in the latter stages of therapy. While there are some commonalities between these two approaches, there are also some important differences. Goolishian and Anderson’s approach is very focused on following the patients’ stories and meanings without having preconceived notions regarding the goal or direction of therapy. In contrast, White and Epston’s approach is based upon the assumption that the self is constructed by narratives which arise from culture-wide social practices, and that deconstructing and externalizing questions must be used to counter the power of the social practices that are contributing to the problem. This assumption clearly guides the therapist to ask questions and interpret the patient’s stories in a particular kind of way. This interpretive line of questioning reflects an inconsistency with the Griffiths’ stated aim to accept the patient’s language *without further interpretation*.²⁸ Accordingly, when the patient is described as eventually coming around to the *therapist’s* view that an unspeakable dilemma is at the root of their mind-body problem, it appears that the Griffiths are no longer operating from within a CLS framework. While it may be pragmatic to combine the approaches in this way, it contributes to some of the foundational inconsistencies in the narrative model.

²⁸ In fact, from a human science perspective this would not be considered possible. Interpretation is viewed as the “rendering explicit” of understanding (Palmer, 1969). Without interpretation, understanding is not complete.

Research Relevance

The narrative model of somatization represents the first comprehensive attempt to theoretically conceptualize and treat somatization from a post-modern, social constructionist perspective. While medical sociologists and anthropologists have emphasized the powerful role played by social-cultural values and expectations in the development of somatization (e.g., Waitzkin & Magaña, 1997; Ware and Kleinman, 1992), and other clinicians have emphasized the importance of working with somatizing patients' stories (Broom, 1997), the Griffiths are the first to bring theory and therapeutic practice together into a conceptual model. They also propose a novel approach to the utilization of psychoactive medications with somatizing patients. For these reasons, the narrative model has some heuristic value.

From a research perspective, the Griffiths have conducted one study of pseudoseizure patients which confirmed their hypothesis that mind-body problems reflect the existence of an unspeakable dilemma (Griffith, Polles & Griffith, 1998). While further studies have yet to be conducted, this primary hypothesis seems specific enough to be testable empirically using human science or other forms of qualitative research methods.

Congruence with a Human Science Approach

Certain characteristics of the narrative model are quite congruent with a human science perspective. This is particularly true of the conversation-based, dialogical approach to therapy that has been adopted from Goolishian and Anderson (1987). The Griffiths view the "heart" of therapy as creating a space for the patient's and family's story, and they work with the unique language and meanings of therapy participants to create a conversational domain where both therapist and patient feel mutually understood. They view patients as more similar than different from themselves, and they attempt to be curious, open, respectful and engaged. They build upon the participants' knowledge and experience and assist them in arriving at their own solutions. From a theoretical perspective, they acknowledge the social-cultural embeddedness of language, and the important role that narratives play in the formation of one's identity. In addition, they view bodily experience as an important form of communication and they attempt to utilize the patient's body language and sensations to understand the unique meanings of bodily symptoms in

the lives of somatizing patients. In these and other ways, the narrative model is congruent with a human science approach.

However, a number of incongruences arise from the narrative model's conceptual framework. While admirably attempting to incorporate insights from hermeneutic philosophy, it seems apparent that the Griffiths misunderstand some of the works of the philosophers they refer to. For example, by positing Merleau-Ponty's (1963) notion of "forms" as equivalent to "stories" and arguing that stories are the irreducible units of human experience, it is clear that Merleau-Ponty's work has been misconstrued. His notion of form or "structure" refers to an interconnected pattern of *meanings* that are intentionally related. It is this meaning-structure that expresses the *irreducible* intentional relation between man and world. In addition, Merleau-Ponty assigned intentionality to the lived body. The implication of this operational intentionality is that, through our bodily gestures, we perceive and attribute meaning at a primordial level of understanding that *precedes linguistic communication*. The Griffiths appear unaware of this pre-reflective mode of perception, as they assume that it is *stories* that grant to us a "pre-knowledge" of the world. However, Griffith and Griffith (1994) make an astute observation that points to this primordial level of understanding: "The stories...that are most malignant for the body are those that are not known as stories. They have become so much a part of the landscape of life that they are known by a patient as 'this is the way life is'" (p. 132).

Without a stronger appreciation of pre-reflective lived experience, the narrative model is unable to offer a clear understanding of the relationship between narrative structure, self-identity and the lived world. In agreement with Merleau-Ponty, Polkinghorne (1997) argues that there is a need to enlarge the identification of the self beyond culturally-defined categories to include the "non-linguaged" or embodied senses of the self. In his words, "to know who one is means taking into account more than one's objective notions about self identity; it requires being in touch with the felt meanings accompanying one's fundamental perceptual experiences" (p. 54). The Griffiths appear to take these "felt meanings" into account when monitoring the body language of patients and attempting to match their posture or breathing pattern to get a sense of their patients' experience. However, they do not provide a way to fit these "non-storied" perceptions into their conceptual framework.

Implications for the Problematic of Somatization

There are many positive implications that follow from the narrative model. Patients are much more likely to engage in therapy when a safe, collaborative environment is established that facilitates respectful, reflective dialogue among all therapy participants. Reflecting teams provide a novel way of approaching clients who may be resistant initially to psychosocial inquiries. These may include individuals referred to as *alexithymic* by other models, who have difficulty accessing or describing their feelings. By working with the body's emotional posture, the narrative model is said to provide a way of working with these individuals that reduces the need to describe feelings directly. In terms of personal agency, patients may experience greater success at resolving their mind-body problems when they are encouraged to actively participate in "co-constructing" solutions rather than passively rely on the expertise of the therapist.

As a corrective to models which intervene solely at the individual level, the narrative model provides ways to counter the impact of social-cultural values and expectations that may be contributing to a patient's somatization. Even patients who are unable to leave a problematic situation are assisted in finding ways to alleviate their symptoms. By externalizing the source of a patient's symptoms to a current dilemma and the stories attached to it, patients are less likely to feel that they are being personally blamed or stigmatized for their problem. In addition, patients may feel less stigmatized if medications are recommended to assist the therapeutic process rather than to "treat" a psychological disorder.

A potential drawback of focusing on interpersonal and social-cultural factors is that relevant *intrapersonal* issues may be ignored or minimized. In addition, patients may feel misunderstood if the therapist holds too strongly to a narrative, social-constructionist interpretation or line of questioning that does not resonate with their own experience.

Summary: Critical Evaluation

The following is a brief summary of how the four models compare with respect to the evaluation criteria set out at the beginning of this chapter.

In terms of *comprehensiveness*, the models were evaluated on two factors: how well they accounted for the facts of somatization (i.e., their scope), and the clarity and precision of their constructs, postulates and treatment recommendations. The scope of the neuropsychiatric model is considerably lower than the other models. The biopsychosocial, psychoanalytic and narrative models appear to have a much better scope, but each model presents certain limitations. The biopsychosocial model discusses a broad range of factors but these are restricted to those which are observable and measurable from a natural science perspective. The psychoanalytic model shows considerable depth in terms of describing intrapsychic factors, but it fails to broaden its focus beyond the psychology of the individual. The narrative model provides good breadth by including the interpersonal and social-cultural environment of the somatizer, but its scope is limited by minimizing the relevance of intrapersonal factors. With respect to clarity and precision, difficulties are evident in each model. Most models are not well grounded theoretically, reflecting a weakness that is most apparent with the natural science-based models.

For a model to demonstrate good *consistency* in terms of its stated assumptions, theoretical principles and treatment recommendations, it needs to be based on a strong, unified theory. For this reason, the psychoanalytic model is evaluated more favourably than the other models on this criterion. However, the consistency of the psychoanalytic model is compromised by the tensions that exist between its goals of understanding the patient's experience and providing natural science explanations for the patient's psychosomatic symptoms. Aside from lacking a strong theoretical framework, the inconsistencies demonstrated in the neuropsychiatric and biopsychosocial models seem particularly related to the taken-for-granted principles and assumptions of the natural science paradigm, including causality, reductionism, determinism and dualism. Proponents of these models seem largely unaware of the impact of their philosophical foundations, overlooking illogical postulates or inconsistencies between their stated assumptions, conceptual frameworks and treatment recommendations. The narrative model provides an innovative conceptual framework to explain its clinical observations, but inconsistencies arise from attempting to combine a variety of theoretical and therapeutic approaches with different foundational assumptions and principles.

In terms of *research relevance*, each model was evaluated regarding its testability and

heuristic value. The neuropsychiatric and psychoanalytic models were both rated low in terms of testability, due to the imprecise nature of their postulates and constructs. However, the strong heuristic value of the psychoanalytic model helps to partially counterbalance this weakness. The testability of the biopsychosocial model is one of its greatest strengths, given that its model of somatization was constructed primarily from the findings of empirical research. The narrative model presented one study to demonstrate how its hypotheses could be tested using qualitative research methods. While its heuristic value is yet to be determined, the narrative model offers a number of innovative propositions and treatment approaches that may stimulate other practitioners to consider “mind-body problems” from a different perspective.

In evaluating the *congruence* of each model with the foundations of a human science approach, it is no surprise that the natural science-based models were found to be the least congruent. The neuropsychiatric model assumes that the theories and methods of the biological and physical sciences can be equally applied to the human organism, reducing human thoughts, feelings and behaviours to neurobiological processes. While the biopsychosocial model represents a significant improvement, it still focuses on *explanation* versus *understanding* and subsumes the patient’s reality under the abstract concepts of science. The psychoanalytic model is similarly constrained by its natural science aspirations, but it combines its theoretical explanations with a sincere attempt to understand the intricacies of the patient’s experience. In line with a human science perspective, the narrative model presents a dialogical approach to therapy that places the unique language, interpretations and self-narratives of therapy participants at the core of their model. It is less congruent from a theoretical perspective, but it raises issues (such as narrative, identity and social-cultural influences) that are foundational to a human science approach.

Some statements can be made regarding the *implications* that arise from these models with respect to the problematic of somatization. In general, it appears that difficulties may be more likely to arise when models are strongly wedded to the natural science paradigm. By failing to move beyond the debate over the biological versus (bio)psychosocial origins of somatization, the neuropsychiatric and biopsychosocial models contribute to the ethical conflict surrounding who or what is responsible for a patient’s symptoms. Furthermore, to the extent that scientific

explanations are held as more valid than a patient's subjective experience of their illness, patients are at greater risk of feeling misunderstood and stigmatized by proponents who put forward these explanations. As a result, they may be less likely to comply with their treatment recommendations. These tend to be over-simplified and focused either on pharmacological agents or on cognitions and behaviours that have been pre-determined as maladaptive. While those who comply may benefit from these recommendations, there is a risk that factors specific to their illness experience may be missed or ignored. As these models fail to study the subjective experience of somatizers, they are not able to address the complexities of somatization as it is experienced and lived by individual patients.

Patients are less likely to feel misunderstood if they are treated by proponents of the psychoanalytic or narrative models who recognize the importance of understanding their unique perceptions, stories and experiences. As their treatment will be more highly individualized, there may be a greater chance for amelioration of their symptoms. However, the farther that a model strays into theoretical formulations to explain or interpret a patient's symptoms, the greater the risk that the interpretation may fail to resonate with the patient's experience. Furthermore, the narrower the scope of the model, the more likely that important contributing factors may be ignored or minimized.

IV. COMPARING THE CURRENT MODELS OF SOMATIZATION

Each of the models reviewed have contributed to our current understanding of somatization and have offered a variety of recommendations for treatment. However, as they present quite divergent perspectives on somatization, it is necessary to look at the four models as a whole to examine the status of our current understanding of somatization. The purpose of this chapter is to step back and reflect on the issues that arise when one compares and contrasts the conceptualizations and treatment recommendations of the four models of somatization. Do the models put forward any novel findings or hypotheses? How are the models similar to each other? How do they contradict each other? What areas have received inadequate inattention or have not been considered? Do they offer any innovative approaches to treatment? Taking these reflections into consideration, the chapter will conclude by identifying the issues that remain unresolved or inadequately addressed. These issues will be taken up in the next chapter and addressed from a phenomenological-hermeneutic perspective.

Conceptualizations of Somatization

Novel Findings or Hypotheses

Each of the four models contribute something unique to the understanding of somatization. For example, the neuropsychiatric model puts forward an interesting “cross-sensitization” hypothesis to account for the high co-morbidity of somatization disorder and functional somatic syndromes with affective disorders, PTSD and physical, verbal or sexual abuse. It is proposed that repeated and intermittent exposure to psychological, physical and chemical stressors may act synergistically to increase neural excitability and over-amplify somatic and psychological responses. This co-morbidity has been recognized by other investigators but few hypotheses have been put forward to explain it.

The biopsychosocial model stands out as being the only natural science-based model to look at somatization from a systemic perspective. It has moved beyond the individual to consider

the potential impact of familial and social-cultural factors on the development of somatization. It is also unique in its proposal that somatization reflects a misinterpretation of one's bodily sensations and symptoms as being more threatening than is warranted.

Psychoanalytic proponents have been studying psychosomatic illness for many decades, resulting in a number of original contributions. These include the concept of alexithymia which has generated widespread discussion and debate regarding its etiological role in somatization. Alexithymia is one of the few concepts that is referred to by all four models of somatization. The psychoanalytic model has also contributed significantly to the understanding of somatizers who have suffered from significant disruptions in early child-caregiver relations, particularly during the separation/individuation phase of development. These are the somatizers who may be more likely to minimize emotional and/or somatic distress, and less likely to seek medical help. Alternatively, for those who regularly seek medical help, the psychoanalytic deficit model suggests that these behaviours may reflect indirect strivings for relatedness rather than an amplifying or neurotic personality style.

As the narrative model is built upon post-modernist principles, it offers quite a different perspective from the other models. With its social constructionist emphasis, it is the first model to view mind-body problems as existing between persons in language rather than in the mind or body of the individual who is suffering. It distinguishes itself by focusing on the powerful role of family myths and social-cultural values in constructing binding self-narratives and dilemmas that may result in somatized symptoms.

Similarities

This section will attempt to temporarily set aside the theoretical differences between models to see if there are similarities with respect to how the phenomenon of somatization is characterized. However, if one compares the natural science models (i.e., the neuropsychiatric and biopsychosocial models) with those that take a more human science approach to understanding somatization (i.e., the psychoanalytic and narrative models), it quickly becomes clear that there is little to be gained by looking for similarities across all four models. The only

similarity one would find is that all models consider current and past “stressful” or traumatic events to be risk factors for somatization. Therefore, to conduct a more fruitful comparison, it makes sense to look at the human science models separately from the natural science models. While acknowledging the natural science characteristics of the psychoanalytic model, it will be referred to as a human science model for the purpose of this discussion. This is because it attempts to understand the phenomenon of somatization through clinical work with patients rather than through natural science research.

The natural science models share some similarities with respect to the factors they propose as being most likely involved in cases of somatization. From a genetic perspective, both the neuropsychiatric and biopsychosocial models refer to neurotic or “amplifying” personality traits that genetically predispose a person to amplify and perpetuate a positive feedback loop between emotional and somatic distress. Reference is also made to somatizers with alexithymic traits who minimize emotional distress, although the biopsychosocial model considers these types of somatizers to represent a small minority. In terms of environmental factors, both models consider past and/or present “stressful” life events to play a significant role. These include experiences of trauma and abuse, with both models suggesting that early childhood trauma can impair a person’s developmental capacity to communicate psychological experiences. The biopsychosocial model suggests that current life stressors involving loss or perceived threat of loss may trigger somatic symptoms, while the neuropsychiatric model refers more generally to any events that result in heightened sympathetic arousal. Finally, both models state that somatization (or somatization disorder) is often comorbid with psychiatric disorders (particularly affective and post-traumatic stress disorders), and that somatization disorder may co-exist with functional somatic syndromes such as chronic fatigue syndrome, multiple chemical sensitivity, and irritable bowel syndrome.

In terms of the human science models, there appear to be a number of similarities in terms of how somatization is characterized. For example, both models refer to determining factors (e.g., unconscious processes, binding self-narratives) that patients are generally unaware of. These include prior “critical life experiences or events,” with both models acknowledging abuse or trauma as a significant risk factor for developing somatization. Narrative and defense model

proponents share the view that a dilemma or conflict underlies the experience of somatization. This conflict typically involves a struggle (conscious or unconscious) between how people *want* to be and behave and how they feel they *should* be and behave. Both models seem to agree that the somatic symptoms are triggered or exacerbated by efforts to silence (i.e., suppress or repress) the experience and/or expression of certain wishes or emotions. The symptom is held to protect people from experiencing or expressing something that they fear would be too overwhelming or threatening at a psychological or interpersonal level. In addition, narrative and defense model proponents suggest that the somatic symptom may have a symbolic meaning. Finally, both models refer to difficulties or disruptions in significant relationships as being a prime contributor to symptom onset.

Contradictions

Given the different theoretical and foundational assumptions of each model, there exists an obvious disagreement over the etiology of somatization, including the role of psychopathology and alexithymia. The neuropsychiatric model holds that somatization is a neurobiological phenomenon caused by dysregulation in various sub-systems of the brain and central nervous system. Alexithymia is believed to result from an impairment of inter-hemispheric communication via the corpus callosum. The biopsychosocial model proposes that somatization is caused by a range of psychosocial factors interacting with benign biological factors. It refers to two models of psychopathology: an amplification model and a defense model. The latter model is put forward as a potential explanation for alexithymia, but defensive processes are not considered to play a significant role in somatization. The psychoanalytic model argues that somatization is caused by unconscious psychodynamic conflicts and processes that result from disturbances in early child-caregiver relations. In contrast to the biopsychosocial model, alexithymia is considered to play a primary role in somatization, indicating either a defensive regression or a psychic deficit. Many proponents consider alexithymia to be reflective of narcissistic, borderline or dependent personality disturbances. From a narrative perspective, somatization is viewed as the result of an “unspeakable dilemma” created by binding (familial and socio-cultural) self-

narratives and/or external constraints (e.g., political oppression, domestic violence). Given the view that mind-body problems exist between persons rather than a person, individual psychopathology is not held to play a role. Narrative proponents acknowledge that some patients have difficulty accessing or describing feelings, but they do not label them as alexithymic or put forward an explanation for their difficulties.

The models also reflect different views regarding the psychological meaning of the bodily symptoms experienced by somatizers. The human science models agree that somatic symptoms are triggered by issues or events that are psychologically meaningful to the individual patient. However, there is clear disagreement between the two psychoanalytic models as to whether or not the symptom is viewed as symbolic. The narrative model presents case examples which suggest that the symptom may be symbolic of a past issue or dilemma, but it is unclear whether proponents assume that the symptom is *always* symbolic. In general, the neuropsychiatric and biopsychosocial models hold that symptoms are not symbolic. However, the biopsychosocial model may consider conversion symptoms an exception.

Finally, there is widespread disagreement regarding the types of factors that models consider most critical to the development of somatization. The neuropsychiatric model focuses on individual biological factors. The biopsychosocial model emphasizes individual factors (biological and psychological) but also refers to familial and social-cultural factors that have been generally found to contribute to somatization. The psychoanalytic model focuses primarily on psychological factors. The narrative model argues against the relevance of individual factors and focuses primarily on familial and social-cultural factors that place the individual in a binding dilemma.

Omissions or Deficiencies

The critical evaluation pointed out that all models ignore or minimize certain factors that may be relevant to somatization, based upon their theoretical framework. They also tend to lack clarity and precision in terms of their theoretical concepts and principles. No models describe a way to study and understand the subjective, lived experience of somatizers without imposing a

varying degree of scientific or theoretical biases. In general, the foundational assumptions of each model are not clearly articulated, with most proponents demonstrating a lack of awareness regarding the existence and implications of these assumptions. While the narrative proponents have made a conscious effort to address this critique, they seem to disregard the fact that theories cannot be seamlessly combined or integrated without taking into consideration the extent of their agreement at a foundational level.

With respect to mind-body relations, none of the models have been able to overcome implicit dualistic assumptions and capture the extent to which mind-body relations and person-world relations are deeply interwoven. While explicitly rejecting mind-body dualism, proponents of the natural science models fail to see how their conceptualizations continue to carry dualistic overtones. This is particularly true of the neuropsychiatric model. The psychoanalytic model posits linear causal relationships between mind and body, with a view of mental processes that is overly immersed in the idealist language of representational thought. The narrative model represents a significant advance because it emphasizes the interconnectedness of mind-body and person-world relations through the medium of language and narrative. As an alternative to mind-body dualism, it puts forward the notion of structural selection (i.e., that language “structures” physiology and vice versa). However, this concept does not take into account the bodily and pre-reflective nature of our lived experience, and the extent to which humans are embodied-subjects-in-the-world. It also does not address the primordial relationship between language, narrative, identity and our lived world. While the narrative model hints at some societal changes that may be contributing to somatization, these could be elaborated further.

Finally, there is an implicit discrepancy between the human science and natural science models that has yet to be acknowledged or adequately addressed. The psychoanalytic and narrative models use the terms “psychosomatic illness” and “mind-body problems” respectively to refer to all physical illness in which there appears to be a strong emotional (or psychosocial) component, *with* or *without* tissue damage. Hence, the factors which lead to somatization are assumed to be the same as those that lead to more serious (psychosomatic or medical) illnesses where functional and/or structural pathology is evident. In contrast, neuropsychiatric and biopsychosocial proponents focus exclusively on somatization and make no reference to a

possible relation between somatization and these other types of illnesses. Their silence on this issue suggests that they consider the processes involved in the development of somatization to be unique, and to require distinctive approaches to treatment. However, by failing to consider the *possibility* that somatization may be related to other medical conditions influenced by psychosocial factors, they have closed the door on a much wider range of hypotheses, empirical findings and treatment approaches. Hence, the distinctiveness of the processes underlying somatization is an issue that is worthy of reflection.

Treatment of Somatization

Novel Approaches to Treatment

Most models contribute something novel to the treatment of somatization. Goldstein (1996) is the only neuropsychiatric proponent to have developed and implemented an apparently successful multi-drug treatment protocol for various forms of somatization, although his results have not been empirically verified. Within the psychoanalytic model, a few practitioners have begun to explore the value of incorporating some form of body work into their therapy with alexithymic patients. The narrative model is unique in a number of ways. It is the only treatment approach that appears to help patients develop concrete ways to counter the impact of social-cultural values and expectations that may be contributing to their symptoms. In terms of working with alexithymic patients, the narrative model describes ways to access the patient's bodily knowing more directly than some of the other models by using questions, working with imagery, and mirroring the patient's body language. Finally, the narrative model puts forward a novel "ethological" approach to pharmacological treatment.

Similarities

From the perspective of the neuropsychiatric and biopsychosocial models, the physician, researcher and/or mental health professional is viewed as the expert with respect to explaining

somatized symptoms and making recommendations for treatment. Based upon the findings and/or hypotheses of scientific research, these treatment recommendations are regarded as applicable and beneficial to all somatizing patients. The recommendations focus primarily on perpetuating factors that are considered to be modifiable by medications (e.g., anxiety, depression, abnormal levels of various neurochemicals) or modifiable by the patient's efforts (e.g., maladaptive cognitions and behaviours). Compliance can be an issue for both models if the patient does not agree with the physician's explanation and/or treatment recommendations.

Proponents of the psychoanalytic and narrative models both consider it critical to attempt to understand the unique meanings, motivations, stories and experiences of the therapy participants. They also consider it important for somatizing patients (and their families) to identify, explore and challenge the validity or authority of their personal stories and experiences to define themselves in ways that lead to somatized symptoms. To this end, therapy participants are assisted in becoming aware of these influences, making more conscious choices, and finding ways to act upon them.

Contradictions

Divergent conceptualizations of somatization lead each model to put forward different recommendations regarding the focus and modality of treatment. The neuropsychiatric model states that somatization can only be treated by developing biological methods to counteract the dysregulation taking place in various sub-systems of the brain. The biopsychosocial model recommends that anxiety or depression be treated by medications, and that maladaptive cognitions and behaviours be targeted by the physician and/or therapist as the focus for individual, group or family therapy. Psychoanalytic proponents recommend intensive individual therapy to uncover and work through unconscious psychodynamic processes and provide a corrective therapeutic relationship. Narrative proponents argue that one should work therapeutically with the "problem-organized system" (Anderson & Goolishian, 1988) and focus on the familial and social-cultural narratives, critical life experiences and oppressive circumstances that are contributing to the patient's unspeakable dilemma.

The models also vary with respect to the degree of symptom resolution considered possible, based upon their foundational assumptions regarding freedom and determinism. Until effective biological treatments are developed, neuropsychiatric proponents appear quite pessimistic regarding a somatizer's prognosis for improvement. The biopsychosocial and psychoanalytic models seem moderately optimistic that a certain amount of improvement is possible with effective treatment. Narrative proponents are the only ones who seem willing to suggest that complete resolution of symptoms is possible.

Omissions or Deficiencies

As no model of somatization is completely comprehensive, each poses a risk that issues relevant to a patient's symptoms may be misconstrued, minimized or dismissed as not being relevant or modifiable. This risk appears greatest with the neuropsychiatric model and least with the narrative model, for reasons already discussed. The farther the model strays from eliciting and addressing the patient's lived experience of somatization, the greater the risk that treatment will not be effective.

With respect to alexithymia, most models have pointed to the difficulties that can be encountered in working therapeutically with patients who have difficulty accessing and verbalizing their feelings. However, proponents of these models continue to rely primarily on verbal forms of therapy to treat these patients. Aside from a few psychoanalysts in Europe (e.g., Müller-Braunschweig, 1998; Wyman-McGinty, 1998), there has been insufficient attention paid to the potential of drawing upon non-verbal modalities (e.g., body-oriented or expressive arts therapies) to gain access to unconscious pre-verbal material. Similarly, greater consideration could be given to working therapeutically with affective imagery. The narrative model is the only one that makes reference to incorporating some imagery work into their treatment.

Summary: Unresolved Issues and Deficiencies

As one considers the various contradictions, omissions and deficiencies that arise when reflecting upon the four models of somatization, certain problems become apparent in the way that somatization is being conceptualized and treated. First and foremost, one can see that an understanding of the phenomenon of somatization has been significantly obscured by the philosophical, theoretical and methodological biases inherent in each model's conceptualization. These biases have led to widely divergent characterizations, explanations, and treatment approaches, with relatively minimal overlap. Until attempts are made to study and understand the *lived* experience of somatizers without imposing explanatory frameworks and biases, progress in understanding and treating this phenomenon will be significantly impeded. Theories should ideally be subordinate to the patient's direct experience. Lacking the appropriate methods for studying human lived experience, the natural science models have shown themselves to be particularly problematic in this regard.

Following are some of the *foundational* issues that remain unresolved or inadequately addressed. Mind-body dualism continues to be a problem and will not be successfully overcome until a foundation is built that takes into account the bodily and pre-reflective nature of our lived experience, and the intentional role of the body in mediating our relationships to the world. There needs to be a greater appreciation of the extent to which our experience of self and others is *co-constituted* by our intentional relatedness to the life world, and not simply *constructed* by the beliefs, values and practices that are prevalent in our society. In addition, the role of primordial, *pre-linguistic* perception in co-constituting our language, narratives and self-identity needs to be clearly understood. The philosophical foundations of existential and hermeneutic phenomenology would help resolve these problematic issues and provide a solid foundation for the understanding and treatment of somatization.

Looking at the *conceptualizations* of somatization, a number of issues have been raised that need to be addressed. Etiological hypotheses are heavily contradictory as they are derived primarily from the theoretical or scientific perspective of each model, rather than from a direct study of the lived experience of somatizers. Hence, there is a definite need to study the subjective

experience of somatizers (e.g., individuals living with chronic pain or fatigue) and to incorporate these findings into a conceptualization of somatization. In terms of contributors to somatization, the relative importance of individual, familial and social-cultural factors ranges widely across the four models. With respect to individual factors, there is a particular need to make sense of the discrepant views put forward with respect to psychopathology. For example, are there two types of somatizers characterized by different types of psychopathology (i.e., amplifiers and minimizers), or are there similar underlying processes that have yet to be uncovered? Or is it the binding social-cultural narratives and practices that are “pathological?” Also unresolved is whether the bodily symptoms of somatization reflect some form of psychological or symbolic meaning. To address these types of questions, a much broader view of psychopathology is needed that looks beyond the individual and incorporates an understanding of our nature as Beings-in-the-world where our experience of self, others and world is co-constitutive and interdependent.

The *therapeutic implications* of each model are equally divergent, given their contradictory assumptions. As discussed, a number of problems result when practitioners rely too heavily on their theoretical or therapeutic framework to guide treatment rather than basing it upon an in-depth understanding of their patients’ lived experience. Hence, there is a definite need to learn how to understand and interpret the meanings, actions and bodily experiences of somatizers without imposing abstract conceptualizations. Treatment can then be guided by this understanding, utilizing appropriate interventions. In working with patients who have difficulty accessing or verbalizing feelings, there is also a need to explore the potential benefit of non-verbal modalities to facilitate the therapeutic process.

V. TOWARDS A PHENOMENOLOGICAL-HERMENEUTIC APPROACH TO SOMATIZATION

The previous chapter identified a number of issues that remain unresolved or inadequately addressed by the current models of somatization. This chapter will demonstrate how a phenomenological-hermeneutic approach can begin to address these issues and provide a contribution to the understanding and treatment of somatization. The first section will provide a glimpse into the lived worlds of somatizers who have articulated their experiences as participants in qualitative research studies.²⁹ It is only through the voices of these individuals that we can begin to comprehend how radically their lives can be affected by inexplicable pain and suffering. The second section will draw from the works of existential-phenomenological philosophers and therapists to provide a conceptualization of somatization that focuses on the existential and social-cultural dimensions that may be involved. Next, the therapeutic implications of existential and hermeneutic phenomenology will be presented. This will be followed by a phenomenological-hermeneutic conceptualization of Mary's case, to provide a comparison with the conceptualizations put forward by the other models. The final section will provide a summary and describe the implications of a phenomenological-hermeneutic approach to the problematic of somatization.

The Lived Experience of Somatization

By now we are aware that the term "somatization" covers a broad spectrum of clinical phenomena that can range from mildly distressing to severely disabling. The following section is based upon the experiences of participants in qualitative research studies whose lives have been affected by chronic pain³⁰ (Jackson, 1994; Walker, Holloway & Sofaer, 1999), chronic fatigue syndrome (CFS) (Hughey, 1991; Clements, Sharpe, Simkin, Borrill & Hawton, 1997), somatization disorder (Morse, Suchman & Frankel, 1997), temporo-mandibular joint disorder

²⁹ The small number of studies is an indication of how rarely subjective experience is considered worthy or feasible as a subject of research.

³⁰ While not all forms of chronic pain involve somatization, the experience of living with disabling chronic pain is quite similar whether there is extensive tissue damage or not.

(TMJ)³¹ (Garro, 1992, 1994; Good, 1992), medically unexplained symptoms (Peters, Stanley, Rose & Salmon, 1997), and psychosomatic illness (Helman, 1985). Hughey was the only researcher to conduct a phenomenological study, describing the lived experience of five individuals suffering from chronic fatigue syndrome. While psychosomatic illnesses are not referred to as somatization phenomena by the natural science models, a phenomenological perspective would agree with psychoanalytic and narrative proponents that the phenomenon of somatization encompasses all bodily symptoms, with or without tissue damage, that cannot be fully explained by medicine. Many psychosomatic disorders have a chronic, relapsing and unpredictable course that can be similar to other forms of somatization. However, they tend to be less debilitating and will therefore provide a useful counterpoint to the more severe forms of somatization such as chronic pain and fatigue which can disrupt and constrict every aspect of one's life-world. These chronic conditions can alter our relationships with our bodies, our selves, other people, and lived space and time. It is to these issues that we will now turn.

Mind-Body Relations

It is important to recall that the lived body is neither subjective nor objective; it is an expression of our existence that is both *of the self* and *in the world* (Merleau-Ponty, 1962). When we are healthy, our attention is primarily directed toward the world. Expressing ourselves through our bodies in a habitual, pre-reflective manner, Leder (1984-85) suggests that our body *disappears* as we engage in our everyday tasks, similar to Heidegger's "ready-to-hand" tool (see page 17). When we become ill, we suddenly become aware of our body as a "present-at-hand" object that is no longer functioning properly. It becomes an obstinate force that interferes with our projects. It makes us feel "useless." As Leder states, the quality of suffering is measured not by the intensity of a bodily symptom, "but by the activities, the people, the experiences put out of reach" (p. 261).

Distressing bodily symptoms present us with a paradox. On the one hand, they make us

³¹ TMJ refers to a variety of symptoms of pain and dysfunction that are believed by some dentists to be linked to the temporo-mandibular joints of the jaw. Similar to many forms of somatization, there is little consensus regarding etiology, pathophysiology and treatment.

painfully aware that mind and body are interrelated and inseparable. It is impossible to experience chronic physical suffering without experiencing mental, emotional and spiritual distress. In this sense, intractable conditions should be considered “existential afflictions” rather than illnesses of the psyche or soma (Jackson, 1994). On the other hand, the sick body (or body part) quickly comes to be seen as a foreign or intrusive *object* that is maliciously constraining and opposing the self. This experience was reported by all somatizers in the surveyed qualitative literature. For example, one group suffering from multiple unexplained symptoms made thematic reference to a malicious disease entity that “played tricks (by retreating and then returning), and moved around autonomously within the body” (Peters et al., 1997, p. 563). Hence, the sick body comes to be experienced as something which forces itself upon them against their will.

Some individuals describe their physical suffering as though they were being attacked by a metaphorical *other*. For one TMJ sufferer, “it seems as though there’s a demon, a monster...something horrible lurking around banging the insides of my body” (Good, 1992, p. 36). Similarly, “it’s just like somebody’s in there with an electric shock thing, going...now it’s time for you to be in pain” (Kugelman, 1996, p. 348). According to Kugelman, these metaphors say that “pain is intensely personal, intensely affects my self, in a way that only an other can” (p. 348). Leder (1984-85) describes a sense of betrayal and loss of trust that may never be regained, as eloquently described by one TMJ sufferer in reference to his body: “I think it’s against me, that I have an enemy...It’s just gonna always let me down” (Good, 1992, p. 39).

Interestingly, one study of psychosomatic illness found that unpleasant or negative *emotions* (e.g., tension, anger, frustration) were frequently objectified as pathogens that attack vulnerable organs within the body (Helman, 1985). According to an ulcerative colitis patient, “I let [stress] get to me, and eat me away. Once something gets inside of me it just bounces around...until I can get rid of it” (p. 19). Helman suggests that this reification process helps shift blame and responsibility to emotions or body parts that are experienced as mostly under the control of outside forces (e.g., stressful relationships or work situations).

Many authors believe that the experiences of alienation and objectification engendered by physical suffering serve as an experiential antecedent to the dualist metaphysics of Western medicine. Thus, Leder (1990) writes, “the sense of the body as an alien thing does not arise

solely in the objectifications of the modern physician” (p. 87). In effect, the alienating nature of pain and suffering leads us to experience the relations between mind and body as lived oppositions. However, the interconnectedness of these relations never disappears.

Self-World Relations

Relationship to Self

The relationship to one’s self and one’s world can become radically altered by the chronic physical suffering experienced by some somatizers. As they lose control over a body that is “rebellious,” their ability to carry out goals and activities can become significantly impaired. Simply stated by one TMJ sufferer, “pain dictates what I do and what I can’t do” (Garro, 1994, p. 782). This restriction of function can pose a significant threat to a person’s identity and self-esteem. For example, prior to their illness, the CFS sufferers in Hughey’s phenomenological study were described as “intellectual, super-responsible, energetic, driven, controlling, perfectionistic and cognition-quick” (1991, p. 45). Since the illness, one participant complained, “I feel useless when I am sick and I hate to feel useless. I am the kind of person who would do 85 things a day” (p. 132).³² Another frustrated participant stated, “How can a person who was so smart and tops in her class become so incompetent?” (p. 62). The self-worth of individuals accustomed to meeting high standards is clearly quite vulnerable to the impact of illness. Similarly, debilitating pain or fatigue can pose a serious threat to the self-esteem of many blue-collar workers whose identity is strongly tied to their physical strength and endurance. These individuals have discovered that they can no longer push themselves the way they used to to pursue their chosen activities and goals. They have involuntarily entered a new world where, as one TMJ sufferer acknowledged, “I have to think of my health as a primary consideration where it wasn’t before” (Garro, 1994, p. 783).

Understandably, somatizers experience significant emotional turmoil over the losses and threats to their functioning and identity. In the qualitative studies under review, somatizers

³² This type of “premorbid hyperactivity” has also been found to be common in patients with chronic pain (Van Houdenhove, 1986).

typically described the process of seeking diagnosis and treatment as anxiety-provoking, depressing and highly frustrating. In general, they reported being given divergent explanations for their symptoms from a wide variety of health professionals, and receiving treatments which were typically unsuccessful, expensive and sometimes quite harmful. When health professionals implied that the cause was psychological, the majority described feeling blamed, stigmatized and powerless. Most study participants experienced fears of serious pathology before receiving some form of diagnosis, which often took many years. Given that somatizers who meet criteria for conditions such as CFS or TMJ represent only a fraction of the somatizing population, one can assume that fear of pathology is a concern for many somatizers who are unable to obtain a medical or “pseudo-medical” (i.e., scientifically controversial) diagnosis for their symptoms.

Somatizers who experience little or no symptomatic relief eventually become disillusioned with health professionals and express significant feelings of helplessness and hopelessness. One TMJ sufferer described it as “like being in a never-ending nightmare” (Garro, 1994, p. 783). Others expressed a feeling of entrapment by medical, disability and legal systems where “your life isn’t yours. It’s controlled by other people” (Walker, Holloway & Sofaer, 1999, p. 625). Many of the CFS sufferers in Hughey’s (1991) study described experiencing boredom, apathy, lack of direction, and numbing of feelings. All participants in this study had experienced suicidal ideation. Hughey viewed these individuals as “concretely living the ‘existential vacuum’ of the meaningless” (p. 60). Garro (1994) found that TMJ sufferers who gained some relief and control over their symptoms were able to participate far more in the everyday world. However, they continued to live with the fear and uncertainty of future flare-ups, comparing TMJ to “having a sword hanging over you” or as “living on a time-bomb” (p. 784).

Interestingly, Hughey (1991) observed two distinctive “ways of being” in response to CFS by his five study participants. In the first few years of feeling ill, some CFS participants found that they could still push themselves to achieve their goals (e.g., graduate from college with a high grade point average). Hughey referred to these participants as “fatigue subsidors” because they experienced the fatigue as initially subsiding while they worked towards their preconceived goals. As these individuals were still able to perform daily functions, they generally took longer to seek medical help. In addition, they continued to remain employed and seemed to

use more "active" coping skills, such as maintaining a social life and setting new goals.³³ Other participants experienced themselves as being unable to continue functioning right from the beginning of their symptoms of fatigue. Hughey referred to these participants as "fatigue augmenters." They quit their jobs shortly after their symptoms first appeared and experienced a more isolated world. These individuals seemed to experience more hopelessness and numbing of affect (e.g., "I have not been able to motivate myself...I am in a fog much of the time") (p. 61). They also seemed to rely more on passive coping strategies such as reducing or avoiding activities.

Hughey (1991) suggested that these differences may be related to different styles of "perceptual reactance" as identified by Petrie (1968) in a series of early studies related to pain tolerance. Petrie identified three categories to describe differences between people in terms of their tolerance for pain: "reducers," "moderates," and "augmenters." These differences are held to reflect processes that occur outside of awareness and are genetically determined to some degree. Reducers are said to experience diminished perception of all sensory experiences including pain. Hence, they tend to prefer being around people and participating in physical activities to experience more sensory stimulation. They are also less likely to be aware of, or preoccupied with, signs of ill health. In contrast, augmenters are said to experience a heightened sensitivity to sensory stimuli. As they feel pain and discomfort much more intensely than the reducer, they experience greater apprehension and increased activity of the autonomic nervous system in response to pain and other bodily sensations. They are also typically more introverted than reducers.³⁴ The sensory experience of moderates is neither diminished nor augmented. Considering the correspondence between Petrie's and Hughey's findings, it is possible that the differences between somatizers who amplify versus minimize their symptoms may be partially related to a difference in sensory experiences and perceptual style.

³³ Hughey (1991) cited an experimental study by Brown and Nicassio (1987) which found that active coping among chronic pain patients was associated with better psychosocial adjustment and less experience of pain. Passive coping mechanisms resulted in greater pain, deeper depression and lower self-esteem.

³⁴ As Neuroticism is held by biopsychosocial proponents to play a significant role in the amplification process, it is interesting that Petrie (1968) found no differences in Neuroticism scores between the three groups.

Relationship to Others

The experience of chronic symptoms such as pain and fatigue often result in a restricted social world and a sense of alienation and isolation from others. Somatizers find very quickly that their experience of suffering is unsharable and very difficult to communicate in everyday language. As Scarry (1985) notes, pain “achieves its aversiveness in part by bringing about...this absolute split between one’s sense of one’s own reality and the reality of other persons” (p. 4). This is one of the reasons why somatizers feel so profoundly misunderstood. As Jackson (1994) writes, “He thinks my back pain is like his morning backache, and I can’t convince him it’s totally different” (p. 218). In fact, many somatizers report fears of being condemned, disbelieved or misunderstood, resulting in limited self-disclosure about their illness. As one CFS sufferer described, “people are terribly misinformed and say things like this illness is not real, it has no cause or, is just psychosomatic...I am afraid they will all tell me to go to hell” (Hughey, 1991, p. 65). While some somatizers have difficulty providing concrete examples of rejection (Hughey, 1991), it is not uncommon for other people to retreat, as “most non-sufferers seem strongly to resist the notion that one can be in severe, unending pain; it is too threatening to contemplate” (Jackson, 1994, p. 211). In addition to fears of condemnation and rejection, limited energy and the unpredictability of flare-ups lead many somatizers to experience significant losses in their ability to participate in hobbies, recreational activities and social engagements.

Given these difficulties, somatizers often report that only fellow sufferers can understand their experience. Whether participating in a support group or pain clinic, “whatever you say about the pain is believable, just because of your common bond and their knowledge” (Good, 1992, p. 40). They report feeling tremendous relief at being accepted without having to prove anything, verbally or nonverbally.

While the experience of suffering may be difficult to communicate, bodily symptoms are in themselves a mode of access and communication between self and world. Kugelmann (1996) sees pain as a “sensor for interpersonal disharmony” which flares up when people experience hurt, lack of social acknowledgement, or other forms of personal distress. Individuals with psychosomatic illnesses are often quite aware of a connection between their symptoms and

feelings of tension or anger that they are unable to express verbally. For example, an asthma sufferer stated that “when I get uptight with my husband...I feel a tightness in my chest and I know I’m going to have an attack” (Helman, 1985, p. 18). Brodwin (1992) described a woman who uses her symptoms as a form of protest or resistance against the social expectations of others which she feels compelled to meet. Unable to confront people with her anger or discomfort, she uses her symptoms to escape certain situations or to gain the sympathy of co-workers or family members. When she experiences symptoms, she reports being unable to determine whether she is *really* sick or whether she is feeling sick because she wants to escape an uncomfortable situation. Hence, Brodwin argues that the patient’s actions cannot be understood by simplistic notions such as “secondary gain.” Instead, her symptoms function like a language that “can speak with an authenticity and power that her verbal messages often lack” (p. 79-80).

Spatiality and Temporality

When people become overwhelmed by pain or fatigue, there is a significant constriction of their spatial world. All of Hughey’s (1991) CFS participants reported a diminished ability to move about in their surroundings. The degree of narrowness ranged from monthly cycles of limited energy to an almost constant restriction to home or bed. As one participant described, “There are times that I feel if I were to walk another 5 feet I would collapse” (p. 69). Similarly, the physical pain and weakness rendered objects “heavier” than they actually were (e.g., “my razor feels like a 20 pound brick at times”) (p. 68).

A similar constriction occurs in one’s temporal world. With chronic suffering, “a painless past is all but forgotten...[and] a painless future may be unimaginable” (Leder, 1990, p. 76). Some people may dwell obsessively on the past and their pre-illness functioning. However, until individuals achieve some control over their symptoms, they typically remain oriented to the present and to searching for ways to relieve their suffering. As one person described, “TMJ has got me so backed up against the wall...I couldn’t even dare think about the future” (Garro, 1994, p. 783). Hence, previous life goals get put on hold indefinitely: “The only thing I can think to do is to try to get better. All I do 24 hours a day is work on my health” (p. 783). As the future

becomes an uncertain and remote place, some CFS sufferers attempt to live life more in the present and appreciate the everyday experiences that they are still able to enjoy (Hughey, 1991).

The Search for Meaning

When individuals suffer from intractable or intense bodily symptoms, they are naturally compelled to seek the reasons for their suffering. This section will begin by examining the roles that somatizers attribute to physical and psychosocial factors in the origin and exacerbation of their symptoms. The next section will look more specifically at somatizers with traumatic histories of abuse, and discuss how their bodily symptoms can be considered manifestations of “as yet” untold or repressed stories that are in quest of narrative expression. The final section will describe some different ways that chronic somatizers attempt to find meaning and come to terms with their suffering.

Patient's Illness Narratives

Examining the illness attributions of somatizers, one can see how strongly their interpretations are shaped by the moral discourse of biomedicine which challenges the legitimacy of medically unexplained symptoms. In the studies which examined patient's illness narratives (Clements et al., 1996; Garro, 1994; Helman, 1985; Peters et al., 1997), almost all somatizers began by describing the physical factors that they viewed as contributing to their symptoms (e.g., previous accidents, physical imbalance, weakness of immune system). While many conceded that psychosocial factors played a contributory role (particularly work-related stress and relationship problems), the psychosomatic sufferers in Helman's study appeared far more willing to accord psychosocial factors an additional contributory role (95% of participants) than the CFS sufferers in Clements et al.'s study (45% of participants). While CFS sufferers have been described as highly driven, active individuals, only 10% of the sufferers in Clements et al.'s study considered their pre-illness lifestyle as a contributing factor. The TMJ sufferers also seemed reticent to look beyond their physical attributions of illness (Garro, 1994). These differences may be due to the

fact that psychosomatic disorders have had a long history of being “psychologized” by professional and lay people alike. In contrast, CFS and TMJ diagnoses are held by sufferers to accord them the legitimacy of a physical condition. According to a socio-historical study of psychosomatic illness, the loss of medical authority since WWII has led many chronic somatizers to embrace newly described “diseases of fashion” that have been popularized by the media (e.g., CFS, TMJ, fibromyalgia, environmental hypersensitivity) as the answer to their long-standing, undiagnosed complaints (Shorter, 1992). Similar observations have been made by Yalom (1980), a renowned existential therapist, who sees the avoidance of assuming personal responsibility in psychosomatic patients as “twice removed.” Firstly, they experience distress somatically rather than psychologically. Secondly, those who acknowledge psychological distress typically attribute it to external sources outside of their control, such as stressful relationships or work conditions.

Regarding the role of personality characteristics, Helman (1985) found that patients with gastrointestinal (GI) disorders were equally as likely as asthma sufferers to describe themselves as being too “sensitive, nervous, tense, or vulnerable.” He also discovered some interesting differences between the two groups. The GI patients tended to describe themselves as people who held onto negative emotions. One person described her experience as: “anger, tension, hostility, fear, any kind of upset - I think of them as being crammed into my colon” (p. 18). Many GI patients considered it therapeutic to be able to express or “unload” negative emotions to another person whom they could trust. In contrast, the asthmatic group tended to present themselves as people who were overly sensitive to social and physical triggers. Rather than “holding too much in” they “took too much in,” and were much more likely to avoid stressful situations than to express their distress. A similar sense of “over-permeable” boundaries is also reflected in the comments of an asthma sufferer from another study (Kruger, 1981). Through existential therapy she came to understand her asthma attacks as being triggered when people “invaded” or “intruded on” her personal space. Experiencing herself as a “rag-doll” who allowed everyone else to live her life for her, she became able to ameliorate her symptoms once she realized that she had the right to express her needs and to prevent this intrusion.

Bodily Manifestations of “Untold Stories”

Given the pre-narrative quality of lived experience, Ricoeur (1984) believes that untold or repressed stories demand to be narrated. Through the process of narration, these pre-figured experiences can be taken up by the self and contribute to a more meaningful, coherent sense of identity. The association between somatization and trauma was recently explored in a study which recruited women with somatization disorder who had experienced physical, emotional and/or sexual abuse in childhood and adulthood (Morse, Suchman & Frankel, 1997). Each of the women described a life-long pattern of seeking medical help for distressing bodily symptoms. Survivors of childhood trauma learn from an early age to hide their experiences from others and to minimize or deny their own feelings and experiences. Living in a continuing cycle of shame and secrecy, the majority of these women had felt unable to disclose their experiences until they entered psychotherapy as an adult.³⁵ Seven of the ten women had come to understand the origin of their symptoms in their early abuse experiences. The mechanisms they described included: “identification with family members who had symptoms, development of nurturing relationships with physicians and nurses...the symbolic reenactment of the abuse or body memories, and the expiation of guilt over childhood sexual behaviour through the pain itself and subsequent invasive procedures” (p. 474). While some participants described gaining this insight through therapy, others arrived at it on their own. This understanding has reportedly enabled them to tolerate their symptoms better and to decrease their health care use. The experiences of these women appear to support the view that the therapeutic process of narrating untold or repressed stories can help somatizers make sense of their symptoms and experience a more integrated, coherent sense of self.

Resistance versus Acceptance

From the qualitative studies reviewed, it appears that most somatizers experience their body as a malicious entity that they must resist, fight against, and attempt to control. Searching

³⁵ Eight of the ten women were in psychotherapy at the time of the study. Given the reported reluctance of chronic somatizers to engage in psychotherapy, the level of insight of these women is likely atypical.

for the meaning behind their suffering becomes equivalent to searching for a physical cause, with many finding it too threatening to consider that their bodily dys-function may be a sign of “disease” in other aspects of their life. The goal of most somatizers is to re-establish their pre-illness lifestyle and relationship with their body. One woman persisted through fourteen years of inconclusive medical consultations before receiving a diagnosis of TMJ (Garro, 1992). Since then, her life has regained a certain sense of meaning and direction. She attributes all of her current and past physical symptoms (as well as emotional swings and learning difficulties) to TMJ, and has spent six subsequent years attempting to regain control over her body through various treatments and recreational activities. Not all somatizers are as resistant as this woman to considering the potential contributory role of psychosocial factors. However, few are willing to accept that there is no physical basis for their symptoms.

In contrast, there appears to be a minority of somatizers who come to accept their limitations, set new goals, and find different ways to bring meaning to their lives. Rather than fighting against their body, they come to accept it: “It’s like I know it’s a part of me now and it really doesn’t have to be as bad as it is if I work with it instead of against it, if I really integrate it into my day (Jackson, 1994, p. 204). Others attempt to forge a more harmonious “mind-body” relationship, with both mind and body serving as valuable sources of knowledge and guidance. For example, two TMJ sufferers used meditation and visualization techniques to listen to and communicate with their bodies (Garro, 1994). Once individuals come to respect their physical limitations, they appear to set more realistic goals and to use their energy to enjoy more simple pleasures, such as going for a walk or playing with their children (Hughey, 1991).

Finally, although it has been reported infrequently, some somatizers come to view their illness as a sign that they need to make significant changes to their values and lifestyle. One TMJ sufferer described herself as an aspiring university professor, driven to excel and to live up to the expectations of herself and others (Garro, 1994). After unsuccessful efforts to control her body through medications, she came to interpret her illness as a message from her body, saying: “We hurt, and you’re not paying attention. You’re trying to live this disembodied state of mind and you haven’t attended to yourself as a person.....stop acting like super scholar and start living like a human being” (Garro, 1994, p. 784). While continuing to work as a professor, she has turned to

art to help others know “that there is a way through the pain” (p. 785). In her words, “I can’t help but feel like...not that there’s a purpose to my pain, but that I haven’t let it triumph. I’ve made it into a way to make connections to people” (p. 785). This woman became able to transform her suffering into something which gave meaning to her life, through helping others.

Conceptualizations of Somatization

This section will describe how existential phenomenology can advance our understanding of somatization. It will begin by examining the contributions of Merleau-Ponty (1962), Boss (1963, 1979), and van den Berg (1972) to a phenomenological understanding of conversion hysteria, psychosomatic illness, and chronic pain. This will be followed by a discussion of existential and social-cultural issues that may be contributing to somatization.

Manifestations of Somatization

Conversion Hysteria and Psychosomatic Illness

Maurice Merleau-Ponty

According to Merleau-Ponty (1962), the lived body actualizes the state of our existence. As embodied-subjects-in-the-world, our body is not experienced as an object or an anatomical mass but as the “living envelope of our actions” through which we perceive and interact with the world (p. 188). Consciousness and body are viewed as an intertwined unity. In his words, “Man...is not a psyche joined to an organism, but the movement to and fro of existence which at one time allows itself to take corporeal form and at others moves towards personal acts” (p. 88). When bodily events become dominant, as in cases of conversion hysteria, they demonstrate how the body can be used to escape from intolerable situations by temporarily bringing one’s existence to a standstill. Merleau-Ponty uses the example of a girl who lost her voice and became anorexic after she was forbidden to see the man she loved. Unable to “swallow” this prohibition, the girl’s ability to communicate with others and to move towards a future became arrested in a

bodily symptom. As Merleau-Ponty describes, “existence is tied up and the body has become ‘the place where life hides away’” (p. 163). According to Merleau-Ponty, we always retain the power to withdraw from the world by drawing our attention to the pains and inner sensations of our bodies. In his words, “when I become absorbed in my body, my eyes present me with no more than the perceptible outer covering of things and of other people, things themselves take on an unreality...and the present itself...takes on an air of eternity” (p. 165).

Merleau-Ponty (1962) is quick to dispel the notion that hysterical symptoms are an act of personal will. Rather, they are the pre-personal, bodily expression of an “ambivalent” consciousness: “if the hysterical patient is a deceiver, it is first and foremost himself that he deceives” (p. 161). The girl does not “cease” to speak, she “loses” her voice, as one loses a memory. Merleau-Ponty rejects the psychoanalytic notion that painful conflicts or experiences survive in the “unconscious” as mental representations of particular memories or events. Rather, these experiences become “sedimented” in our habitual, pre-personal body as general structures or ways of being. Based upon the notion of operative intentionality, the sphere of lived intentions is viewed by Merleau-Ponty as much larger than that of conscious thought (see page 34). Thus, in hysteria and repression, there is a bodily knowing of the situation that is experienced outside of conscious awareness. As Merleau-Ponty eloquently states, the “lost” memory or voice can only be recovered when one’s bodily existence “unfreezes” and opens out upon the world again.

In addition to conversion hysteria, Merleau-Ponty (1963) offers some key insights into mind-body relations that can help us understand why a dualistic relationship between mind and body seems more apparent in somatizing patients (or any people with mental or physical illness) than in people who are healthy. When weak, fragmented or rigidified structures are operating, these fragmented structures appear to have a certain autonomy and are perceived as evidence of a cause-effect relation between body and mind. However, to the degree that various aspects of a person’s being are integrated, the apparent duality disappears. As Merleau-Ponty (1963) states: “everything which revealed partial and independent dialectics without relationship to the total signification of his life, has been assimilated and centered in his deeper life. Bodily events have ceased to constitute autonomous cycles, to follow the abstract patterns of biology and psychology, and have received a new meaning” (p. 203). Hence, while the frequent appearance of

separation between mind and body may have a place in pathology, “the body of the normal subject...is not distinct from the psychological” (p. 181).

Medard Boss

Boss is an existential-phenomenological psychiatrist who was born in Switzerland where he studied medicine and psychoanalysis. In “Psychoanalysis and Daseinsanalysis,” Boss (1963) took up and developed Binswanger’s phenomenological critique of the Freudian paradigm based upon Heidegger’s ontology.³⁶ In 1979, he extended his critique to the vast realm of general medicine in “Existential Foundations of Medicine and Psychology.” These works contain extensive discussions regarding hysteria and psychosomatic illness.

A basic postulate of Daseinsanalysis is that all illnesses reflect a loss of human freedom and openness (Boss, 1979). Whether the illness is considered psychoneurotic, somatogenic, or psychosomatic, a person is unable to freely carry out potential ways of being. This loss of freedom affects the patient’s existence as a whole, including his/her bodyhood, spatiality, temporality and attunement. In Boss’ words, “it is a matter of letting it be revealed for each patient in which way basic traits of his nature are not able to unfold fully” (1979, p. 69).

For Boss (1963), the body is “one of the media through which the world-disclosing relationships which constitute existence are carried out” (p. 140). Hence, psychosomatic symptoms are viewed as reflecting the bodily carrying out of a specific world-relation. Symptoms can develop in two ways: 1) when a specific world-relation has become impaired or arrested, or 2) when one’s whole existence becomes dominated by one kind of relation to the world. Boss (1979) describes “the stress syndrome” as a modern affliction which contributes significantly to the development of psychosomatic illness. In his opinion, psychosomatic symptoms reflect “the bodying forth of an overstrained relationship to the world” (p. 207). These symptoms can develop with or without tissue damage.

In describing the first way that psychosomatic symptoms develop, Boss (1963) challenges the psychoanalytic distinction between *meaningful* hysterical symbolization versus *meaningless*

³⁶ The term *Daseinsanalyse* was originally introduced by Ludwig Binswanger to characterize his method for investigating psychopathological phenomena. However, Binswanger’s method came to be referred to in American publications as “existential analysis,” and Daseinsanalysis came to designate Boss’ approach exclusively (translator’s note, Boss, 1963).

organ-neurotic functional disturbances. From a Daseinsanalytic perspective, both types of neuroses involve world-relations which are prevented from being carried out openly in a voluntary, responsible, interpersonal manner. In such cases, the relationships which are not openly admitted carry themselves out in the somatic realm. Whether a hysterical or organ-neurotic symptom appears is dependent upon the *degree of concealment* required to keep the meaning hidden. The greater the prohibition against carrying out a specific world-relation, the further it has to retreat, from the hysterical language of gestures (whose meaning is only partially veiled), to the more thoroughly disguised organ-neurotic phenomena (e.g., ulcers, heart palpitations) which take place inside the body.

Boss (1963) illustrates the blocking of a world-relation through the case of a young girl of 19 who frequently became excited while passing by a handsome gardener. As an erotic world-relation threatened to form between her and this desirable man, her legs suddenly became paralyzed. Due to her puritanical upbringing, this woman was not able to perceive the erotic quality of this potential world-relation so that she could respond to it directly and openly. Instead, the world-relation could only be met and blocked through the bodily sphere of her existence. Boss described another woman with similar hysterical symptoms. Once the physician hinted at the sensual nature of her gestures, greater concealment became necessary. Her symptoms subsequently shifted from hysterical pelvic convulsions to more organ-neurotic symptoms, including excessive vaginal discharge and a pathological heart condition. Boss argues strongly against the view that these physical symptoms *express* or *symbolize* repressed sexual urges. Being an existential-phenomenologist, he argues that the patient's existence, "attuned to the 'overflow of love,'" *carried itself out directly* in the patient's hysterical and organ-neurotic symptoms (p. 166). In his opinion, any other interpretation goes beyond the phenomena as experienced, and thus represents an arbitrary intellectual abstraction.³⁷

Boss (1963) describes a second way that organ-neurotic symptoms can develop. Even if there is no prevention of carrying out a possible world-relation openly, organ-neurotic symptoms can occur when "the whole existence of a person is one-sidedly...reduced to one kind of relation

³⁷ While Boss argues strongly against the symbolic nature of psychosomatic symptoms, most existential-phenomenologists would suggest that bodily symptoms do carry symbolic meaning. However, in agreement with Boss, they would argue against the validity of interpretations based upon theoretical frameworks such as psychoanalysis.

to the world” (p. 144). For example, Boss describes an anorexic as openly and voluntarily reducing almost all of her potentialities to one existential world-relation: the denial and avoidance of becoming a sexually mature feminine being. The result puts such a severe strain on the body that it is drawn into the denial by ceasing the production of hormones which stimulate the release of ovaries. In another example, Boss describes the world-relations of ulcer patients as exaggeratedly oriented toward “seizing, overpowering, and taking possession” (p. 144). The focus of these patients becomes so excessively reduced to this world-relation that the somatic realm becomes subordinated to the intentionality of *Dasein*.

Within a psychoanalytically-oriented approach to psychosomatic medicine, the question has frequently been raised as to whether or not the psyche *chooses* a specific organ to express or symbolize a particular conflict. Boss (1963) argues that terms such as “choice” and “organ” are inappropriate, as “it is always a relation to the world...which determines the specific corporealization at any given time” (p. 168). The somatic realm where symptoms develop is dependent upon the specific *kind* of world-relation which is not being carried out freely. For example, Boss suggests that the heart or the hand could be involved whether the arrested world-relation is related to love or to hate. However, he would not expect a person holding back from an erotic world-relation to develop colitis, as the colon belongs to a world-relation of expulsion or retention. In his words, “the disturbance of a bodily realm *is* the restricted world-relation itself – its somatic part” (p. 170). Cohn (1997) provides a Daseinsanalytic interpretation of a more recent psychosomatic case involving a tense, withdrawn university student suffering from severe eczema. As a picture of his world emerged, it became clear that his skin was embodying a rule reflective of the boundaries in his relationships: “Don’t touch - don’t be touched.” Hence, his body reflected disturbances in his relational world through the boundary of his skin.

In summary, Boss’ Daseinsanalytic approach conceptualizes psychosomatic symptoms as the embodiment of disturbed world-relations which reflect an impairment in one’s ability to carry out these relations in a voluntary, responsible, interpersonal manner. Hysterical gestures and organ-neurotic symptoms both carry out the same world-relationship, but conceal this relationship to different degrees. Thus, the primary concern is not to search for the “psychogenic” cause of a symptom, but rather to determine the specific kind of world-relation that is being

carried out somatically, and to understand those individual and social-cultural factors which are disrupting the world-relation from being carried out freely.

J. H. van den Berg

J. H. van den Berg is an existential-phenomenological psychiatrist who was born in Holland in 1914. He is the originator of “metabletics,” or the science of change, which is based upon the assumption that human nature changes as social and historical conditions change. Van den Berg became known in the Anglo-American world through the translations of several major works, including his introduction to phenomenological psychiatry, “A Different Existence.” In this book, van den Berg (1972) shows how a phenomenological therapist would use description to seek the lived meanings behind a patient’s complaints as they evolve around four themes: the world, his body, other people, and time. He does this by presenting an extensive case study of a patient who was experiencing medically unexplainable chest pains and weakness in his legs (*body*). The patient also complained that the streets seemed wide and the houses seemed like they were about to fall (*world*), that he had no real contact with others and experienced most of them as life-less puppets (*other people*), and that he perceived his childhood as bad and avoided the future as much as possible (*temporality*).

To discover the deeper meaning of the patient’s psychopathology, van den Berg (1972) explored the contextual implications of his lived meanings. The patient’s body, as well as the buildings in his life-world, seemed about to collapse. His pre-reflective body “had lost the ability to stand” (p. 55). Other people were experienced as collapsible wooden puppets. And the patient’s future collapsed under the weight of a chaotic past. Thus, the patient felt anxious, strange, lonely, and disconnected. Van den Berg found this pattern so prevalent that he refers to psychopathology as the science of loneliness and isolation.

Distinguishing between the anatomical body which we *have* and the pre-reflective body which we *are*, van den Berg (1972) argues that the relations between physicians and psychosomatic patients are frequently strained because they speak of *different* organs. The cardiologist views the heart as a “hollow muscle” while the patient experiences his heart as that which “can be broken by a gesture or a glance” (p. 54). Van den Berg concludes that

psychosomatic symptoms can only be understood by examining the pre-reflective, dialogical relationships that exist between one's self, body and world.

Chronic Pain

Van den Berg (1972) also provides a brief example to demonstrate how some forms of chronic pain can reflect a disturbance in one's relational world. He discusses the case of a factory workman who fell and broke his leg. While the doctors insisted that his fracture had healed, the workman complained that he was in too much pain and was unable to return to work. Prior to the accident, significant tension had existed between the workman and his employer. Thus, when he fell, "he fell out of his difficulties" and found that a life of physical pain and lameness was somehow easier to bear than "the pain of a constant humiliation and the lameness of an enslaved life" (p. 94). Rather than reflecting a deliberate deception, van den Berg argues that the workman had likely concealed the meaning of his pain so forcefully that he believed his own story to be true. According to van den Berg, "self-concealment is equal to leaving one's body and the surrounding world to others in a self-chosen manner" (p. 113). Thus, the patient's recovery could not occur by simply healing his "anatomical" body. Instead, it required a healing of the conflictual relationship between the patient and his employer that was being concealed in his pre-reflective body.

Existential and Social-Cultural Dimensions of Somatization

Based upon the patient narratives and existential conceptualizations, two characteristics of somatizers seem to emerge: 1) the need to suppress the awareness or expression of negative emotions from self and/or others, and 2) the need to meet the demands and expectations of others to gain their acceptance and approval. These needs seem more intensified and more hidden from awareness among sufferers of chronic pain and fatigue versus psychosomatic illnesses or less severe forms of somatization. Those suffering from CFS or TMJ appear to be more alienated from their emotions as well as their bodies. Propelled by a need to meet (and often exceed)

parental and societal standards of success, these individuals appear to routinely push themselves to engage in multiple career, family and social activities without taking into consideration their physical or emotional needs and limitations. Similar to the earlier shift from hysterical to organ-neurotic symptoms (Boss, 1963), perhaps the chronic somatizers of today are experiencing a greater need for self-concealment regarding the meaning of their symptoms. When psychosomatic symptoms are experienced periodically in a localized area of the body, it is much easier for the sufferer to tie the symptoms to psychosocial triggers. In contrast, the meaning of chronic, non-specific and debilitating pain and fatigue is much less obvious. This greater need for self-concealment might help to explain the historically unprecedented rigidity with which chronic somatizers at the end of the 20th century are attributing their symptoms to popularized, “organic” diagnoses (Shorter, 1992).

Submitting to the pressures of social conformity, the experience of somatizers appears to reflect an alienation from self and others, and a self-deceptive refusal of the freedom and responsibility to live authentically. This tendency towards inauthenticity and alienation can partially be explained by the neuroticizing factors of contemporary Western society (May, 1953, 1991; van den Berg, 1971). For decades, existential-phenomenologists have been pointing to the modern era of technology and industrialization as a key source of estrangement from self, others, nature and one’s body. With the increasing mechanization and “bureaucratization” of daily life (Gadamer, 1996), people are “less able to see themselves except as mechanisms whose purpose it is to function as cogs in a machine geared to production” (Boss, 1979, p. 195). Max Frisch refers to technology as “the knack of so arranging the world that we do not experience it” (cited in May, 1991, p. 57). In a world dominated by the natural sciences, people have come to view abstract scientific explanations as more real and valid than their personal lived experience. As people’s lives have become more and more immersed in technology, opportunities for meaningful human contact have significantly declined, leading to increased isolation, fragmentation and the loss of a sense of community. In addition, many people have developed an impersonal, objectified attitude toward nature, including their bodies. Viewing it as a machine, most adults treat their bodies “as though it were a truck to be driven till it runs out of gas” (May, 1953, p. 107). In fact, people are generally more attentive to the needs of their cars than they are to their bodies.

In addition to technology, the post-modern era has ushered in an escalating period of social, political and economic upheaval that is unprecedented in terms of its magnitude and rate of change. On a global level, people are confronted daily with stories of violence, wars, human suffering and threats of mass destruction. In a time of unstable financial markets, job layoffs, and diminishing income, employment has become an increasing source of stress and uncertainty, particularly for parents who are trying to balance the demands of work and family.

We are also living in an age of transition where the beliefs and values of society have come seriously into question. No longer do we look to the family, church or state as our primary sources of strength, guidance and solace in times of stress. The structure of the modern nuclear family has crumbled and been replaced by a multitude of diverse family arrangements (e.g., single mothers, childless couples, gay/lesbian families) that form and dissolve with much greater frequency than families of the past (Mook, 1999b). The roles, functions and boundaries between parent/child, husband/wife, and home/work have also become much more fluid and unclear, leaving many families “fraught with insecurities and uncertainties as they move forward and backward in experimenting with the new and nostalgically reaching back to the old” (Mook, p. 23). Children feel pressured to achieve and become competent at an early age without the protection, guidance and support they need from their parents to feel secure (Elkind, 1994). In addition, high divorce rates have led to greater social isolation as adults are living alone more frequently and for longer periods of time. These pressures and uncertainties have led to increased levels of stress and somatization for all members of the family (Elkind, 1994).

As the influence of the family has diminished, so too has the influence of church and state. Van den Berg (1971) asserts that the paramount neurosis-producing agent of our times is repression of the spiritual domain of life. For many people in our secularized society, spirituality is no longer a source of strength and guidance. Instead, it has “receded to the unconscious,” leading many people to experience loneliness and fear (van den Berg, 1971). With increasingly high rates of corruption and unethical behaviours by church, government and business leaders, cynicism has become widespread and people are left feeling lost and confused. According to May (1991), a recent university student described his graduating class as “not knowing how it ‘relates to the past or the future, having little sense of the present, no life-sustaining beliefs, secular or

religious,' and as consequently 'having no goal and no path of effective action'" (p. 21). Without the social institutions that traditionally provide a sense of order, coherence and community, people are experiencing high levels of anxiety, isolation, alienation and fragmentation (Mook, 1975).

The neuroticizing effects of these societal changes have clearly impacted Western society in many ways, including increased levels of somatization. However, one cannot ignore the existential dimension when considering key issues such as inauthenticity and alienation. According to May (1958), symptoms of anxiety, alienation and fragmentation reflect the state of a person whose "relation to the world has become broken" (p. 56). Many people have lost their sense of being and their sense of relatedness as a Being-in-the-world. They often do not know what they want or feel or value. Recalling Heidegger's discussions regarding inauthenticity and the "fallenness" of everyday *Dasein* (see page 19), humans are anxious because of a self-deceptive refusal to live authentically in the face of ontological anxiety and guilt. These existential responses arise when some emerging potentiality is denied because it is experienced as too threatening to one's present sense of security. May (1991) considers the fear of not being accepted as the greatest threat and greatest cause of today's anxiety. Since living authentically would risk rejection by being different from the norm, much of contemporary society is engaged in fleeing from awareness of the ontological "call of conscience" to fulfill their unique potentialities.

This flight from ontological anxiety takes many forms. To avoid rejection and social isolation, people repress awareness of their negative emotions and avoid situations which could cause them to feel anxious, hostile or aggressive toward others. They tend to align with and internalize the expectations of others and attempt to play whatever role the situation requires. People can also experience a desperate need to be around others to counter their feelings of alienation and isolation. Similarly, compulsive activity can be a way of covering up anxiety and escaping from self-awareness. People can get a "pseudo and temporary sense of aliveness by being in a hurry, as though...being busy is a proof of one's importance" (May, 1953, p. 117). However, "the compulsive activity is never action *for its own sake*...it is action in the service of flight" (May, 1991, p. 180). According to May (1991), much of this activity is driven by the myth

of the American Dream which sanctions the aggressive, individualistic and competitive pursuit of material success and prestige. People engaged narcissistically in this pursuit can find themselves pulled toward addictive or hedonistic behaviours to escape from feelings of apathy, boredom, meaninglessness and despair. These emotions and escapist behaviours are all defensive responses to experiencing ontological anxiety and guilt.

Finally, people can unconsciously flee from fulfilling their potentialities by becoming physically ill (May, 1953). Rather than experiencing a vague “floating” anxiety, physical illness or pain can give a person something concrete to worry about and deflect responsibility away from themselves onto health professionals to fix the problem. Physical illness can also provide a much-needed respite for persons feeling overwhelmed by excessive and unrealistic demands, whether they be imposed by self or others. When people are under constant stress and push their bodies to work without rest, they open themselves up to psychosomatic and physical illnesses of all sorts. Shorter (1994) believes that women are particularly vulnerable to psychosomatic illness because they “have always born the greater burden of unhappiness” through economic, physical and psychological misery. According to Shorter, the rate of psychosomatic illness has consistently been higher among women than men, regardless of culture or historical period. In 1980, two physicians described a population of symptomatic young women who, “overextended by peer pressure, social demands, and their own aspirations,” acquired somatoform symptoms as “an excuse for their recent failure to live up to their growing responsibilities” (Shorter, p. 87). As Shorter states, “the lives of women at the end of the 20th century, with ‘two careers’ of job and family strapped to their backs, retain the potential for misery as much as ever” (p. 87).

May (1953) proposes that all illness (physical or psychological) should be taken “not as periodic accidents which occur *to* the body...but as nature’s means of re-educating the whole person.” He refers to a tuberculosis patient who learned from his disease that he had been trying to be something he was not: “It is as though the disease were nature’s way of saying, ‘You must become your whole self. To the extent that you do not, you will be ill; and you will become well only to the extent that you do become yourself’” (p. 110). The same can be said for people who suffer from somatization. Their symptoms reflect a turning away from the freedom and responsibility to let go of parental and societal expectations and develop their own values, beliefs and potentialities.

Therapeutic Implications

From the previous section it appears that somatizing patients have succumbed to many of the neuroticizing factors of today's culture, thus altering their sense of being and relatedness to the world. Their bodily symptoms reflect alienated aspects of their being which are unable to be expressed freely and authentically. The following section describes how a therapeutic approach based upon existential and hermeneutic phenomenology can help address issues of anxiety, inauthenticity and alienation. It will also include a discussion of non-verbal modalities that can be used to help somatizing patients who have difficulty accessing and verbalizing their emotional and bodily experiences.

Existential Phenomenology

According to Yalom (1980), "existential psychotherapy...focuses on concerns that are rooted in the individual's existence" (p. 5). Practitioners are guided by an existential understanding of man as Being-in-the-world, and have incorporated this understanding in a variety of ways. As many existential therapists (e.g., Daseinsanalysts) were initially trained in psychoanalysis, they remain psychoanalytic in their basic clinical procedure while adopting an existential interpretation of the patient's experience. However, May (1990) argues that existential attitudes can shape any form of depth-oriented psychotherapy. The following section will describe how existential attitudes and assumptions impact upon the therapeutic relationship and the process of therapy. An additional section will briefly discuss some experiential interventions that can be used to help access non-verbal and bodily aspects of lived experience.

Therapeutic Relationship

Most existential therapists describe the therapeutic relationship as a "meeting" or "encounter." According to Phillips (1980-81), "the existential encounter is an authentic relationship which is entered upon with the express goal of helping the patient assume a more

authentic attitude in the rest of his life” (p. 144). The existential encounter is considered important for three reasons. Firstly, it is viewed as a real intersubjective relationship between two human beings rather than between a “therapist” and “patient.” Secondly, it provides a powerful medium for understanding the patient by participating in his/her lived world. Finally, it stimulates self-confrontation and promotes healing and change. Each of these features will be discussed in turn.

Following Buber (1970), many existential therapists believe that psychotherapy is dependent upon the emergence of a type of I-Thou relationship, involving acceptance, selflessness, trust and a “reverence for the patient’s existence and uniqueness” (Moss, 1978, p. 321). As such, the therapist attempts to be fully present and attentive, listening with caring and empathy to the patient’s problems and demonstrating a willingness to share in their experiences of confusion, conflict and suffering. Mook (1987) views the psychotherapeutic encounter as rooted in “mutual respect, belief and hope” (p. 23). By approaching the patient with openness and receptivity, Mook describes the experience of “being-there” where the patient is, “transported” into his/her world of perceptions, feelings and experiences. In her words, “my being-there in intimate sharing and active participation, creates a state of communion in which the self-other boundaries are transcended” (p. 24). Progress in therapy is not considered possible without building an authentic relationship based upon acceptance, trust and faith in the patient’s “ability to be.”

Contrary to the Western emphasis on technique and objectification, existential therapists assume that the human is a “being to be understood” rather than an “object to be analyzed” (May, 1958, p. 81). While assessment tools and standardized interviews can generate knowledge *about* a patient, they cannot provide an empathic understanding of the patient’s being and life world. This type of understanding is only considered possible through the medium of the therapeutic encounter which involves “a kind of union, a dialectical participation with the other” (May, 1958, p. 38). It also involves a sincere attempt by therapists to set aside their presuppositions, distortions and biases to the extent that they are able. This bracketing process enables them to be more fully present and open to participating in the world of the patient. Through the process of “being-there” with the patient, an intuitive understanding of the nature of his/her problems is

born (Mook, 1987). It is clear from this description that techniques do not hold an essential place in existential therapy. Different techniques and therapeutic modalities can be used, as long as they support the central task of understanding and are used with flexibility and versatility, varying from patient to patient and from one phase of therapy to another (May, 1958).

Of course, the goal of existential therapy is not simply for patients to understand themselves better but to become more authentic in their relationships with self and others. Because this goal is different from other therapies, the means of bringing about healing and change are also different. For example, many therapeutic approaches teach patients skills and principles to solve particular problems so that they can be controlled or better managed. However, existential therapists argue that directive approaches run the risk of “robbing the patient...of initiative and responsibility” by providing ready-made tools and strategies (Moss, 1989, p. 201). This is viewed as a form of “intervening care” in which the therapist “acts for the other person” by providing tools which the patient, as passive recipient, can accept or reject (Moss, 1989, p. 201). In contrast, existential therapy is guided by Heidegger’s “leaping ahead” mode of solicitude (see page 18) which Boss (1963) refers to as “anticipatory care.” In this mode of caring, the therapist helps patients “find the courage to risk living” by becoming aware of their unique potentialities and gently challenging them to act on the basis of them (Willis, 1994, p. 71). The therapist assists the patient by confronting resistances or obstacles to change, but leaves it up to the patient to decide upon the nature and direction of change. From this perspective, “cure of symptoms” will be a natural by-product of becoming a more authentic, integrated human being.

Existential therapists are also in disagreement with psychoanalytic practitioners who consider intellectual interpretations of “transference” phenomena as sufficient to promote change. According to Dillon (1984), the function of the therapeutic relationship is to “restructure” the patient’s past, not merely to “rethink” it. In Merleau-Ponty’s words, “it is...a matter of reliving the past as significant in this way or that, and the patient attains to this only through *seeing* his past in the perspective of his coexistence with the doctor” (cited in Dillon, 1983, p. 27). Thus, existential therapy aims to provide the patient with *experiences* rather than interpretations. As May (1958) explains, “to know fully *what* we are doing, to feel it, to

experience it all through our being, is much more important than to know *why*....if we fully know the *what*, the *why* will come along by itself" (p. 83). Hence, change occurs through a "joining of spirits" in the therapeutic encounter rather than a "collusion of intellects" (Willis, 1994, p. 71).

Process of Therapy

In the opening phase of therapy, patients typically begin with the expectation or hope that the therapist will direct the course of therapy and provide solutions to their problems. They may experience a longing for growth, but their fears will initially manifest as a resistance to becoming aware of aspects of their being which they have concealed from themselves. Therefore, the goal of this phase is primarily to develop a strong therapeutic alliance, to gain an initial sense of direction, and to elicit hope and commitment to the therapeutic endeavour. Therapists listen attentively and give patients the space and freedom to discuss their personal and relational problems with minimal interruption. When appropriate, they guide and facilitate the patient's disclosure, accepting and confirming their self-expressions (Mook, 1987). According to Willis (1994), therapists may gently begin the process of self-exploration by calling attention to the over-identified, internalized voices of family members which criticize the patient and issue directives regarding how the patient "should" be. They may also begin to note incongruities in the patient's self-presentation.

As patients grow to trust the safety and healing potential of the therapeutic relationship, the focus of therapy shifts to increased self-exploration and confrontation. Patients are helped to access and clarify their thoughts, feelings and experiences, including disowned and unknown aspects of themselves. As Mook (1987) states, they are encouraged to "risk into the threatening, painful and hitherto closed-off realms of [their] existence" (p. 25). Through the medium of the therapeutic encounter, therapists attempt to intuit and reflect aspects of the patient's experience that are struggling for expression (Willis, 1994). Patients come to rely on their therapist's authenticity to help them recognize when they are relating defensively or inauthentically. Ultimately, patients are challenged to accept the factual givens of their past, to view their lives as a product of personal choices, and to responsibly steer a course "toward a future dimly seen"

(Moss, 1989). To the extent that they choose to meet this challenge, patients become able to let go of parental and societal expectations and to develop their own values, beliefs and potentialities.

Accessing Non-Verbal and Bodily Experience

Willis (1994) is an existential therapist who emphasizes the importance of enlisting the intuitive, imaginative, and body sensing capacities of patients to access their subjective experience more directly. He suggests a number of creative interventions to help cut through intellectual defenses, confront ambivalence and overcome inner divisions. These include guided imagery, dream work, role-playing, meditative exercises, gestalt exercises, art therapy and journal writing. In addition, therapists can help patients attend to and work with their bodily experience (e.g., facial expressions, posture, muscular tension, breathing patterns) or access a bodily “felt sense” by a process called “focusing” (Gendlin, 1981). Aside from dream work, these exercises have not traditionally played a strong role in existential therapy. However, they seem particularly suited to the challenges of working with somatizing patients who have difficulty accessing and verbally communicating their emotional and bodily experience. In fact, Mook (1975) argues that many contemporary patients would benefit from imagery-based experiential approaches because they are already “too fragmented, logical and verbal themselves” (p. 213). She suggests utilizing imaginary, metaphorical and/or allegorical modes of communication to help concretize the patient’s experiencing (Mook, 1987). As it would be beyond the scope of this thesis to discuss each of these modalities, this section will provide a brief description of two experiential interventions: imagery and focusing.

While expressive arts and imaginative play have been used for many years in therapeutic work with children (e.g., Hellendoorn, 1988; Mook, 1998; Singer, 1994) the use of imagery in adult therapy has typically been more limited to the interpretation of dreams or to certain schools of therapy (e.g., psychosynthesis, Jungian analysis). However, there has been a rise in the use of imagery with patients experiencing medical health problems, including chronic pain (e.g., Bresler, 1984; Rossman, 1984). For example, patients can learn to ask questions of an “inner

advisor” regarding their problems or illness. Once they are relaxed, they can imagine themselves in a quiet place and evoke a figure or image which represents the qualities of wisdom and caring. Rossman (1984) describes a patient who complained of aching in his shoulders, neck and head. “In the conversation with his advisor, he had a spontaneous image of himself with armor on his shoulders. He was told that the armor was made of ‘thinking and planning’ and was there to protect him from his feelings” (p. 246). Alternatively, patients can dialogue with an image which directly represents their pain or illness (e.g., a dog chewing on one’s spine) (Bresler, 1984). It seems that by gaining access to their intuitive and imaginative capacities, patients are able to attain wisdom from inner sources “that seem wiser than the ego or personality” (Willis, 1994, p. 186). The promise of imagery is that it helps people connect with their pre-reflective, lived body and access an operative intentionality which “shapes significations without conscious awareness” (Mook, 1998, p. 246). Once individuals come into contact with these primary experiences, they can develop and verbalize personal meanings in an affective, synthetic way and heal feelings of alienation (Mook, 1975).

Focusing is another therapeutic approach which offers significant promise. Influenced by Heidegger, Merleau-Ponty and others, Gendlin (1981) has developed a process which teaches people how to bring “fuzzy, preverbal knowledge into definition and expression” (p. x-xi). He instructs individuals to focus on a particular problem or situation, and wait for a bodily “felt sense” to emerge which reflects “how the situation is lived in the body” (Gendlin, Grindler & McGuire, 1984, p. 259). While the initial felt sense is often vague (e.g., heaviness, jumpiness, tightness), the person remains attentive to the felt sense and to the immediate flow of feelings about the situation. By focusing and dialoguing internally with the felt sense, a series of shifts occur and “new language and new metaphors, appropriate to the fresh understanding emerge” (Gendlin, 1981, p. xii). Focusing is described as an affective, holistic process which allows a constellation of previously hidden emotions and meanings to emerge by connecting with the wisdom of the lived body.

Hermeneutic Phenomenology

Hermeneutic phenomenology encompasses and moves beyond existential phenomenology. It emphasizes the historical, dialogical and linguistic nature of understanding (Gadamer, 1975) and the pre-narrative structure of lived experience (Ricoeur, 1984). Therefore, it pays close attention to the ways in which human experience is co-constituted by familial, social-cultural and historical narratives and traditions. Mook (1991) views hermeneutic phenomenology as relevant to psychotherapy because both disciplines engage in the task of understanding and interpreting “the meaning of human expressions through words, images and symbols” which are often obscure and need to be deciphered (p. 183). Hermeneutic phenomenology provides a method for understanding verbal and non-verbal communications (e.g., play, art) and for interpreting the meanings of actions or experiences which are too veiled, over-determined or symbolic to be revealed through phenomenological methods alone. Given its recent emergence as a field of study, the implications of hermeneutic phenomenology for psychotherapy have not been as clearly drawn as they have been for existential phenomenology. Mook (1989, 1991, 1994, 1999) makes a significant contribution by describing her application of key insights of Gadamer and Ricoeur into therapeutic work with children and families. The following section will describe the implications of hermeneutic phenomenology on the therapeutic relationship, the process of therapy, and the interpretation of non-verbal and bodily experiences.

Therapeutic Relationship

A hermeneutically-informed therapist would argue that the meanings, narratives and experiences of patients can only be understood, interpreted and transformed within an authentic and supportive therapeutic dialogue. Through a process of dialogical and interpretive inquiry, a deeper understanding of the patient’s lived experiences and actions can emerge. This intersubjective process provides a foundation for the creation of new narrative structures that are more cohesive, complete and intelligible (Mook, 1989). To reduce the risk of imposing personal

biases or making premature interpretations, therapists are encouraged to follow a number of principles.

Firstly, therapists should recognize that their efforts to “set aside” personal prejudices will always be incomplete. Therefore, they must be watchful of the impact of their biases and allow them to be challenged and modified by the therapeutic dialogue. This requires a stance of humility, open-mindedness and genuine respect for the value of the patient’s perspective. It also requires a tolerance for ambiguity and uncertainty and a receptiveness to the plausibility of multiple perspectives.

Secondly, the therapist should attentively strive to grasp the patient’s meanings and intentions as comprehensively as possible before considering possible deeper, hidden meanings of which the patient is unaware (Mook, 1994; Sass, 1998). This helps the therapist stay close to the patient’s experience and reduces the risk of presenting inaccurate or biased interpretations. While Sass acknowledges the importance of looking for the “unsaid” meanings, he argues for the need to find an appropriate balance “between empathy and confrontation, between surface comprehension (hermeneutics of intention) and a hermeneutics of suspicion, [and] between reticence and self-expression” (p. 293). Naturally, it is always important for therapists to be exploratory and tentative when putting forward possible meanings or interpretations for the patient to consider.

Keeping these principles in mind, the therapist facilitates open-ended, exploratory conversations whereby patient and therapist share, reflect upon and modify their perspectives on particular issues. This process leads to a broadening of each person’s unique horizon of understanding until there is a “fusion” and a new understanding is born (see page 43). Thus, therapist and patient are able to arrive at a mutually shared understanding that transcends their individual perspectives and provides a foundation for therapeutic change.

Process of Therapy

In the beginning of therapy, patients share stories with the therapist that are often “emotionally laden, fragmented, conflictual and incomplete” (Mook, 1989, p. 262). They seek

meaning out of their chaos and confusion to help clarify and resolve symptomatic problems that appear unintelligible. As therapist and patient tell and listen to each other's stories, the therapist also listens for and facilitates the discussion of potential stories which are "as yet untold" but cry out to be narrated (Mook, 1989). From this dialogical process, a deeper and more complete understanding and interpretation emerges. According to Mook, this process of narration can be seen as "analogous to the configurational act when the different perspectives and incomplete stories are gradually configured into a more complete, cohesive and intelligible whole" (p. 262).

Given the constitutive role of language, the creation of a new narrative structure is far more powerful than a simple intellectual exercise. From a hermeneutic perspective, it is clear that the structure of language and experience are deeply intertwined. For example, the words of patients can describe their experience of "a world that discloses no hope, a world with no words for emotion, or a world in which things happen to a powerless, passive individual" (Moss, 1989, p. 206). Therefore, it can be deeply transformative for patients to linguistically define themselves and their world in a different way and have previously unnarrated experiences brought into the realm of language (Mook, 1989; Moss, 1989).

A hermeneutic approach would disagree with social constructionist approaches to narrative therapy because proponents hold a relativistic view of truth and therefore rely solely on pragmatic criteria for determining the value of new narratives (Chessick, 1990; Guignon, 1998). While stories may be subject to on-going revision, they can still be grounded in and reflective of the patient's experience and life history. According to Guignon (1998), "deciding which story is the best or truest will depend on such factors as the scope of what is explained; the quality of the future it implies; its applicability to new situations; its ability to display past events and actions as meaningful in relation to the agent's unfolding projects; the way it presents the person's life as having coherence, continuity and direction; and its plausibility in comparison with other possible stories" (p. 574). He also notes that, even without absolute criteria for validating a narrative, this rarely poses a problem in practice. "As beings whose very being is shaped by stories, we are remarkably good at spotting the truth in the stories we tell" (p. 575). Guided by the works of Gadamer and Ricoeur, therapists can dialogue with and reflect upon the stories and experiences of patients to arrive at a mutual agreement regarding the most probable interpretation of their

experience.

Interpreting Non-Verbal and Bodily Experience

According to Gadamer (1996), a hermeneutic approach to therapy is particularly called for with psychosomatic patients because they are driven by anxiety to keep feelings, desires and experiences out of their awareness. The therapist is thus challenged to “reach understanding with the patient, even where the patient withdraws from such understanding” and is invested in keeping hidden what is being expressed through his/her bodily symptoms. Experiential therapeutic work can begin the process of accessing and revealing the buried and unknown aspects of the patient’s inner world. Sometimes the meaning of dreams, images or bodily sensations will seem clear and self-evident to the patient. However, more often than not, the meaning will be veiled with multiple interpretations possible. Therefore, the question remains as to how symbolic images, dreams, and bodily symptoms should best be interpreted.

Mook (1999a) is one of the few therapists who has attempted to describe a phenomenological-hermeneutic approach to interpreting imaginative symbolic texts in therapy. She reminds us that “interpretation applies to the whole dialectical process that encompasses both understanding and explanation as two different phases in the hermeneutic circle” (p. 179). While focusing specifically on the interpretation of a child’s imaginative play session, she describes a number of principles which are applicable to the interpretation of all forms of imaginative symbolic communication, including dreams. For example, a therapist presented with a patient’s dream should first suspend reference to reality and attempt to understand the text of the dream before considering the relevance of the dream to the patient’s world. This would involve exploring and reflecting upon the whole-part-whole relations of the dream text, and submitting possible interpretations to the hermeneutic circle until one emerges that seems most probable. In appropriating the meanings of the dream to the patient’s real world, the therapist should be careful to situate the dream text within the larger context of the patient’s life-world, including his/her life history. Mook observes that a child’s play text “may project not only his past and present conflicts but also his possibilities towards new ways of being and relating” (p.

184). In addition, the therapist should take into account the meanings and interpretations that have been derived from previous dreams and therapy sessions. While hypotheses may be generated by dialoguing with theoretical frameworks (e.g., psychoanalysis), these hypotheses must be submitted to the hermeneutic circle. In the end, all interpretations posed by the therapist are necessarily tentative and subject to modification and verification by the patient. Through the dialogical process described earlier, the patient and therapist will ultimately arrive at a mutually agreed upon interpretation of the dream through a fusion of their respective horizons of understanding.

To interpret the meanings of bodily symptoms in somatizing patients, one would need to draw upon the existential-phenomenological conceptualizations of somatization and the therapeutic implications of both existential and hermeneutic phenomenology that have already been discussed. This would include a phenomenological analysis of the patient's life-world, as described by Boss (1963) and van den Berg (1972), to identify the disturbed world-relations which are being carried out somatically. It would also include an exploration of the personal, familial and social-cultural narratives which may be playing a co-constitutive role in the patient's development of somatization. In addition to an authentic, supportive and dialogical therapeutic relationship, experiential exercises can be used to help patients access, understand and interpret the meanings concealed within their suffering body so that they can heal alienated aspects of their being and live more freely and authentically.

Conceptualization of Mary's Case

To preface this discussion, it should be made clear that a phenomenological-hermeneutic conceptualization of Mary's case would require much more detailed information than is available from the current case description. It would entail a detailed case history and a series of in-depth interviews to disclose Mary's life-world and the narratives which co-constitute her life history and experience. For these reasons, the following is a necessarily incomplete conceptualization based upon the information available.

From a Daseinsanalytic perspective, psychosomatic symptoms are viewed as the

embodiment of disturbed world-relations. In Mary's case, there are a number of world-relations that are prevented from being carried out freely in a voluntary, responsible, interpersonal manner. These disturbed world-relations are reflected in her relationship to her self, to others, and to her body, which will be discussed in turn. Temporal disturbances are viewed as central to Mary's problems and will therefore be integrated into the discussion.

As temporal and historical beings, our past is carried forward into the present, constituting our conception of ourselves and our future possibilities. Mary's present world appears to be strongly shaped by unresolved issues related to childhood experiences that have been pushed out of conscious awareness. No matter how many parental responsibilities she took over, or how hard she tried to be the perfect child, she was never able to stop the fighting, the drinking and the dysfunction that went on in her family. As a result, she appears to have unknowingly adopted and carried forward a generalized stance towards the world that states: "It must be my fault. I should have been able to make it better." The feelings of guilt and shame generated by this self-defining narrative have impaired her ability throughout her life to determine what is reasonable to expect of herself and others. She describes many instances of self-doubt, worry and guilt over perceived "negative outcomes" in her family and work life that she should have somehow been able to prevent. She views herself as an inadequate mother and feels guilty for inadvertently teaching her children to deny and suppress their emotions. Somehow, she should have been able to prevent the emotional and behavioural problems of both her children, including her son's addiction to cocaine. With respect to work, Mary's recent escalation of pain and fatigue coincides with guilt and worry over how she may have inadvertently contributed to the firing of her V.P. Without allowing herself to view her parents' conflict and alcoholism as *their* responsibility and not hers, she has been unable to look beyond herself to consider the potential responsibility of others (e.g., husband, children, co-workers, supervisors) towards the perceived "negative outcomes."

Mary states that she learned to deny and suppress her emotions from the example provided by her parents. One could imagine this happening in a number of ways. Her father numbed the experience of painful emotions through alcohol. Her mother battled with her father to quit drinking and behave more responsibly. The expression of her mother's feelings and

desires resulted in intense conflict which failed to change her father's behaviour. Ultimately, her mother resigned herself to the situation and escaped from her own feelings of misery and helplessness through alcohol. Such experiences could conceivably have taught Mary that expressing her needs and feelings would only lead to conflict or withdrawal, and would ultimately be futile. Therefore, Mary learned to suppress her own painful emotions and unfulfilled needs. She describes a lifetime pattern of over-utilizing her rational, intellectual abilities and under-developing her ability to identify and articulate her emotions. Rather than escaping from painful emotions and unmet needs through alcohol, Mary escaped through compulsive activity and workaholism. Her work provided an escape from the chaos at home, and allowed her to engage in activities which gave her a sense of competence, self-esteem and control. Mary continues to relate to her world by focusing on what she can actively do to keep herself busy and distracted from her thoughts and emotions.

In her interpersonal relations, Mary describes a life-long pattern of seeking acceptance, validation and approval from others to boost her self-esteem. To meet her need for acceptance, she has typically avoided conflict and strived to meet or exceed other people's expectations. Again, this is an example of unmet emotional needs from Mary's childhood being carried forward into the present. Mary struggled to be accepted by her peers in high school and felt deeply hurt when her brother, whom she idolized, paid little attention to her during those years. (Describing herself as not having fully grieved her brother's death, one may wonder if she is keeping ambivalent emotions towards him out of her awareness.) In her work, Mary believes that her perfectionism and Type A personality have been driven, in part, by her worry over other people's perceptions. Mary has typically avoided conflict with others by assuming primary responsibility for problematic situations and by denying or minimizing her own conflictual emotions. Held back by feelings of guilt, self-doubt and worry, Mary was unable, in her final year of employment, to express and act on feelings of frustration and hurt toward supervisors who had used her as a "scapegoat" to avoid taking responsibility for their mistakes. In a similar manner, she expresses frustration and disappointment with her daughter's defensive and age-inappropriate behaviours, yet is held back by feelings of guilt from expressing these frustrations. With respect to her husband, Mary chose a man who was similarly disposed to repress emotions

and to meet the challenges of family and work life in a concrete, rational way. Recently coming to recognize the lack of closeness in their relationship, Mary has expressed a desire to improve their level of emotional intimacy. Yet having learned from her mother's unsuccessful attempts to change her father, she holds back from expressing these desires and expresses little hope that her husband will change. Both partners appear constricted in their ability to risk the emotional vulnerability that is required to experience love. As a result, Mary carries her wounds close to her heart and experiences loneliness and a sense of resignation.

While Mary allows herself to experience feelings of frustration, anxiety, guilt and depression, her whole being has been recruited into defending against her awareness and expression of more painful, conflict-ridden emotions such as anger, hurt, resentment and grief. Unable to experience these emotions freely, they have been carried forward in her body. It is helpful to recall that the lived body is comprised of two "layers," the habitual body and the present body (Merleau-Ponty, 1962). The former signifies the phenomenal body that has lived in the past and has acquired certain habitual ways of relating to the world. With its two layers, the body is the meeting place of past and present which is carried forward into the future. Mary's lived body has habitually carried forward suppressed emotions through bodily symptoms. From the "rheumatic arthritis" in her childhood to the chronic back pain, headaches, and fibromyalgia in her adulthood, Mary's symptoms have typically taken the form of muscular tension and physical pain. She also reports occasional episodes of abdominal discomfort which may be suggestive of holding onto emotions in a similar manner to patients with gastrointestinal psychosomatic disorders. In addition, her high post-exercise blood pressure, which involves the heart, may be reflective of a restriction in her freedom to experience love and joy (Condrau, 1998).

Mary's alienation from her emotional life extends to her body as well. Since 1994, she gradually became unable to notice increasing levels of physical tension spreading throughout her body. When her fibromyalgia symptoms began, she kept her physical pain "under control" in a similar way as her emotional pain: she maintained constant activity to avoid time for rest and reflection. While she continues to keep active in her retirement, this defensive strategy has become much less effective in keeping her physical symptoms under control and her distressing

emotions at bay. She reports that her symptoms and pain are worst at night-time. It seems that when she is forced to lie in bed and remain inactive, the tension in Mary's body increases significantly, as if to create a suit of armour that will guard against the threat of painful emotions breaking into her conscious awareness.

In summary, a number of concurrent factors may be seen as potentially contributing to Mary's recent escalation of pain and fatigue. Firstly, her symptoms escalated at a time when she felt that she had inadvertently contributed to the firing of her V.P. This corresponds with her metaphorical description of "beating herself up" whenever she feels that she should have been able to prevent a negative outcome. Secondly, her sooner-than-expected retirement placed her at a crossroads. She has no longer been able to distract herself from personal or interpersonal issues by engaging in long hours at work. Spending more time at home, she has become increasingly aware of her frustration with the status of her relationships with important family members (i.e., daughter, husband). However, feelings of guilt, self-doubt and hopelessness have prevented her from taking any actions to improve them. Together, these recent experiences have intensified Mary's ontological "call of conscience" to live more authentically and to fulfill her unique potentialities. To defend against this awareness, increased physical symptoms have become necessary to deflect Mary's attention from emerging potentialities that are calling for expression. Mary has acknowledged that she needs to become more aware and expressive of her needs and emotions to face her current challenges. This is a positive and necessary first step towards living more authentically. However, until she is ready to narrate and work through the painful and untold experiences of her past, the anger, hurt and grief concealed in her pre-reflective body will continue to cause her physical pain and suffering.

Summary and Implications for the Problematic of Somatization

This chapter has attempted to deepen our understanding of somatization and address the unresolved issues and deficiencies raised in the previous chapter. From a foundational perspective, it has aimed to demonstrate how the problematic aspects of mind-body dualism and social constructionism can be successfully overcome by an understanding of the lived body and

the role of primordial, pre-linguistic perception in co-constituting our language, narratives, identity and bodily experience. It is hoped that the rich, experiential data provided by a handful of qualitative studies has underlined the importance of conducting studies into the lived experience of somatization.

The unresolved conceptual issues identified in chapter IV have been addressed in the following ways. In response to the relative importance of individual, familial or social-cultural risk factors, a broader view of psychopathology has been put forward that views these “factors” as highly interdependent, based upon our existence as Beings-in-the-world. To be truly comprehensive, a conceptualization of somatization needs to consider the individual, social-cultural and existential dimensions of somatization as a whole. It is therefore considered of little value to question their relative contribution to the development of somatization. This chapter also attempted to respond to questions regarding the role of “amplification” versus “minimization” in somatization. It was proposed that the differences between these types of somatizers may be related to different sensory experiences and perceptual styles rather than different types of psychopathology. However, this is a tentative suggestion that requires further exploration. Finally, in response to questions regarding the symbolic versus non-symbolic nature of bodily symptoms, this chapter has attempted to demonstrate that medically unexplained physical symptoms reflect meaningful disturbances in one’s relational world that call for understanding and interpretation.

To address the problematic treatment issues raised in chapter IV (see page 180), the therapeutic implications section described how the verbal and non-verbal communications and bodily experiences of somatizing patients can be understood and interpreted without imposing abstract theoretical or scientific conceptualizations. It also described how non-verbal modalities can be used to help somatizing patients who have difficulty accessing and verbalizing their emotional and bodily experiences.

By addressing the unresolved issues and deficiencies of current models of somatization, a phenomenological-hermeneutic approach offers a number of positive implications for the problematic of somatization. Most importantly, patients are much less likely to feel misunderstood and stigmatized if their stories and interpretations are listened to and explored

within a therapeutic relationship based upon acceptance, compassion and respect. Given the non-dualistic nature of a phenomenological-hermeneutic approach, no attempts are made to persuade patients of the psychological versus biological origins of their symptoms. Rather, disclosure of all aspects of a patient's life-world and life-history is considered necessary to arrive at a deeper understanding and interpretation of their symptoms.

There are a number of benefits to avoiding the imposition of scientific or theoretical frameworks. Firstly, patients are much more likely to accept insights and interpretations that arise from a mutually shared understanding between therapist and patient. These interpretations arise as therapists and patients work together *in partnership* to discover, explore and heal hidden issues that are relevant to the patient's symptoms. Secondly, the therapeutic process is more likely to be successful when the therapist steers away from generalized preconceptions and is attuned to the unique meanings, stories, experiences and life-world of each patient. By utilizing a variety of means to disclose and re-figure hidden meanings and experiences, issues relevant to each patient are much less likely to be missed or ignored. Finally, patients are encouraged to arrive at an *experiential* understanding rather than an intellectual interpretation of their problems. They are also challenged to take responsibility for the nature and direction of therapeutic change, thus avoiding the issue of patient "compliance" to therapist directives. As a result, patients are more likely to make meaningful changes in their being and life-world, and are less likely to become dependent upon the therapist.

VI. CONCLUSIONS AND RECOMMENDATIONS

This thesis attempted to arrive at a deeper understanding of the phenomenon of somatization. It raised a simple question that reflects a problematic: Why does the Western health care system have such difficulty providing effective treatment to individuals suffering from medically unexplained physical symptoms? Based upon a phenomenological-hermeneutic investigation of four models of somatization, a detailed and novel response to this question has emerged. Philosophical, theoretical and/or methodological assumptions have been identified which seem to be interfering with the ability of models to adequately capture the richness and complexity of somatization as it is lived and experienced by individual sufferers. Some models are contributing inadvertently to the problematic of somatization because of implicit foundational assumptions that are incongruent with human lived experience. As a result, incomplete or inaccurate conceptualizations are hindering models in varying degrees from being able to design effective treatments. While the models varied significantly in terms of their strengths and weaknesses, a number of foundational, conceptual and treatment issues were identified that remain unresolved or inadequately addressed. In closing, it was shown how a phenomenological-hermeneutic approach could address and potentially resolve these issues and make a real contribution to the conceptualization and treatment of somatization.

To address the goals of this thesis, a theoretical approach was clearly required. The phenomenon of somatization covers a vast range of symptoms with widely varying levels of severity, chronicity, and dysfunction. The author chose to maintain a broad focus so that foundational issues relevant to the overall study and treatment of somatization could be identified and addressed. By doing so, it is hoped that a foundation has been laid for the future development of a more comprehensive, integrative approach to conceptualizing and treating somatization that builds upon the strengths of the various models and is grounded in existential and hermeneutic phenomenology.

Naturally, this type of theoretical work presents some limitations. One could argue, for example, that the description of each model may not be an accurate depiction of the perspective of its proponents. Similarly, one may question the validity of the inferences that have been made

in identifying the models' foundational assumptions and applying their conceptualizations to an individual case. These concerns are not without merit and the author's interpretation of these models remains open to debate. However, it is believed that the author's hermeneutic stance toward the study of these models has reduced the risk of misinterpretation and bias. The author approached each model with a sincere intention to understand and articulate the perspectives of its proponents as faithfully as possible. This involved a conscious, but necessarily incomplete, attempt to set aside theoretical preconceptions and personal prejudices and listen with curiosity and open-mindedness to the ideas being presented. Sources were frequently quoted to present the concepts and principles as accurately as possible. In conducting the critical evaluation, texts were read and re-read many times to identify stated assumptions and to pay close attention to implicit assumptions of the writers as revealed through the language used to describe their model. Following the text-in-context principle, hypotheses regarding implicit foundational assumptions were generated by considering the larger theoretical, scientific and social-cultural context from which each model emerged. These hypotheses were repeatedly subjected to the hermeneutic circle to assess their plausibility. In the end, the author has attempted to provide a clear rationale, with supportive evidence, for each of the conclusions drawn. In so doing, the author's reflections are exposed to the reader for verification and correction or refutation.

One also needs to consider the limitations of the phenomenological-hermeneutic conceptualizations and treatment implications presented in Chapter VI. These conceptualizations are based upon a limited number of qualitative studies and the writings of existential therapists who have worked with psychosomatic patients. Hence, the author's conceptualizations suffer from the dearth of human science research into the lived experience of somatization which is needed to provide a more substantive empirical grounding. The conceptualizations and treatment implications also lack specificity, given the broad scope of the phenomenon under investigation. These limitations point to the need for future phenomenological-hermeneutic research into specific forms of somatization (e.g., lower back pain, migraines, fibromyalgia, irritable bowel syndrome) as well as response styles to somatization (e.g., minimizers versus amplifiers) so that more comprehensive and differentiated conceptualizations and treatment implications can be arrived at. This type of rich, experiential data could also point natural science researchers toward

more relevant topics for investigation. In addition, it would be fruitful to examine how the “hermeneutic turn” in psychoanalysis could provide a contribution to the development of a phenomenological-hermeneutic approach to somatization.

The author chose to focus on the experience of somatization in Western culture among adults. This thesis is therefore unable to respond to theoretical and empirical questions regarding the nature of somatization in other populations and cultures. For example, is the experience of somatization different for people of different age (e.g., children versus adults), socioeconomic status or culture? One could expect the cultural differences to be particularly strong, given that conceptualizations for somatization are tied to cultural beliefs regarding illness and disease. For example, the term “somatization” would have no meaning in countries such as China or India because it is based upon Western dualistic assumptions regarding mind and body. Instead, medical practitioners would base their explanations for “somatization-like” phenomena upon non-dualistic traditions of medicine which view psychological, physical and spiritual health as a unified whole. Consequently, spiritual and health-related practices (e.g., yoga, meditation, tai chi, acupuncture, herbs, diet) would more likely be recommended to prevent and/or treat such bodily symptoms. These practices have been promoted by a growing holistic health movement in North America, with practitioners providing services to many somatizers who are unsatisfied with their medical treatment (Astin, 1998). These issues point to many fruitful areas for future theoretical and empirical investigation, including the study of somatization in children, in people of different socioeconomic status, and in people of different cultures. From the author’s perspective, cross-cultural anthropological research is necessary for the development of a truly comprehensive and integrative approach to somatization. Otherwise, there is a risk that valuable conceptualizations and therapeutic approaches will remain undiscovered or under-utilized.

Finally, with respect to the therapeutic implications of a phenomenological-hermeneutic approach, a few comments need to be made. While many of the implications are relevant to all health professionals who seek to understand and treat somatizing patients, they are primarily geared toward psychotherapy with adults. Further elaboration is needed to specify modifications for briefer forms of therapy, as well as for different therapeutic modalities (e.g., child, couple, family, group) if they are deemed to be more appropriate for a particular patient. In addition, the

exclusive focus on psychotherapeutic implications is not meant to ignore or dismiss the potential value of other approaches that can improve physical, emotional and spiritual well-being (e.g., body work, exercise, meditation, nutrition). As somatization is a complex phenomenon involving all aspects of a person's being, it makes imminent sense to try to effect change through as many different avenues as possible.

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