

Title : Medicine and story : a novel clinical panorama arising from a unitary mind/body approach to physical illness.

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Medicine and story: A novel clinical panorama arising from a unitary mind/body approach to physical illness

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Abstract: Since 1987, all patients referred by family physicians for internal medicine consultation at the Institute for Integrative Health Studies (Christchurch, New Zealand) have been assessed by the author from both physical (normative internal medicine) and psychological (psychodynamic, interpersonal, object relations, and self psychological) perspectives. Depending upon the material emerging in each case, the treatment options available for the particular disorder, and patient preferences, many patients have gone on to mind/body oriented discussions or psychotherapy with the author (detailed in Broom 1997), or with one of a team of therapists supervised by the author. This clinical experience, mixing internal medicine and psychotherapy approaches to physical illnesses (with or without organic findings), points to the following: (1) Profound connections between the patients' perceptions of their life-events and experience and the development of illness in both organic and nonorganic illnesses; (2) a rich fund of information in the patients' verbal language about the meaning of the illnesses; (3) the crucial importance of clinical attunement to macro- and micro-life events surrounding symptom emergence; and (4) the decisive role a clinician's implicit paradigm of "personhood" plays in patient care. This paper broadly outlines the presuppositions for this integrative clinical approach, and illustrates the approach with case material. Additionally, it summarizes the kinds of listening, and other skills, that have proved clinically useful. In all, the material illustrates that a combination of orthodox biomedical approaches and a "story approach" (which focuses on meaning leading to illness) offers considerable potential benefits to patients with physical symptomatology including those with organic findings.

A challenge to the biomedical model

In Western culture and medical practice the human experiences of subjectivity and of physicality are not only categorized separately but are reified into separate compartments or entities of mind and body which are then seen to have some influence upon one another. This paradigm

gives rise to the "mind/body problem," and, in a medical context, to questions about how a separate nonphysical mind can influence a physical body. It also gives rise to certain assumptions, accepted "truths," and taxonomies that for the most part remain unquestioned. An example of such a "truth" is Western culture's assumed boundary between physical illness and *story*—defined here as that *tapestry of elements relating to the patient's*

past, present, and future experience as a subject. While few clinicians would deny that illness has meaning for the patient, most assume there is little connection between the patient's story (his/her experience of life) and the development of physical illness.

This boundary between physical disease and story is a pervasive consequence of the particular (and restrictive) metaphor of "personhood" dominating medical practice and implicit in the biomedical model—*person-as-machine*. Within this metaphor there is very little room for story. The person-as-machine metaphor, applied to medicine, can be summarized as follows:

- most diseases are seen as ultimately biological (genetic, degenerative, traumatic etc.) disturbances;
- biology gives rise to subjectivity, brain gives rise to mind; mind is a complex derivative, or epiphenomenon of body or brain;
- occasionally (sic) the derivative subjectivity that we call mind feeds back (by yet to be discovered mechanisms) on to the body to cause what is called psychosomatic illness.

A consequence of the dominance of this model is that most clinicians have learned to see illness as either "organic" (having a manifest or measurable physical disturbance, with therefore no room for subjective aspects) or "functional" (physical symptoms accompanied by less obvious tissue abnormalities, in which some role for subjectivity might be conceded, if not pursued). Put slightly differently, the common dualistic medical posture allows for *real* organic diseases and generally less respectable illnesses originating *in the mind*.

A basic premise is that there is a clear split between mind and body, and therefore between functional and organic disorders. Other constructions of illness are resisted and experienced as a challenge not only to orthodox medical thought but also to medical competence and mastery. Orthodox diagnostic systems, clinical management, and disease research are mostly grounded in the "biomedical model," which is, in essence, a mind/body compartmentalization model, in which the body is taken to be fundamental (physicalism) and subjectivity is devalued.

Even clinicians and researchers honoring the role of mind in physical illness tend to work from dualistic and physicalist perspectives. Mind factors are accorded a possible role primarily in disorders where there is no established organic disease process (the chronic fatigue syndrome [Strauss 1994] is a current example), a view that betrays the dominance of the biomedical model, which conceptualizes disease "in the same way as other natural phenomena—viewed independently from the person who is suffering from it and from his or her social context" (in the words of McWhinney [1989], one of the pioneers of patient-centered medicine). This view of the possible role of mind in illness generally excludes disorders with easily observable disturbances of structure or function at an anatomical, histological, biochemical, or genetic level.

Since 1987 I and my psychotherapist colleagues have had to revise our acceptance of these assumptions. We have responded to patients with physical presentations by attending concurrently to orthodox diagnosis and treatment and also to a patient's story. Though story might appear to be another version of the notion of narrative currently popular in many fields of the post-modern study of literature, philosophy, sociology, psychotherapy (McLeod 1997), and now medicine (Greenhalgh & Hurwitz 1998), my use of the term here is different. Story emerges out of a powerful reciprocity of meaning between the actual words used by patients in the accounts they give of their ordinary and extraordinary lives and the physical manifestations they present for treatment. That is, the use of story here has to do with mundane (not necessarily reaching psychopathological status) subjective meanings which, we maintain, are part of or contribute to the development of disease. In contrast, contemporary narrative approaches in medicine have more to do with how the clinician and patient together create a way of seeing the illness which has already developed. Narrative has to do with stories that the clinicians and patients weave around an already existing disease (Greenhalgh 1999). While accepting the validity of narrative approaches I am more concerned

with patients' personal meanings that appear to be an intrinsic part of disease development.

The case history of Patient Z, a 71-year-old woman, illustrates how we have come to see the relation between verbal meaning and physical illness. She presented with an 18-month *history* of generalized thickening of the subcutaneous tissue causing uncomfortable splinting of the chest and tightness of the arms and upper legs. Despite intensive investigation, including skin biopsy, a firm diagnosis had not been made. The appearances were not classical for scleroderma or mixed connective tissue disease, but as they appeared to be in that illness continuum, she was told she had "connective tissue disease" and accordingly was treated with the drugs prednisone and cyclophosphamide. Her family history included a son diagnosed with scleroderma at age 18, who subsequently recovered (now aged 36).

Asked about the onset of her skin thickening, the woman proffered, with alacrity and conviction, that it began when she fell over in the local garden nursery, sustaining injuries to her face and legs. She described the event as "shattering." Mystified as to the relevance of this statement (and initially inclined to pass over it) I asked what effect this event had on her. She replied: "I went into my shell for a while." I was struck by the language, and invited further comment, and within the next 3 to 4 minutes she used the words "I went into my shell" 3 times. Moreover, she further volunteered: "I went inside the four walls of my house, and closed the door, and sat and sat and sat." In the few weeks following the injury skin thickening developed first in the legs and then became more generalized.

She had enjoyed very good health throughout her life, but the accident compromised ("shattered") her self-concept in which she saw herself as perennially invulnerable. The embarrassing facial trauma induced social withdrawal. She improved as she started to "come out of my shell," though it was difficult to assess what contribution the medications were making.

I suggested to her that the thickening of the skin was a somatic representation of what she was also expressing in using the term "shell." She accepted

this, though without much insight. She was encouraged to become active, resume her previous social contacts, and was followed up regularly for support, encouragement, and continued "holding" through explanation, education, and the reorganizing of her home situation so that coping could be ensured for as long as possible. After her third visit she declined further psychological intervention. One year later both she and her physician reported marked clinical improvement, and she is on no medication.

The symbolic congruence of her verbal story (the use of the "shell" metaphor) and the physical manifestation (of skin thickening) seems obvious to me. It is also difficult to avoid the perception that somehow the physical presentation and the verbal presentation express concurrently aspects of the same total personal reality. There seems little justification (other than the view that dualistic mind/body assumptions must constitute the correct interpretative system) in seeing one or the other presentation as primary or secondary, or as one leading to the other. They are both there, together.

There is something else to note. The meaning of the illness in this patient was immediately discernible. Harry Stack Sullivan, the interpersonal psychoanalyst, said of psychotherapy: "If the therapist has the wit to see it, the truth is there to be seen in the first session" (quoted by Levenson 1990). I am urging that something similar applies in medical practice.

An alternate view of personhood

Our approach is based on a unitary model of personhood that not only emphasizes an integration of mind/body elements across the board in clinical medicine but also resists a body-first (physicalist) or a mind-first (mentalistic or idealist) position. It sees the patient's subjectivity dimension (and therefore language) as expressing a story that is complementary or analogous to that which the body dimension expresses in illness and disease. This is a radical position (and invites questions like "what about cancer, or genetic diseases?"—I comment on cancer later), but I believe the case examples presented here and elsewhere (Broom 1997) support it.

For example, what sort of illness did Patient Z, with her manifestly thickened skin and her "shell" metaphor, have? Was it organic or functional? Which elements of her data should have been attended to, and which regarded as superfluous in the task of treatment? A majority of physicians would not consider the *language/story/meaning data* offered by her to be useful. On the contrary, physicians generally take their first responsibility to be a diagnosis, especially the diagnosis of physical disease. And what is a diagnosis but essentially a process based on the physician's recognition of a typical pattern of symptoms and signs, combined with the results of important technical investigations? This is the focus of the observer within the biomedical model. In this approach, then, the patient is essentially an object. In our alternative view, the patient must also be seen as a subject with a meaningful story relevant to the appearance of illness.

There is a substantial literature acknowledging the relevance of the subjectivity of patients, but it was Georg Groddeck (1866–1934), a German general practitioner, who introduced the "knowledge of the unconscious into the treatment of all patients, and particularly those patients who suffer from organic illnesses" (Groddeck 1977). He claimed that "the distinction between body and mind is only verbal and not essential, that body and mind are one unit, that they contain an It, a force which lives us while we believe we are living," and, further, that "psychogenesis does not exist." Groddeck's notion of the It referred to a mysterious force that was supposedly the substrate for the many dimensions of human functioning and experience, including thoughts, emotions, the brain and body, and organic and mental illnesses. Even the human capacity for the symbolic was seen by Groddeck as being deposited in the It and prior to conscious thought and language.

These might be seen as wild ideas, but they are of rich interest when considering the problem of somatic metaphors, a subject that is infrequently addressed in mind/body medicine. In Patient Z (and in the other cases I discuss below) the body "language" or disease presentation appears to be "saying" exactly the same thing as the verbal

language, a confluence suggesting that they are dimensions or aspects of a unitary reality. For Groddeck this multidimensional symbolic capacity arises from the more fundamental and unitary It. More modern support for unitary assumptions can be found variously in neuroscientist Pribram's holographic theory that the whole being is expressed in every part (Ferguson 1982); or in physicist Bohm's implicate and explicate reality states where "we do not say that mind and body causally affect each other, but rather that the movements of both are the outcome of related projections of a common higher dimensional ground" (Bohm 1980); or in theologian Gunton's notion "of the world as an order of things, dynamically related to each other in time and space. It is perichoretic in that everything in it contributes to the being of everything else, enabling everything to be what it distinctively is" (Gunton 1993). (The notion of perichoresis is stronger than permeation or interpenetration. It allows us to talk about the experience of mind and body without ultimately separating them.) Finally, the philosopher Shalom (1985) takes us full circle back to Groddeck, arguing cogently that the person is not reducible to a combination of body and mind and therefore that the problem of mind/body integration is not soluble by attempting to connect mind and body categories as if they were fundamentals. Shalom sees the "existing person" or "personal identity" or the "I," as the ultimate fundamental (Shalom 1985). He says: "the problem is not 'the body/mind problem,' but the problem of the person or the 'I.'"

Shalom seems to me to put the issue clearly. I believe that the challenge we face in mind/body medicine is to conceptualize a unitary model of personhood. This is the crucial issue. Putting this challenge in the context and idiom of this paper, we need a model that allows us to assume a natural reciprocity between physical disease and story.

Shalom's philosophical view, applied to medical practice, emphasizes that physicians are not dealing primarily with bodies but with whole persons and personal identities, physical subjects who, because their experience of themselves can be conceptualized and abstracted into categories

such as "body" and "mind," provide the physician/observer with several sets of data. The data of the whole can be separated and clustered together into sets, in one case in terms of physical disease, in another in terms of story. These sets exist merely as focused-upon dimensions; they are all derivatives of the unitary reality of the *I*, or, as I prefer to say, the *I am*. To move in this direction—of the importance of the *patient as subject* in the development of physical and organic disease—constitutes a revolution for modern medicine. But this is a revolution that empirical clinical reality demands.

Critiquing the somatization model

Many protagonists for mind/body approaches use the language of somatoform disorders and somatization (the terminology of the *Diagnostic and Statistical Manual of Mental Disorders IV*), referring, for example, to the processes "by which an individual, 'hiding' from threatening psychological information ... expresses his or her emotional distress in ... physical symptoms or maladaptive behavior" (Wickramsekera 1998; for an alternative definition of somatization see Kleinman & Kleinman 1985). In this framework somatoform disorders are characterized by symptoms suggesting a physical disorder, a lack of organic findings, and evidence (or a presumption) that psychological factors are involved. In contrast to Groddeck these definitions subscribe strongly to a notion of psychogenesis, a notion of a mind compartment acting on a body compartment to cause disease.

This construct of somatization unquestionably has considerable utility. Numerous studies have established the high frequency of somatization, generally between 20 and 40%, in both general practice and internal medicine (Bain & Spaulding 1967; Bridges & Goldberg 1985; McCauley et al. 1997). It has been argued that these figures are in fact very conservative (Broom 1997; Wickramsekera 1998), and, of course, depend on the observer's definition of somatization (Goldberg & Bridges 1988; Lipowski 1986; Smith

1985). Kroenke and Mangelsdorff (1989) further showed that only 15% of the patients presenting with the 14 most common symptoms for outpatient internal medicine assessment had organic findings. Thus, "nonorganic" symptomatology forms a major fraction of internal medicine practice and expense, and they are likely to become an increasingly important issue in the era of managed care (Barsky & Borus 1995).

In my view, the terms somatization and somatoform disorders, as conventionally used, implicitly or explicitly represent:

- Constructs rooted in mind/body dualism;
- Labels for disorders attributed to emotional factors seen as being inappropriately expressed in the body;
- Conditions for which there is no (or only minimal) evidence of "organic" findings in the presenting patient; and
- Physical symptoms accompanied by psychopathology.

Such perspectives underlie the thought of a prominent analyst of somatization, Wickramsekera, who in a recent paper (1998), referred to the "kinds of medical problems that are typically regarded as expressions of somatization and psychophysiological disease," and included the following: chronic fatigue, various chronic pain states, muscular and vascular headache, irritable bowel syndrome, primary dysmenorrhea, flushing, hyperhidrosis, chronic urticaria, primary hypertension, and chronic allergic conditions. While I heartily endorse his emphasis on the importance of emotional factors in these conditions and agree that the majority do not have demonstrable "serious organic disease," I believe his listing of disorders such as chronic allergic reactions, primary hypertension, and chronic urticaria actually undermines the general definition of somatization and somatoform disorders as a combination of emotional factors and a lack of organic findings. For instance, chronic urticaria is in fact identified by the organic changes (bodily signs) due to an abnormal release of mast cell mediators just as hayfever, asthma,

bee sting anaphylaxis, and peanut allergy are. Chronic urticaria differs in that a physical cause of the mast cell activity has not been established. Thus a mind factor is allowed!

In our experience the majority of chronic urticaria patients not only suffer irritable skin lesions but also carry troublesome and often unexpressed affects in the anger continuum. Therefore such patients are somatizing and also have an organic condition. The question is when does something become "organic" rather than "functional?" Is a patient's conditioned anaphylaxis, or anaphylaxis related to "black hole" affects (Broom 1997) with massive release of mast cell products (and maybe death) as opposed to the relatively minor release of such products in chronic urticaria, an organic condition or a somatization disorder? On the face of it, the difference is merely quantitative. Is a patient's chronic vasomotor rhinitis (rooted in a chronic grief reaction) with severe nasal obstruction and complicated by sinus infection, or a patient's florid five-year facial rash (while maintaining, as she put it, a "brave face" on her husband's depression), organic or not? (I note that these chronic recurrent conditions—"black hole" anaphylaxis, vasomotor rhinitis, and facial rash—responded very well to a story approach).

Thus, terms like "organic" or "functional" or "somatization" do not adequately categorize what they attempt to describe. Organicity turns out to be a construct of the biomedical perspective. It exists when there is something that can be observed by the biomedical observer. A condition is "organic" when there is clear or irreversible physical change, or when it can be treated with physical means. "Functional" and "somatization" are often used when it cannot. "Somatization" tends to be used when there are either unmeasurable changes (for example, pain states, chronic fatigue) or reversible or self-limited phenomena (for example, chronic urticaria or irritable bowel syndrome). But, as Wickramsekera suggests, such reversible states may become irreversible states. Reversibility and irreversibility may be quantitative rather than qualitative issues, and a function of time. Hypertension and asthma are probably good examples of this.

In all, then, it becomes very questionable whether we can legitimately exclude issues of subjectivity and meaning from illnesses that are considered "organic" within the dominant biomedical paradigm.

Data and case histories

Our patient-centered clinical outcomes database identifies 347 patients with both physical symptomatology and an apparently relevant story. We have entered each patient into the database, maintained through software designed to monitor clinical outcomes* (Bullmore et al. 1992; Marks 1998; Marks et al. 1995), after deciding at first assessment whether the story element is best seen in one of three tentative categories devised over ten years of working in the combined internal medicine and story approaches. These categories are:

- Physical disorder with onset apparently associated with significant emotional material or life events;
- Physical disorder with apparent metaphorical or symbolic meaning;
- Physical disorder with apparent meaning which is neither metaphorical nor symbolic.

Further detailed analyses of these data are being pursued but some simple points can be made. Among the 347 patients with apparently relevant story (according to the categories above) there are 196 with the following manifestly *organic* and, moreover, *chronic* or *chronic recurrent* conditions: urticaria (including vasculitic forms), nonallergic eczema, nonspecific chronic skin rashes, seborrheic dermatitis, skin thickening (patient Z), aphthous ulceration, granulomatous

*The Clinical Outcomes and Resource Monitoring software, or CORM-Qualcare, was developed by Professor I. Marks, at the Maudsley Institute, London, principally for use with behavioral therapies. The software has been specifically modified for our use, and includes a taxonomic capacity around physical illness, body system, and anatomical location. It allows data entry from psychodynamic psychotherapy and internal medicine perspectives, and has a sophisticated clinical outcomes ability across a number of parameters and scales, including symptom levels and both work and social function in relation to such symptoms.

cheilitis, conjunctivitis, blepharitis, rhinitis, chronic sinusitis, nasal infections, laryngitis, middle ear disease, chest infections, asthma, leukoplakia of the mouth, chronic recurrent herpes simplex, vulvitis, vulvo-vaginitis, urethritis, prostatitis, interstitial cystitis, recurrent urinary tract infections, idiopathic hematuria, infertility, endometriosis, Crohn's disease, ulcerative colitis, recurrent anaphylaxis, epilepsy, neuropathy, Parkinson's disease, transient recurrent or chronic liver enzyme abnormalities, idiopathic hepatic fibrosis, and alopecia. Moreover, among these 196 patients with manifestly "organic" findings there are 70, a third of this group, with clear somatic metaphors or obvious symbolic elements. The other 151 of the 347 patients, with supposedly nonorganic conditions (that is, those without clear physical, structural, measurable changes), largely mirror the composition of Wickramsekera's list, the group of disorders typically characterized as "functional" or due to somatization. But we see no difference between the two groups (196 organic or 151 nonorganic) in terms of the presence of apparently relevant story aspects.

The notion that an organic finding rules out psychological factors (or story) is in our view a very questionable assumption.* I hope to make this point as strongly as I can with an assorted cluster of case histories. I give three in some detail, but to show they are not rare and inexplicable exceptions to the biomedical "rule," I introduce them with a brief overview of 8 cases of the same sort—"organic" disorders that presented with clear somatic metaphors or obvious symbolic elements. Even if these cases were rare exceptions (which, in our experience, they are not), they should still be taken seriously (Cronbach 1975).

- Female age 34; 8 years of nonallergic nasal congestion, facial soreness, puffy eyes; began when her mother was diagnosed as having scleroderma; patient says, "I will always grieve."

- Female aged 54; during a 15-year period first developed supraventricular tachycardia when working in a cardiac catheter lab, then Crohn's disease when treated badly by her colonic surgeon employer, then nonallergic rhinitis (unexplained, but disappeared after one session talking it through).
- Female age 50; chronic eye inflammation for 2 years; diagnosed as Sjogren's disease; exhausted by wandering around the world with her religious husband; says, "I am tired, I can hardly open my eyes," and is angry and frustrated. Husband would not allow further discussions.
- Female age 52; 20 years of cystitis, hematuria, vaginal discomfort, and lachrymation; sexual abuse at age 8; cystitis unremitting since honeymoon; she says, "I was such a go-er but I crash after sex; every now and again I give in to sex"; "I feel sickened."
- Female age 26; 2.8 years of chronic diarrhoea and many investigations; husband works too hard and they had moved away from her beloved father; she says, "I hate arguing"; after she told her husband "I am not going to be treated like shit any more," her diarrhoea remitted.
- Male age 42; 10 years of severe tendinitis (visible swelling and redness) of any exercised region of the body; highly ambivalent about the role of house-husband and father, longs to be free in the wilderness, hunting and shooting; had a very stifling controlling mother, and experiences his wife like that; symptoms appear to be a metaphor for physical constraint and ambivalence.
- Male age 76; 40 years of severe facial dermatitis (requiring oral steroids) following a bitter family conflict; was cheated of his farm inheritance; he bought the farm next door, and "it [the family farm] was constantly in my face"; problem cleared when away from the farm for long periods.
- Female age 54; 6 years of urticaria and inflammatory bowel disease, both flaring each year in September; has a rigid workaholic husband who refuses intimate relations; she starts each year hoping things will change but by September "my hopes begin to sag," and "how else can I show what I feel." She feels

*Our ongoing studies concern: the role of various organ systems and anatomical zones as preferred sites for meaning; patterns of meaning typical or generic for the range of human dilemmas out of which stories come; and clinical response to story-oriented therapies.

frustrated, angry, lonely, and afraid. In our experience, chronic urticaria often represents anger and frustration.

The 3 patients I now present in more detail provide vivid examples of the relevance of story to "organic" conditions. Once one starts to attend to the story data such vividness is far from unusual (for example, the 70 patients in our database with somatic metaphors, and the many other examples published previously [Broom 1997]). In these 3 chronic cases (from, to repeat, a database of 197 "organic" cases), the problems are manifestly organic, the body and language dimensions say the same thing concurrently (as if they mirror one another and emerge out of the whole), the biomedical treatment model is inadequate, and the symptoms resolve while the patient works with the clinician on the meaning of the problem. The language used in the stories given by the patients is uncannily relevant to the illness presentations, and has clear metaphorical or symbolic status.

The question arises as to how to categorize the story material further. I am not convinced that stories are best seen as "psychopathology," which is another construct that seems to allow some clinicians to identify somatization. A detailed discussion of what is psychopathology and what is not is beyond the scope of this paper. I will say only that I prefer the term story to "psychopathology" because it allows notions of patients' subjective "meanings" into the arena without having to judge the meanings as severe enough to be abnormal, the usual basis for attending to them. This is an important issue. In the Manchester Somatization Study (Goldberg & Bridges 1988) patients were classified as somatizing only if they could also be classified and treated psychiatrically. Therefore, severity of emotional disturbance, or emotional disturbance recognized by certain professional observers, determines who will be allowed to be seen as somatizers. But in our work this is unhelpful.

A woman with a "brave face" and a facial rash

Consider Patient A, whom I alluded to briefly earlier in the paper. She is a 70-year-old woman

with a 5-year history of florid facial rash, who is keeping a "brave face" on her husband's depression, who has never been good with expressing her feelings, who has no history of depression herself or other medical or psychiatric help-seeking, and who cannot easily be psychiatrically classified. She would be ruled out of the Manchester Somatization Study! But she improves after a session of empathic listening and the framing of her symptoms as her *physical way* of expressing her difficulties in the relationship with her husband, her *language way* being in the use of the term "brave face." In a sense, both physical and language conduits of expression are metaphorical.

As I have said, the somatization construct has great utility, but in this "brave face" facial rash woman its usefulness is not obvious. We do not have to decide whether she has psychopathology before we justify attending to her "brave face" language. The organic/functional split and the linear dualistic model do not "work" either. There is no utility in asking whether she got the rash first and then came up with the "brave face" language, or vice versa. I contend the self-evident reality is that she is expressing the same set of issues in multiple dimensions concurrently. In short, we are back to a unitary approach to patient personhood.

A woman who felt sexually undermined and suffered from genital disorders

Patient B, a 39-year-old woman with a 15-year history of vulvodynia, vaginal candidiasis, vulval eczema, and planar vulval warts, was referred for "psychotherapy to help her cope with her vulvodynia." Around age 20 she had 3 unsatisfactory sexual relationships, the third being emotionally abusive, leaving her "bloody angry" and "undermined in what I felt about myself sexually." She vowed to remain "celibate." Soon after this, the genital symptoms began, and persisted despite all forms of treatment. At age 38 she started exploring her first relationship after 14 years, and the prospect of marriage made a resolution of the symptoms urgent. She entered psychotherapy mid-1997 and explored many issues, including her underlying sense of

inadequacy. By the thirteenth session she was reporting freedom from symptoms, and there were no visible abnormalities of the vulva. She married, and soon after her symptoms exacerbated as she struggled anew with conflicts relating to trying to be more than adequate on a number of fronts, as a wife, lover, mother, income provider, home keeper, friend, and hostess. Resolution of these conflicts led to resolution of the symptoms again.

From a unitary personhood point of view, Patient B is expressing the same story concurrently in her body, thinking, language, behavior, and relationships. As pointed out, physicians operating out of a dualistic paradigm involving mind and body compartments will reflexively move to decide whether the problem arose first in either one or the other. Most medical literature is not only similarly dualistic but dominated by an implicit physical fundamentalism that sees the physical aspects of personhood as primary or prior to other aspects of human functioning, including mind. Therefore, in the case of Patient B, it is the physical genital data that is attended to for many years by numerous clinicians, and the "inadequacy" story is never heard. This is reminiscent of Wickramsekera's story of the man who had two million dollars' worth of investigation before his story was attended to (Wickramsekera 1998). This is not a rare phenomenon. We see similar cases every day. The "blow out" of health costs world-wide is partly due to the accelerating availability of technology in a climate of excessive expectations. These expectations are partly rooted in a physical fundamentalism, the biomedical model, which assumes that most answers to disease will be technological. Inevitably this engenders costly repetitive attempts to discover organicity. Meanwhile story is ignored and is effectively invisible.

I certainly believe that rigorously addressing the physical aspects of patients is crucial to good practice, but physical fundamentalism implies that ultimately the only things that really matter are those things that can be measured. The handmaids of physical fundamentalism are methodology, measurement, mathematization, objectivity, jargon, standardization, instruments, and rating scales (Rotov 1991). Story does not easily fit this perspective and its derivative approaches and technology.

The exclusion of story is not just a manifestation of organic/functional splitting but also a result of what has been called *essentialization* (Rotov 1991). Essentialization describes the process by which a person's particular illness gets assigned to a labeled disease category. The process is as follows. A disease is a pattern of symptoms, signs, and technological findings recognized by physicians. For example, to belong to the asthma disease category a patient must have *essential* findings (cough, wheeze, certain abnormalities of lung function, etc) in common with the rest of the patients who make up this disease category. The physicians focus on what these individuals have *in common*, on that which is *essential* to belong to the asthma category. Herman (1995), in critiquing randomized controlled trials, which rest entirely upon essentialized categories, defined bias as "the tendency to see what we are looking for and to overlook whatever challenges the paradigm framing our observations." Certainly essentialization (and most current medical practice) overlooks highly individual data, or story; and the vigor of some negative responses to the notion of story suggests bias is playing a role. The problem is not the validity of measurement, or the usefulness of group data, or the diagnostic approach, but the exclusion of story.

Patient data can be divided into two categories: the essentialized physical/group/measured data, and the story/subjective/individual/not measured data. Medicine neglects the latter. In this climate, Patient Z, discussed at the outset of the paper, is screened for the essential physical features of the connective tissue diseases, but the "I have gone into my shell" data is excluded. Patient B is treated for 15 years for possible fungal, bacterial, and viral infections of the genital tract, but her "inadequacy" and "celibacy" themes are never observed. This neglect of story is repeated many times a day in clinics the world over, constituting medical neglect of scandalous proportions.

A woman with an athletic husband and many musculoskeletal injuries

Patient C, a woman aged 35, was referred with a 6-year history of numerous musculoskeletal injuries.

Feature article

Broom

Analysis of the general practitioner records showed the following history of medical consultations:

- 5/85 back injury whilst tramping
- 7/85 back injury whilst swimming
- 8/85 sore back, sore right knee
- 3/86 sore back
- 11/87 left knee sore on movement
- 2/88 musculoskeletal specialist consultation—writing of general practitioner illegible
- 5/88 long-term sacroiliac problems
- 5/88 motor vehicle accident whiplash
- 6/88 left sacroiliac joint painful when running and tramping
- 1/89 torn left popliteus—problems for 6 months
- 3/89 tender right humerus
- 4/89 right hamstring tear—problems for 8 months
- 5/89 right biceps tear—problems for several months
- 9/89 strained right biceps again
- 2/90 gastrocnemius muscle insertion injury
- 3/90 painful coccyx
- 4/90 painful coccyx
- 5/90 sore lower back
- 8/90 coracobrachialis tear; very despondent
- 4/91 patient initiates psychotherapy at suggestion of a friend; deteriorates, bilateral anterior compartment syndrome diagnosed, and wheelchair suggested
- 4/91 stress fracture left tibia (confirmed by X-ray)
- 10/91 numerous small muscle injuries/ anterior compartment syndrome continues

Patient C had undergone numerous investigations, including bone density and endocrine studies, none of which had been helpful. Prior to and during psychotherapy she had consulted many clinicians, medical, paramedical, and alternative. After nearly a year of psychotherapy she was referred to me for a second opinion, the question being whether I thought emotional factors were operating, or whether psychotherapy should be abandoned in favor of yet more physical investigations. Despite her psychotherapy, the injuries had continued unabated.

Her history revealed that her lifestyle was focused around physical recreation, and she appeared to get injured in circumstances that all the experts agreed hardly warranted injury. Within minutes of the start of the interview she was referring to her marriage. Her husband was a very keen outdoors man, she explained, and her injuries were interfering with their outdoor life style.

Salient early history included the fact that her parents broke up when she was at primary school, and there was a serious question that she might be given up for adoption. It did not happen, and she stayed with her mother who eventually married again, the stepfather bringing with him a daughter of similar age to C. This other girl fell off a horse and broke a leg. C perceived her as "stealing" her mother. Two weeks later C fell off her bicycle and got her mother back.

There appeared to be no more points of interest until C was around 30 years of age when she injured her back tramping. Around that time she met her husband who encouraged her rehabilitation. They married, and soon after he and his friends put pressure on her to do a triathlon. She did not want to do it, rather she wanted to start a family, but succumbed to the pressure, and prepared for the triathlon. An injury then supervened, and she had to pull out. This was the beginning of the list of injuries.

There were a variety of interlacing themes in this story. She was eager to have a family, but this would limit the couple's outdoor activities, and possibly endanger her relationship with her husband who put enormous stock on his weekend activities. She felt she could not have both a family and her husband. It seemed that her injuries were a somatic representation of an unwillingness to confront her husband directly because of a fear of losing him, and also a refusal to be ruled by his preferences. It was pointed out that her fear of losing her husband and her reluctance to wrestle with this in the interpersonal space between them meant that she was left with very indirect expressions of her feelings, and therefore with continuing injury. It was suggested that she have no more tests, and the following comments were made to the psychotherapist who had asked for a

second opinion: "I have no concerns that you are sitting on some undiagnosed disorder, and if it were me I would resist such concerns confidently." It was recommended that the patient and her husband have a marital session in which these issues were disclosed and explored. C. had 2 more psychotherapy sessions, and one of these included her husband. Within a month she had done an extensive tramping trip without difficulty.

I did a follow-up review 3 years later. She had continued an active physical life since, and has had no more injuries. She had given birth to one child. Her husband remained reluctant to have more. At the review, she said: "I was punishing him because I wanted a baby"; "I was turning everything in on myself, and everything was being put into my body"; "I saw clearly what was going on, and I thought what a waste of my life."

Again, attending to story was crucial. The question is, would it have mattered whether I had viewed this patient within a dualistic model of personhood instead of a unitary model? After all, the important thing is that *meaning* was considered in a patient with unexplained tendon and bone injuries. I contend that meaning will be considered in such patients only if the clinician's model will allow it. The biomedical model and the variants that add an adjunctive psychological factor constrain acceptance of story-related spontaneous tendon ruptures and stress fractures, or widespread thickening of the skin (as with Patient Z), or, as I indicate later, a major role for meaning in the initiation of cancer (Greer 1999), because there is no conceivable "mechanism of action" (Foss 1999). In the dualistic mind-on-body model the notion of mind causing a stress fracture is so contrary to predominant culturally conditioned systems of medical thinking that it does not get near consideration. The biopsychosocial model (Engel 1977) does nudge us closer, but adherents mostly subscribe to a biomedical model with "tack on" adjuvant effects of the dualistically separated mind.

This problem is illustrated in the burgeoning field of psychoneuroimmunology. At first sight, the term "psychoneuroimmunology" might encourage the assumption that in this new multidisciplinary exploration story will be

attended to. But in reality physicalist and essentialist presuppositions drive most of the research. Much of the available clinical literature in psychoneuroimmunology presents reasonably sophisticated micro-studies of changes in the immune system or brain, but the mind, when considered, is seen in fairly restrictive ways. For instance, in chronic fatigue syndrome, the mind side of this condition is represented by a restricted focus upon diagnoses of depression, anxiety, and somatization, and upon aspects of cognitive functioning and related cognitive-behavioral techniques to manage the patient's beliefs about the illness (Sharpe 1994). We hear no story. The patient remains an object with a mere shadow of subjectivity.

Does cancer have a story?

For many, the whole idea that illness can have a meaning—a "story"—is foreclosed by the mention of cancer. A facial rash is one thing, cancer is quite another. I believe cancer can have a story—some cancers at least. What sorts of stories and what sorts of cancer remain researchable questions. I offer as one example a woman in whom the onset of oral leukoplakia (an "organic" precancerous condition) began at age 33 and continued for 23 years. Consultation indicated that the onset was related to factors of shame associated with her dentist father's suicide also at age 33. Brief psychotherapy in this case (detailed in Broom 1997) was remarkably effective, the turning point centering on resolution of the shame issues. Thus, after 23 years of leukoplakia and major surgery for oral cancer she is now clear, and has been so for 5 years.

Such cases raise provocative paradigmatic issues relevant not only to psychooncology but to the whole of medicine. Many of these issues were highlighted in a recent discussion of psychooncology in *Advances*. In a target paper, Greer (1999) offered a broad hypothesis about the role of psychological factors in the course of cancer: "Whatever the random mutation and other biological initiators of the cancer process, its further promotion and spread will depend partly on homeostatic controls which can be influenced

by psychological factors." He took pains to note that his hypothesis "does not state that psychological factors are either necessary or sufficient causes of cancers." Several of the eight commentators on the paper took issue with this critical point.

Greer seems to me to illustrate well the growing body of research and commentary asserting the influence of mind while retaining a body fundamentalism. He sees psychological mechanisms influencing "promotion and further progress of cancer" but shies away from such factors initiating cancer, and in the discussion refers scathingly to counselors who "suggest to patients that they may have unconsciously wished the cancer on themselves." How a patient and a clinician construe the possible emotional antecedents of an emergent cancer has many more possibilities than this, but I agree that problems of "blaming" emerge with simplistic interpretations of the role of subjectivity. As I tried to make clear in my presentation of the "brave face" / facial rash woman, it serves no value to say which comes first, which "causes" the other. Both express the same set of issues. So with the leukoplakia/shame woman, who manifests "organicity" and story material to match: both are, in essence, concurrent phenomena.

Foss (1999), commenting on Greer's paper, questions the character of its underlying mind/body perspective. He writes that the foundational issue turns on "the relation between patients as objects and patients as subjects as well as objects—agents capable, by changing their consciousness, of actively participating in their own healing process." He continues: "On this reading, embedded in the claim for a science of psychooncology are the seeds of revolution." I think we need a revolution. I suspect that where any model of cancer sees physical factors as fundamental and psychological factors as adjunctive or permissive or as cofactors, that model inevitably and implicitly inserts a "hopelessness" factor. There is a skewing of the clinician towards an overly "fixed," hard-to-influence mechanistic physical disease, and a notion of weak and secondary mind factors. This, I think, is the current status of mind/body medicine.

In Greer's paper and in many of the comment the emphasis appears to be on essentialized mental categories such as anxiety, depression, passive coping responses, stress, hopelessness, "fighting spirit," hardiness, resilience, sense of coherence (Greer 1999), emotional well-being, family support, social and cultural issues, socioeconomic factors, downward causation (Block 1999), mind as regulator (Cunningham 1999), cognitive appraisal, positive emotion (Folkman 1999), effects of supportive / expressive group therapy, and stress reactivity (Spiegel 1999). These abstractions have great relevance. They are more categorical, measurable, researchable, and fundable according to orthodox views as to what constitutes good research. They are also nomothetic—that is, as if derived from laws—and therefore more clinician-centered than story. Story is extremely patient-centered and idiographic—that is, particularistic—and emphasizes the less measurable and highly individual aspects of psychological functioning such as imagination and meaning. The philosopher Langer (1967) called these less measurable aspects "the embarrassing elements—[such as] willing, intending, feeling—that is, all words for introspectively known factors." Pataki (1996) puts it another way: "Love, friendship, caring for oneself and for others, loss of others and the loss of one's self in madness or death concern us more in daily life, art, literature (though they do not much concern contemporary psychiatry and Anglo-Saxon philosophy) than anything else." Nor do such things concern modern medicine in its understanding of pathology. But love and friendship and numerous other things crucial to our human subjectivity are the essential elements of the notion of story presented here. It is these elements that are carefully attended to in patients presenting with physical symptoms.

The basic contention is that a novel clinical panorama emerges as the clinician keeps both physicality and subjectivity in focus at the same time, in many different types of illness, irrespective of whether they would normally be regarded as psychosomatic, physical, functional, or organic. Further, I suggest it is neither valid or even ethical for physicians to persist with a body-

only focus in respect to a vast number of diseases commonly accepted as physical or organic.

Theory, clinical experience, and story-gathering

The development of this approach (Broom 1997) was not driven by a favored theory of mind-body connectedness or integration but more by an instinct and penchant for integrative approaches to healing and by insights emerging from a growing clinical experience combining internal medicine and psychotherapy. These have forced a relinquishing of ingrained residues of dualistic thinking and practice. It has been necessary to develop different conceptualizations of personhood and disease.

Here I list and explore some of our experiential findings:

- *Persons present their responses to the world in a multidimensional way.* Patient B is an example. She feels inadequate, vows to become "celibate," avoids male/female relationships for many years, and concurrently develops genital pathology.
- *Rather than operating out of a linear psyche-to-soma or soma-to-psyche dualistic interpretation of the data, it is better to see a patient as a personal identity, or an I, or an I am.* The I is expressed in dimensions of experience that conventionally are categorized separately and compartmentally as *body* (in Patient B's case, genital inflammation) and *mind* (the celibate vow) and *behavior* (avoiding male/female relationship).
- *The categories of body, mind, and action are not reified into entities or compartments, thereby freeing us from all the difficulties of dualistic medicine.* In essence, the person is seen as reacting as a whole, and able to provide subjective, somatic, and action expressions of the whole.

The crucial point is that the unitary approach works at the clinical level with many conditions in a way that the dualistic approach does not. I think the problem in the mind/body medicine area is that its advocates find it too difficult to confront

the reality that our current dualistic and mostly physicalist model does not work a lot of the time. To refer again to Greer (1999): while lamenting "the baneful influence of Cartesian dualism and the major conceptual problems involved in trying to explain mind-body problems in the language of science," Greer still hopes (in the modernist and positivist tradition) that the biomedical model can accommodate mental influences upon bodily function and structure in terms of the promotion and progress of a disease—yet excludes any consideration that such influences could be involved in initiation. Is this because the physicalist biomedical model simply does not allow it, that is, does not allow a crucial role for subjectivity in "organic" illnesses?

Foss (1999), in response to Greer, argues that the problem of psychooncology (and therefore mind/body medicine) is that it lacks a good enough "explanatory strategy" or mechanism of action for the explanation of psychological factors in disease while it dances to the tune of the biomedical model—it has not, in other words, cut itself free from the restraints of that model.

In our own approach the combined internal medicine and psychotherapy clinical work with hundreds of patients has gradually forced us to a unitary model. What seems to have worked clinically has led theory rather than conversely. We have ended up with something similar to the philosophical framework provided by Shalom (1985) as outlined above.

But concepts are one thing, clinical application another. How should we go about "story gathering?" This is a huge subject, but first and foremost the "core clinical skill" (Duffy 1998) is the capacity for physician/patient dialogue. Suchman and colleagues (1997) observed that patients give *clues* to their emotions rather than offer them directly, and physicians mostly bypass these clues. In a randomized study of residents trained or untrained in patient-centered interviewing, Smith and colleagues (1998) showed that clinicians can be trained to "encourage the personhood of patients to re-emerge in clinical medicine." Our approach (Broom 1997) emphasizes many of the skills for patient-centeredness assessed in that study, but, in addition to patient-centeredness,

there are skills that are specific to ascertaining the meaning of disease. These can be summed up as *clinical attunement to the macro- and micro-life events surrounding an individual's symptom emergence and to the way that the individual describes these events or alludes to them.*

Clinical attunement to meaning involves a number of foci, attitudes, and skills, which I outline here:

- *Attention to patients' actual, idiosyncratic use of language.* Two instances from earlier examples: the patient with a facial rash who says she is keeping a "brave face" on her husband's depression; and Patient Z with skin thickening who has gone "into my shell."
- *Willingness to "pursue the particular"* (Levenson 1988). Two examples: a patient, unaware of her feelings and with irritable bowel symptoms, feels pain at 09.10 a.m., five minutes after her boss changes his plan to send her to the other branch of the bank; and the patient whose chest pain begins in the office at 3.15 p.m., at a moment when he imagines he is being scrutinized by all the staff.
- *Seeing the times of onset (and exacerbations) of physical illness as "faultlines."* The clinician must rummage among events in the patient's life happening about the time the symptoms first began, and again when any subsequent exacerbation begins. The time of onset of the illness should be seen as a faultline, a place where defenses give way, a place where significant story material can be seen.

It is also very useful to compare sequential faultlines to see if story material repeats itself. For example, a patient gets headaches at age 13 when her father dies, at age 17 when a boy breaks a relationship with her, and chronic headaches begin at age 21 when she is pregnant and the father of the child abandons her. Such a pattern of useful story data, revealed through a comparison of major events relating to symptom exacerbations occurring over months, years, or decades, we term the *story in the macro*. But it is just as important to compare very recent (emotional) circumstances surrounding the onset of episodes of headache (or any physical symptom) just hours or days apart;

this is the *story in the micro*. Because the latter episodes are very recent, there is the advantage of freshness of memory, and much clearer and more detailed information. We expect the symbolism and the emotional nuances of the macro- and micro-stories in any one patient to mirror one another.

- *Patient-friendly questions allowing story to emerge.* One of the most useful of questions is, "What was the most interesting, difficult, important, worrying, memorable, hard, significant, tiring (etc.) thing going on for you around the time or just before the time you got ill?" It is extremely important to give the patient the idea that, though you are looking for something that may be affectively negative, you are still allowing him/her to choose how this will be described.

Many patients will deny relevant events if they get locked into a word that does not fit. For instance, some people claim they "never get stressed!" It just is not allowable for them to acknowledge it. For them the word "significant" may be a very acceptable euphemism. They might acknowledge that a change of job, or house, or the arrival of twins is very "significant" but refuse to own the "difficult" or "stressful" aspects. Some will allow "stressful" but not "worrying," the former term being a little more external and admitting less vulnerability.

- *The clinician must be a "terrier" while also offering a "holding" empathy.* The clinician must develop an acute listening capacity and determination to pursue fine details of the patient's story, becoming a terrier determined to sniff out the truth, while developing collateral skills of holding the patient empathetically so that the patient can tolerate such interest and the clinician thus avoids a persecutory stance (Meares & Hobson 1977).
- *Emphasizing the view that it is the patients who "know" the truth.* The expertise of a standard biomedical doctor centers around his/her ability to diagnose, an ability to come up with a label for a pattern of essential symptoms and signs that the clinician recognizes as having seen before. In the story approach, the clinician

goes beyond this essentializing and discovers fresh every time a particular patient's emotional truth, as discerned from the patient's language. The balance shifts from sole emphasis on the clinician's quiver of diagnoses to include the patient's unique subjective pattern or story waiting to be discovered.

- *The need to go slowly and, from the little that is given, find what is needed.* Most clinicians go far too fast, and end up sliding across faint or meager hints of story. Even well-trained psychotherapists find listening to nuances difficult. It is the little hints that are so important, and a clinician in a hurry will nearly always miss them. Indeed, most clinicians are not really very patient – or client-centered, and listen mainly to those things that support the clinician's diagnoses and theories. In the story approach, all nuances of affect and meaning are potentially relevant.
- *An assumption that things are fundamentally connected.* Though the biomedical model would see this point as very radical, it is assumed here that everything the patient says is important and connected in some way to that which is fundamental to the patient's presentation. To repeat a point emphasized earlier, language and symptoms are seen as different projections of the patient's gestalt and are inevitably connected.

Some clinicians find the notion of interconnectedness not only hard to accept but also impractical, because they imagine they will have to listen to a lot of patient talk to get the truth. On the contrary, it is often a matter of listening very carefully to a little of the patient's talk, and taking it very seriously. In an average doctor-patient encounter, a clinician is flooded with tidbits of story but most of this is either not attended to or is actively screened out.

All information should be seen as emerging out of a patient's unitary reality, which has physical, story, and other dimensions. The truth is there to be seen. The patient who sidles through the clinician's doorway awkwardly is proffering an initial piece of information, the tip of an iceberg. The tip is always connected to the rest of the

iceberg. Anything is connected to everything else. Everything the patient proffers is ultimately connected to that which is fundamental to the person's healing needs. In a sense it does not matter where one starts: this is an implication of a unitary view of personhood. There is much less of an either/or, mind-or-body dilemma. One just starts with what one is given, keeps one's eyes open, believes in the connections, and sees what unfolds.

In practice, it seems that patients always manage to convey something that leads to what is helpful. This is very difficult for most clinicians to comprehend because Western culture is not only dualistic but also atomistic. Reality is carved up into compartments, and, further, into bits and pieces. For example, though cardiology recognizes its relationships with nephrology, and cognitive psychology acknowledges affect theory, the overall tendency between medicine and psychology has been to compartmentalize our understanding. It is easier to comprehend bits than to grasp the whole. The net effect is a pervasive assumption of disconnection rather than connection.

The clinical examples given here illustrate the panorama that comes into view when one works from an assumption of connection. Once the assumption of connection is established, the clinical skill of putting the bits of information together into an increasingly coherent story is quite easily achieved. We ask supervisees to reflect on what they have *already been given* by the patient and to ponder what it may mean and see where it leads.

- *Educating the patient about mind/body connections.* Patients with physical symptoms rooted in story are trapped not only within their own defensive style but also within the dualistic paradigm of orthodox Western medicine, which neglects and stigmatizes illness with emotional connections. Patients need a clear explanation of the nature of somatization and, more importantly, of how common and "normal" it is (Goldberg & Bridges 1988).

It can also be extremely useful to share other patient's stories (with adequate confidentiality).

Such stories imply universality, and, not infrequently, the patient will identify with an aspect of the anecdote and lead the clinician to much more relevant material.

Pre-emptive strikes can also be helpful. For instance, in the first therapy session I might say: "I am going to ignore your physical symptoms—not because I am not interested in them, but because I am really interested in them, yet if I focus on them, I will not help you get to the solution"; or, "I might annoy you by constantly pursuing feelings, when what you feel most is your troublesome physical symptoms"; or, "For a while you may find all this puzzling, uncomfortable, and difficult—just tell me if this is so and we will deal with it together"; and so on. By this means, one is preempting hurdles frequently encountered early in the treatment relationship.

- *Believing in the mind/body connections against the odds.* Apart from resistance due to patient defensiveness, there are a variety of elements that may derail story-gathering and consequent treatment. For instance, dualistic residues in the patient, therapist, or doctor can cause major problems. The patient may continually swing back to a focus on physical symptoms. The therapist may lose heart, and give up belief that story is relevant. What is developing into a good psychotherapeutic journey may be derailed by other involved doctors who are not "on board" and who continue to reinvestigate out of their own needs or anxieties, thereby fomenting the patient's anxiety and a return to a body-only focus. Certainly such circumstances test a therapist's self-confidence, illness paradigms, and skills. These problems can be transcended with adequate supervision.

Resistant patients/clients raise all sorts of dilemmas for clinicians. Most therapists prefer to work with clients who are "ready," who are psychologically-minded, and who have reasonable access to their affect states. Many clients presenting with primarily somatic symptoms are none of these. The art of engaging them in a psychotherapeutic journey at initial medical assessment, and in the early stages of therapy requires, in the clinician, capacities to endure

skepticism from patients and colleagues, resilience in the face of patient unwillingness and hostility, and holding oneself calmly in the face of what is an uncertain journey.

A large amount of work is clearly needed to ascertain the benefits of story-oriented approaches in a wide range of physical conditions. Such studies require certain conditions: (a) the clinician's model of personhood is more unitary than dualistic; (b) meanings of illness will be actively sought; (c) the clinician will be person-centered as well as disease-centered; (d) the patient will be seen as expressing him/herself in multiple dimensions simultaneously, and will be responded to multidimensionally; and (e) the clinician will have been trained sufficiently so that a sound enough base of insight and skill can provide trustworthy data in regard to the effectiveness of story-oriented interventions.

The question remains whether an appreciation of story leads to a good therapeutic outcome in a significant number of patients. Our group is currently accumulating systematic clinical outcome data on all those patients assessed in respect to both the orthodox biomedical approach and story and who go on to a mind/body-oriented psychotherapy with therapists trained to do the work.

References

- Bain ST, Spaulding WB 1967 The importance of coding presenting symptoms. *Candian Medical Association Journal* 97:953-959
- Barsky AJ, Borus JF 1995 Somatization and medicalization in the era of managed care. *Journal of the American Medical Association* 274:1931-1934
- Bohm D 1980 Wholeness and the Implicate Order. London: Routledge and Keegan Paul
- Block KI 1999 Psychooncology and total survivorship. *Advances in Mind-Body Medicine* 15:244-251
- Bridges KW, Goldberg DP 1985 Somatic presentation of DSM 111 psychiatric disorders in primary care. *Journal of Psychosomatic Research* 29:563-569
- Broom BC 1997 Somatic Illness and the Patient's Other Story. A Practical Integrative Mind/body Approach to Physical Illness for Doctors and Psychotherapists. London/New York: Free Association Books
- Bullmore E, Joyce H, Marks IM, Connolly JJ 1992 A computerized quality assurance system (QAS) on a general psychiatric ward: toward efficient clinical audit. *Mental Health* 1:257-263

- Cronbach LJ 1975 Beyond the two disciplines of scientific psychology. *American Psychologist* 30:116-127
- Cunningham AJ 1999 Mind-body research: What directions will be most useful? *Advances in Mind-Body Medicine* 15:252-255
- Duffy FD 1998 Dialogue: The core clinical skill. *Annals of Internal Medicine* 128:139-141
- Engel GL 1977 The need for a new medical model: a challenge for biomedicine *Science* 196:129-136
- Folkman S 1999 Thoughts about psychological factors, PNI, and cancer. *Advances in Mind-Body Medicine* 15:255-259
- Ferguson M 1982 Karl Pribram's changing reality. In: Wilber K (ed) *The Holographic Paradigm and Other Paradoxes*. Boston/London: Shambala
- Foss L 1999 Psychooncology: A view from medical ontology. *Advances in Mind-Body Medicine* 15:236-281
- Goldberg DP, Bridges K 1988 Somatic presentations of psychiatric illness in primary care setting. *Journal of Psychosomatic Research* 32:137-144
- Greenhalgh T, Hurwitz B (eds) 1998 *Narrative-based Medicine*. London: BMJ Books
- Greenhalgh T 1999 Narrative based medicine in an evidence based world. *British Medical Journal* 318:323-325
- Greer S 1999 Mind-body research in psychooncology. *Advances in Mind-Body Medicine* 15:236-244
- Groddeck G 1977 *The Meaning of Illness*. Selected Psychoanalytic Writings. The Hogarth Press and The Psychoanalytic Institute, London
- Gunton C 1993 *The One, the Three, and the Many*. Cambridge, MA: Cambridge University Press
- Herman J 1995 The demise of the randomized controlled trial. *Journal of Clinical Epidemiology* 48:985-988
- Kleinman A & Kleinman J 1985 Somatization: The interconnections in Chinese society among culture, depressive experience, and the meanings of pain. In: Kleinman A & Good B (eds) *Culture and Depression*. California: University of California Press
- Kroenke K, Mangelsdorff D 1989 Common symptoms in ambulatory care. *The American Journal of Medicine* 86:262-266
- Langer SK 1967 *Mind: An Essay on Human Feeling*, Vol 1. Baltimore MD: The Johns Hopkins University Press
- Levenson EA 1988 The pursuit of the particular. *Contemporary Psychoanalysis* 24:1-16
- Levenson EA 1990 Self-psychology conference, Sydney.
- Lipowski ZJ 1986 Somatization: A borderland between medicine and psychiatry. *Canadian Medical Association Journal* 135:609-709
- McCauley J, Kern DE, Kolodner K et al. 1997 Clinical characteristics of women with a history of childhood abuse. *Journal of the American Medical Association* 277:1362-1368
- McLeod J 1997 *Narrative and Psychotherapy*. London: Sage Publications
- McWhinney IR 1989 Philosophical and scientific foundations of family medicine. In: *A Textbook of Family Medicine*. London: Oxford University Press
- Marks IM, Blanes T, McKenzie NJ 1995 Computerized clinical benefit-cost audit of mental health care. Theoretical and practical issues. *Mental Health* 1:63-69
- Marks IM 1998 Overcoming obstacles to routine outcome measurement: The nuts and bolts of implementing clinical audit. *British Journal of Psychiatry* 173:281-286
- Meares RA, Hobson RF 1977 The persecutory therapist. *British Journal of Medical Psychology* 50:349-359
- Pataki T 1996 Psychoanalysis, psychiatry, and philosophy. *Quadrant*, April:52-63
- Rotov M 1991 Phenomenology or physicalism. *Schizophrenia Bulletin* 17:183-186
- Shalom A 1985 *The Body/mind Conceptual Framework and the Problem of Personal Identity*. Atlantic Highlands, NJ: Humanities Press International
- Sharpe M 1994 Cognitive-behavioral therapy and the treatment of chronic fatigue syndrome. In: *Chronic Fatigue Syndrome*, Strauss SE (ed) New York: Marcel Dekker
- Smith RC 1985 A clinical approach to the somatizing patient. *Journal of Family Practice* 21:294-301
- Smith RC, Lyles JS, Mettler J et al. 1998 The effectiveness of intensive training for residents in interviewing. A randomized controlled Study. *Annals of Internal Medicine* 128:118-126
- Spiegel D 1999 Embodying the mind in psychooncology research. *Advances in Mind-Body Medicine* 15:267-273
- Strauss SE (ed) 1994 *Chronic Fatigue Syndrome*. New York: Marcel Dekker
- Suchman AL, Markakis K, Beckman HB, Frankel R 1997 A model of empathetic communication in the medical interview. *Journal of the American Medical Association* 277:678-682
- Wickramsekera I 1998 Secrets kept from the mind but not from the body or behavior: The unsolved problems of identifying and treating somatization and psychophysiological disease. *Advances in Mind-Body Medicine* 14:81-132

Comments

Broom's story

Laurence Foss

Laurence Foss' new book, *Biological Medicine Under a Microscope*, will be published this year.

The human being is a machine—an enormously complicated machine, but a machine nonetheless. This view has

NAME: _____

Use BLUE pen for Mood
P= Menstrual period

Stress Scale

Use red pen for stress scale

• tension * uptight

*anxiety *hassled

[illegible]