ABSTRACT. This pilot-study examines the self-perceptions, and explanatory models, of 42 patients with either respiratory or gastrointestinal psychosomatic disorders. For several reasons, these disorders comprise an anomalous category within the biomedical model. It is suggested that clinicians explain their chronic, unpredictable course by 'psychologization'—shifting responsibility for etiology, exacerbations or therapeutic failure to patients' emotions, personality, or lifestyle. Evidence is presented that psychologization is socially constructed, in clinical encounters over time. Patients respond to this process by reifying pathogenic emotions, personality traits, or malfunctioning body parts, and thus separating them from an idealized concept of the social self. It is also suggested that patients with gastrointestinal or respiratory conditions differ in their self-perceptions and explanatory models: a proportion of patients in each group organize their experiences around a central natural symbol—respiration or digestion/excretion. These 2 images link physiological experiences to concepts of pathogenic emotions or personality, physical weakness, and types of social relationships.

INTRODUCTION

Since World War Two, there has been increasing interest in the concept of 'psychosomatic' disorders. A new field of study—psychosomatic medicine—has been developed, with the aim of understanding ill-health from a more holistic perspective; its purpose, according to Lipowski (1968), is 'to study, and to formulate explanatory hypotheses about, the relationships between biological, psychological, and social phenomena as they pertain to persons'. As a result of this approach, a wide range of conditions have been described, all of which have some psychosomatic component (Knapp 1980). However, little research has been done on how—and why—the diagnosis of 'psychosomatic' disorder is negotiated between clinicians and patients, and on the lay explanatory models (see Kleinman 1980: 105) used by patients with these conditions. In particular, it is important to understand how these patients make sense of their physiological experiences, of the diagnostic label of 'psychosomatic', and of the 'stress', 'emotions' or 'tension' said by clinicians to cause or exacerbate their disorders. The pilot-study described below attempts to shed light on these problems, in the case of certain gastrointestinal and respiratory conditions.

THE CATEGORY OF 'PSYCHOSOMATIC'

Despite decades of research, psychosomatic disorders remain, to some extent, an anomalous category within the biomedical model. As numerous authors
(Cassell 1976; Eisenberg 1977; Engel 1977; Kleinman et al. 1978) have pointed out, contemporary biomedicine is characterized by a mind-body dualism, the reduction of ill-health to physicochemical terms, and an emphasis on biological (rather than social or psychological) information in reaching a diagnosis. As a result psychosomatic disorders are often difficult to diagnose, or to confine within the biomedical model — especially as they are often ‘illness without disease’, where emotional or behavioral changes occur in the absence of any identifiable organic abnormality. This group, which Minuchin et al. (1978: 29) term secondary psychosomatic disorders, should be distinguished from primary disorders where an identifiable physiological dysfunction is already present, but is exacerbated by psychological factors. But even in primary disorders — which Engel (1975: 657) terms ‘somatopsychic-psychosomatic’ — the relationship of the organic abnormality to the patient’s symptoms and signs is often tenuous and unpredictable. In both groups the clinical picture is frequently time- or context-specific, and diagnosis depends on knowing why a particular individual got a particular symptom, at a particular time. In many cases these contexts are social, psychological or environmental, and this information may be inaccessible to some clinicians, especially those with a bias towards biological explanations of ill-health. A further difficulty, from the biomedical point of view, is that many psychosomatic disorders have a chronic, relapsing, and unpredictable course (e.g., Drossman 1977); where social or psychological factors play an important role in exacerbations, this course is less controllable by clinicians reliant on chemotherapy or a ‘technological fix’. Another problem with these disorders is the difficulty in explaining, or predicting ‘organ choice’ — i.e., why a particular organ or physiological system is involved in a particular individual — by using a strict biomedical paradigm. This is because each occurrence of the disorder may only be explained by reference to the unique biological, social and psychological aspects of that patient’s life — and not by the characteristics of a particular disease entity.

Lipowski (1968) has also pointed out that the very term ‘psychosomatic’ “connotes an assumption that there exist 2 classes of phenomena, i.e., psychic (mental) and somatic, which require separate methods of observation and distinct languages for their description”. The term imposes, therefore, both a semantic and a methodological dualism on the study of ill-health. Engel (1967) pointed out the difficulties, given this assumed dualism, in reconciling the paradigms used to explain phenomena in the biological and the psychological domains. He noted the difficulties in establishing relationships between these two frames of reference, since the principles used in establishing relationships within the psychological frame are different from those needed to establish relationships within the somatic frame of reference. For example, behavior and mental activity are subdivided into subcategories such as affects, object relations, ego defences,
and cognitive functions, and these abstractions do not constitute discrete, measurable functions in the same sense as, say, the components of gastric secretions. Also, each subcategory is always part of others; e.g., affects always involve drives, ego defences, cognitive functions and so on. Psychic activity, therefore, is a 'configurational unit', while somatic activity involves "multiple interrelated unitary functions more or less susceptible to identification and measurement". To overcome the seeming incompatibility of paradigms, both Lipowski (1968) and Engel (1977) proposed a more holistic model that would integrate the biological, psychological, interpersonal and social aspects of the patient's life. Engel, in particular, has stressed the inter-relationships — especially positive and negative feedback loops — between these different domains. Other writers, however, have tended to view psychosomatic disorders along one of three etiological axes — as originating in the 'psyche', 'soma' or 'society'.

_Psyche: The Psychogenicity Hypothesis_

Early writers on psychosomatic disorders explained both their pathogenesis and 'organ choice' by 'psychogenicity' — that is, a linear, causal relationship between certain psychological factors — such as personality type (or trait), intrapsychic conflicts, defensive patterns, or dysphoric affects — and specific somatic symptoms or structural changes. This approach implied a dichotomy, as well as etiological link, between 'inner' (psyche, emotions, conflicts) and 'outer' (somatic signs, symptoms, and behavioral changes) realities. In a sense, psychic factors were seen as 'pathogens' acting upon, or expressed in, the material body in a patterned way. This formulation followed Freud and Breuer's (1966) earlier theory of conversion hysteria, as the symbolic somatic expression of intrapsychic conflicts. Weiss and English (1942) postulated a subjective 'organ language', whereby selection of affected organs was based on the symbolic meaning of that organ for the individual: diarrhea and vomiting were attempts by the patient "to rid himself of a guilty feeling or of the thoughts that produce it", while asthma was a form of 'symbolic crying'. Sontag (1948) suggested that the individual developed a conditioned response in childhood which later determined "the expression of an anxiety through certain physiological channels". Other writers focussed less on specific emotions, or conflicts, and described instead dysfunctional 'personality types' or 'traits'. According to Dunbar (1948), each psychosomatic disorder was associated with a specific 'personality profile' which contributed towards to its development. In this context, the notion of pathogenic personality types can be seen as cultural constructs, based on normative models of social behavior. For example, Groen (1948) described the 'character structure' of ulcerative colitis patients as: "They are fearful, and when in imminent danger often overtly cowardly." More recently, the emphasis has shifted
from an emphasis on the pathogenic ‘personality type’ to specific traits, or clusters of traits. Gildea (1968) reviewed the “personality malfunctions” of psychosomatic disorders, reported by various authors; his study attempted to link psychological ‘maladjustments’ to specific traits such as ‘subnormal assertiveness’ (“Rarely able to verbalize feelings even when aware of them. Just takes it from boss, wife, friends etc.”) with specific disorders, such as hypertension, peptic ulceration and rheumatoid arthritis. Knapp (1975) described the ‘consistent characterological features’ of asthmatics, including “unusually strong passive and dependent personality traits” reflecting needs to maintain gratification and support from key persons. Cheren and Knapp (1980) have also described the ‘typical personality traits’ or ‘character disturbances’ of patients with ulcerative colitis, Crohn’s disease, irritable bowel syndrome, and bronchial asthma; e.g., those with Crohn’s disease had ‘compulsive or paranoid traits’ with excessive dependency, compliance, and ‘explosive manipulation’.

While the linear, psychogenic model has gradually given way to more complex, multi-causal or systems models (e.g., Minuchin et al. 1978), the contributory role of intrapsychic conflicts or personality traits in psychosomatic disorders remains part of the biomedical model — and of lay explanatory models. This is despite Lipowski’s (1968) review of the literature, which cast doubt on the existence of disease-specific personalities or psychodynamic constellations in these disorders.

**Soma: Physical Weakness or Vulnerability**

Parallel with theories of psychogenicity, several researchers postulated an inherited or acquired physical ‘weakness’ — either local or generalized — which determined the choice of ‘target organ’, especially in the presence of pathogenic personality traits or intrapsychic conflicts. Bauer (1942) suggested that there was an ‘inherited organ inferiority’ which led to specific psychosomatic disorders, but he largely ignored the psychodynamic aspects, while Hendrick (1948) suggested ‘physical infantilism’ — an “immaturity in the homeostatic processes in an organ system” — as the reason for ‘organ choice’. Sontag (1948) and other ‘constitutionalists’ argued for more general physiologic predispositions to these conditions, such as inherited disorders of enzyme systems or autonomic nervous system functions. Alexander and his colleagues (1968) have tried to explain organ choice or psychosomatic specificity by a multi-causal model, involving (1) the individual’s “characteristic psychodynamic conflict pattern” present from childhood (such as “frustrated urges for accomplishment” in ulcerative colitis patients), (2) a specific ‘onset situation’, which involved activation of this conflict pattern, and (3) a physical, constitutional ‘Factor X’, defined as a ‘specific organ vulnerability’ or weakness. Alexander suggested that some organic diseases
have not only a specific pathophysiology, but also a specific psychopathology. This implies either psychogenesis, or that physiological phenomena are the expression of "certain basic qualities of the organism which manifest themselves on the somatic side as an organic predisposition". However, this hypothesis assumes a consistency of conflict patterns, onset situation, and constitutional predisposition. If "characterological patterns or emotional constellations" are consistent phenomena, then one would expect a particular 'target organ' to be consistent over an individual's life. While some patterns — such as ulcerative colitis — seem more consistent, others vary greatly. Vaillant (1968), in his 30-year prospective study of 95 men, found that there were no consistent target organs over the years in those who developed psychosomatic disorders.

Engel (1975: 667) has suggested that physical factors — particularly in the 'somatopsychic-psychosomatic group' — may in their turn influence the development of specific psychological characteristics. The relationship of physical to psychological symptoms was also examined by Grace and Graham (1952) and Grace et al. (1962). They related specific psychological 'attitudes' to certain physiological symptoms in psychosomatic disorders; for example, diarrhea occurred "when an individual wanted to be done with a situation or to have it over with, or to get rid of something or somebody". However, their research did not indicate the nature of the link between attitudes and symptoms.

Society: The Role of Social Categories

An alternative to the mind/body dualism outlined above has been the study of the categories through which physical and psychological states are cognized, labelled, ordered, and acted upon. In this view, 'mind', 'emotions', 'personality', 'body' and 'organs' are all cultural categories, which are socially derived. They result from, and are maintained by, personal experiences, interpersonal interactions, and institutionalized role structures (Katon et al. 1982). Douglas (1973) has pointed out the social dimensions of the human body, whereby experiences of the body are modified by the social categories through which it is known, and the categories of social experience and bodily experience enhance one another. In every society, according to Douglas, there is pressure to create consonance between the perceptions of social and physiological experience. Littlewood (1984) points out the reciprocity of this relationship, whereby natural symbols derived from human biology help pattern or reinforce social categories, as in the binary division of the social and natural worlds into 'male' and 'female' categories. Taussig (1980) has also noted how the body is a condensation of social categories — a "cornucopia of highly charged symbols — fluids, scents, tissues, different surfaces, movements, feelings, cycles of changes constituting birth, growing old, sleeping and waking" — all of which are linked to different forms
of social relations. The social and cultural worlds, therefore, provide the categories through which both bodily and psychological experiences are perceived, and interpreted (Fisher 1968; Mechanic 1972). Similarly, the internal perception of bodily disease, or of abnormal symptoms, is in part learnt from social interactions, and depends on "external cues, interpersonal communications, and the information at hand about the situation" (Barsky and Klerman 1983). These also influence whether, and how, emotional problems are expressed via somatic complaints (Katon et al, 1982), and vice versa.

To some extent, both emotions and personality are cultural constructs. Kleinman (1980: 147) points out that while affects occur as universal psychobiological states, cultural beliefs and values determine how they are cognized — before they take the form of "perceived, felt, labelled, and valued experiences recognized as emotions". In his study of the Australian Pintupi, Myers (1979) suggested that emotions he seen as an ideology, as models of how one should feel and behave in relation to others. The Pintupi view of the emotions provides individuals with a moral system, an internal representation of the normative order, with some emotions more socially acceptable that others. In that sense, emotions recognized and interpreted through socially-derived categories represent different types of social relationships, and different types of relationship of the self to the moral order. Engel (1960), for example, noted how some (socially) 'bad' emotions — such as rage, fear, envy, greed or disgust — are reified by some individuals into external agents that somehow 'cause' them to feel ill or unhappy. The perception of emotions, therefore, may involve the cognitive distinction between socially 'good' and socially 'bad' emotions, with the latter — like diseased organs (Cassell 1976) — reified, and thus separated from the concept of 'self'. This reification may be a function of the construction of illness realities in the encounters between clinician and patient (Good and Good 1981). On this basis I would hypothesize that the diagnosis, in psychosomatic medicine, of the pathogenic social personality trait or emotion, may be a way of shifting responsibility for etiology, exacerbations or therapeutic failure from the clinician to the patient — or to reified parts of the patient's 'self'. These socially 'weak' parts of the self can be seen as analogous to the physical weaknesses described earlier, such as Alexander's constitutional 'Factor X'.

In psychosomatic disorders, as in other conditions, it is important to understand the cognitive categories through which patients (and clinicians) are interpreting the illness, and also how these categories are derived from the patient's social milieu. There is evidence that once a 'cognitive set' for the interpretation of psychological or bodily states has been established, it may adversely affect both physiological responses and mood states. Wright and Beck (1983), for example, have described the "self-defeating cognitions and behavior" of depressed patients, while Barsky and Klerman (1983) point out how even physiological
responses such as heart rate, breathing, or pain response may all be affected by “the thoughts a person has about his or her physical state and the ideas supplied by others”. The research of family therapists, such as Minuchin et al. (1978) sheds light on the social origins of these ideas, especially the role of family members in the development, and maintenance, of the symptoms and cognitions of the psychosomatic child. They point out that “the psychological unit is not the individual. It is the individual in his significant social contexts”. One dimension of this social context is described in this study — the explanatory models and self-perception of patients with chronic psychosomatic disorders.

METHODS

The study sample consisted of 42 adult patients, diagnosed by their clinicians as having chronic disorders with a definite ‘psychosomatic component’ — either primary or secondary, as described above. Half the sample (21 patients) had a psychosomatic disorder of the respiratory system (in this case, bronchial asthma), while the other half had disorders of the gastrointestinal tract (ulcerative colitis, irritable bowel syndrome, functional vomiting, and Crohn’s colitis). A further 16 patients, approached to take part in the study, either refused or failed to turn up to interviews. The patients were attending the Departments of Medicine at the Cambridge City and Mount Auburn Hospitals in Cambridge, Massachusetts, and a private family practice in that same city. The interviews were semi-structured, and were based on a detailed and standardized questionnaire. They usually lasted 1–1½ hours. The interviews were designed to collect three types of data: (1) social and demographic details of the patient sample, (2) patients’ explanatory models of their disorder, particularly of its ‘psychosomatic’ component, and (3) patients’ perceptions of the role of their social relationships in causing, maintaining, or alleviating their disorders. The aim was to discover common themes between, and within, each diagnostic category — especially the ways that patients made sense of their physiological experiences, of the diagnostic label of ‘psychosomatic’, and of their interactions with clinicians over the years.

RESULTS

Details of the patient sample, and of their diagnoses, are shown in Table I. The majority of the sample had been diagnosed as having the psychosomatic disorder many years previously — the mean number of years since diagnosis was 20.9 years in the asthmatics, and 8.1 years in the gastrointestinal group. In most cases this period was characterized by chronic, relapsing and unpredictable ill-health.
<table>
<thead>
<tr>
<th></th>
<th>Combined sample (N = 42)</th>
<th>Gastrointestinal group (N = 21)</th>
<th>Respiratory group (N = 21)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Female</td>
<td>32</td>
<td>19</td>
<td>13</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18–39 years</td>
<td>30</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>40–59 years</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>60 + years</td>
<td>7</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>Mean age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years</td>
<td>39.7</td>
<td>41.9&lt;sup&gt;a&lt;/sup&gt;</td>
<td>37.5&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>13</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Single</td>
<td>14</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Divorced/Seperated</td>
<td>9</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Widowed/Other</td>
<td>6</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>College graduate</td>
<td>19</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Partial College or high school graduate</td>
<td>17</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Partial high school or less</td>
<td>6</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>31</td>
<td>13</td>
<td>18</td>
</tr>
<tr>
<td>Black</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4</td>
<td>4</td>
<td>–</td>
</tr>
<tr>
<td>Indian</td>
<td>1</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>20</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Protestant</td>
<td>11</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Jewish</td>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Mean years since diagnosis</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years</td>
<td>20.9&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td>8.1&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup> s.d. 16.2; s.e. 3.5.  <sup>b</sup> s.d. 13.6; s.e. 3.0  
<sup>c</sup> s.d. 16.2; s.e. 3.5.  <sup>d</sup> s.d. 10.7; s.e. 2.3

**Gastrointestinal group: diagnostic categories**

- Ulcerative colitis: 12
- Irritable bowel syndrome: 6
- Functional vomiting: 2
- Crohn's colitis: 1
It also corresponded to exposure to biomedical models of psychosomatic disorders, especially of their etiology and treatment.

Although this pilot-study was based on a small, and not necessarily representative sample, it was possible — in analyzing the transcribed interviews — to isolate common themes within each diagnostic category. Despite the heterogenous educational and ethnic composition of each diagnostic group, a majority of its members seemed to share a similar explanatory image — an image based on physiological experiences, and one which condensed the physical, psychological and social aspects of their condition. These common images will be described in more detail below.

**Explanatory Models of Psychosomatic Disorders**

The range of patients' explanatory models of the etiology of their condition is shown in Table II. These models show some resemblance to the biomedical

<table>
<thead>
<tr>
<th>Etiology</th>
<th>Respiratory Group (N = 21)</th>
<th>Gastrointestinal Group (N = 21)</th>
<th>Total (N = 42)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td></td>
</tr>
<tr>
<td>1. Emotion and stress</td>
<td>21 (100)</td>
<td>19 (91)</td>
<td>40 (95)</td>
</tr>
<tr>
<td>2. Personality type</td>
<td>14 (67)</td>
<td>18 (86)</td>
<td>32 (76)</td>
</tr>
<tr>
<td>3. Hereditary predisposition</td>
<td>14 (67)</td>
<td>7 (33)a</td>
<td>21 (50)</td>
</tr>
<tr>
<td>4. Allergies</td>
<td>15 (71)</td>
<td>-</td>
<td>15 (36)</td>
</tr>
<tr>
<td>5. Infection</td>
<td>9 (43)</td>
<td>2 (10)b</td>
<td>11 (26)</td>
</tr>
<tr>
<td>6. Constitutional weakness (local or generalized)</td>
<td>4 (19)</td>
<td>10 (48)c</td>
<td>14 (33)</td>
</tr>
<tr>
<td>7. Weather</td>
<td>11 (52)</td>
<td>-</td>
<td>11 (26)</td>
</tr>
<tr>
<td>8. Smoking</td>
<td>7 (33)</td>
<td>-</td>
<td>7 (17)</td>
</tr>
<tr>
<td>9. Dust or sawdust</td>
<td>3 (14)</td>
<td>-</td>
<td>3 (7)</td>
</tr>
<tr>
<td>10. Exercise</td>
<td>2 (10)</td>
<td>-</td>
<td>2 (5)</td>
</tr>
<tr>
<td>11. Divine punishment</td>
<td>1 (5)</td>
<td>-</td>
<td>1 (2)</td>
</tr>
<tr>
<td>12. Ethnicity</td>
<td>1 (5)</td>
<td>-</td>
<td>1 (2)</td>
</tr>
<tr>
<td>13. Gender</td>
<td>-</td>
<td>1 (5)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>14. Medication</td>
<td>-</td>
<td>2 (10)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>15. Eating habits</td>
<td>-</td>
<td>5 (24)</td>
<td>5 (12)</td>
</tr>
<tr>
<td>16. Bowel training</td>
<td>-</td>
<td>1 (5)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>17. Swallowing ocean water</td>
<td>1 (5)</td>
<td>-</td>
<td>1 (2)</td>
</tr>
<tr>
<td>18. Auto-immune</td>
<td>-</td>
<td>2 (10)</td>
<td>2 (5)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>103</td>
<td>69</td>
<td>172</td>
</tr>
</tbody>
</table>

* a p < 0.04.  b p < 0.02.  c p < 0.05

**Mean number of etiologies per patient:**

- Respiratory group: 4.9
- Gastrointestinal group: 3.3
explanations of psychosomatic disorders described above. Like them, they include notions of the role of pathogenic emotions or personality, physical weakness (inherited or acquired), and social factors, in their development or exacerbation. Most of the patients’ models involved *multi-causal* explanations for their disorder, with an average of 4.9 etiologies per asthmatic patients, and 3.3 for the gastrointestinal group. These models constitute a lay ‘biopsychosocial’ model (see Engel 1977), which links together the physical, psychological and social aspects of the patient’s life. For example:

(54 year old woman with asthma) I guess I was having the kids when it began. That might be one major catastrophe in my life. Also I was separating from my husband at the time. I used to get upset. I used to get an attack when my father went back to Maine. He lived in Maine, he worked there. I think it was all the factors together, plus the fact that I had a series of bronchitis when I was a child. I was a croupy child. My father was bronchial, my mother was bronchial when we were kids. Also, I used to live on coffee and cigarettes at the time – 30 cigarettes a day, maybe 40 –

A large majority of the patients (40) saw ‘emotion’, ‘stress’ or their own ‘personality’ as contributing towards their ill-health. Half (21) ascribed it to heredity, and a third (14) to a local or generalized ‘weakness’. Overall, etiologies over which the individual had *no* control — such as heredity, constitutional weakness, weather, allergies, or gender — were more common in the asthmatic group. This difference may be related to gender, since the majority were female (19); when selected illness etiologies were compared between females in each group some differences persisted, though with the small size of the sample these were not statistically significant. Like the biomedical models, patients viewed the origin of their ill-health along the three etiological axes — ‘psyche’, ‘soma’, and ‘society’.

*Psyche*

While the majority of the sample saw emotional state as a causative factor, they varied in defining what emotions were defined as negative or pathogenic — though there was no significant differences between the two diagnostic groups. Often two or three emotions were defined as negative by each patient: the asthmatics identified ‘tension’ (15 patients), anger (6), ‘stress’ (3), uncertainty (3), upset (7), unhappiness (2) and guilt (1), while the GI group identified ‘tension’ (18), anger (10), frustration (4), ‘stress’ (8), and uncertainty (2). In 31 of the interviews (twelve asthmatics and nineteen GI group), unpleasant or negative emotions were spoken of as an ‘it’, separate in some way from the concept of ‘self’. These reified emotions were described as pathogens, attacking vulnerable organs or systems within the body. This image may be derived from contemporary US popular culture (e.g., “Suddenly, without any warning, she was gripped by an attack of raw, stomach-wrenching terror” — Houck 1983: 30).
There were significant differences – to be described below – in how most patients in each diagnostic group described the effect of these emotions on their health.

As with emotions, a majority (40) of the patients saw their own ‘personality’ as contributing towards the origin, exacerbation, or chronicity of their condition. In that sense, personality type or trait was described as separate, to a variable degree, from the ‘self’ and, as such, only partially under its control. Personality was conceived of as either congenital or inherited (familial). Eleven asthmatics and eleven in the GI group described themselves as too ‘sensitive’, ‘nervous’, ‘tense’, or ‘vulnerable. Twelve GI patients (and three asthmatics) described themselves as people who ‘held too much in’, while three of the GI group described themselves as being ‘obsessive’, ‘perfectionist’ or ‘anal’ personalities. In some cases patients saw themselves as having several of these pathogenic personality traits.

Soma

Half the sample (21) ascribed their condition to a hereditary physical ‘weakness’ or predisposition (see Table II), while others saw this weakness as being constitutional (14) or acquired (25). Examples of these three, overlapping, types of ‘weakness’ are:

(31-year old woman with asthma) All my family have it (asthma). My aunt, mother, two sisters, a brother, three nephews, a baby niece. I don’t know if it’s hereditary. Some doctors say no, but I figure yes – how come a baby be born with a sickness? Maybe from the father, no?

(24-year old woman with asthma) Everyone has a weakness. It’s my weakness. It’s the way your body reacts to negative stimuli – like allergies –

(67-year old woman with ulcerative colitis) If you’re upset about something, your stomach is the weakest part. Like when my sister was at the hospital and she passed away, and the doctor called to tell you she died, and then I had to fly up to the bathroom.

(64-year old woman with ulcerative colitis) A hereditary tendency. It’s a problem in our family. When we’re upset colitis – not ulcerative – would result. My mother, my daughter, my uncle in Ireland, have it if they’re stressed. Also, in November I was awaiting a hip replacement, and I was given Naprosyn 500 mg two or three times a day, plus aspirin. Within one week I started with colitis, bleeding. Yes, it was the over-strong medication – a physical cause.

As illustrated in Table II, physical ‘weakness’ can be acquired by exposure to a number of external influences, including drugs, infection, allergens, tobacco smoke, or weather conditions. In addition, nineteen patients (fifteen asthmatics and four in the GI group) spoke of their diseased organs (lungs, bronchi, stomach, colon) as being in some way autonomous, and independent of the
individual's control. This reification of diseased organs was also noted by Cassell (1976). He suggested that this was a method of distancing a disease, or diseased part, and thus enabling the victim to see it as 'non-self': no longer part of the intact body image - but rather something intrusive on it. In this study, 'autonomous' organs were understood as 'attacking' the self, sometimes in association with pathogenic emotions or personality traits, or external physical or social influences. For example:

(54-year old woman with asthma) The bronchial tubes close, tighten up on me, so no air goes into the lungs. When I feel nervous, I feel them tightening up.

(30-year old woman with irritable bowel syndrome) (To help the condition) Trying to monitor what's happening. Being in touch with what's inside before the colon knows. Using relaxations. Talking to the various organs. It helps.

(32-year old woman with asthma) When I'm, under acute stress, I can feel myself tightening up. If people are not aware of how their emotions can damage their health, it can be detrimental. If you're unhappy, angry, it can cause them to tense up, cause their resistance to be low so that they're open to infection. With asthma it causes them to tighten up their bronchi. If my son is going through a bad time, the stress can cause my bronchi to spasm.

(60-year old woman with asthma) Bad relationships — they can make it worse — anxiety, upset. If something happens, it may make an attack come on. A row can make me tighten up. You get anxiety, and that gives you an attack.

As with reified emotions or personality, these organs are to some degree separate from the concept of self; in some cases they are 'public' organs, directly responsive to interactions with other people, as mentioned in this last example. The experiences of bronchospasm and feeling tense — 'tight' bronchi and feeling 'uptight' — were fused in a number of cases. For example:

(24-year old woman with asthma) When I get uptight with my husband, which has been happening a lot lately, I feel a tightness in my chest and I know I'm going to have an attack.

Overall, these explanatory models saw the psychosomatic disorder as arising in part from a physical 'weakness', or from an autonomous organ. In both cases, therefore, its etiology was largely out of the patient's control.

Society

The third etiological axis — the perceived role of social relationships in the disorder — is illustrated in Table III. A majority of the sample (thirty-nine patients) believed that 'bad' relationships could adversely affect their condition, or explain its etiology. Similarly, thirty-one patients believed that 'good' relationships could affect their health in a positive way, while twenty-eight believed that these good relationships could actually cause, maintain, or restore good health. A large
TABLE III
Health and social relationships

<table>
<thead>
<tr>
<th>Table III</th>
<th>Health and social relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory group (N = 21)</td>
<td>Gastrointestinal group (N = 21)</td>
</tr>
<tr>
<td>No. (%)</td>
<td>No. (%)</td>
</tr>
<tr>
<td>1. Bad relationships can influence one's health</td>
<td>20 (95)</td>
</tr>
<tr>
<td>2. Relationships can cause illness</td>
<td>20 (95)</td>
</tr>
<tr>
<td>3. Good relationships can influence one's health</td>
<td>16 (76)</td>
</tr>
<tr>
<td>4. Relationships can cause, maintain or restore health</td>
<td>11 (52)</td>
</tr>
<tr>
<td>5. One's health affects one's relationships</td>
<td>9 (43)</td>
</tr>
<tr>
<td>6. One's relationships would be different if one were healthy</td>
<td>1 (5)</td>
</tr>
<tr>
<td>7. Have had bad relationships with family members</td>
<td>13 (62)</td>
</tr>
<tr>
<td>8. Have had bad relationships with non-relatives</td>
<td>10 (48)</td>
</tr>
</tbody>
</table>

a = p < 0.05, b = p < 0.05

number of GI patients also believed that their relationships with others would have been different if they had not been ill. There was wide variation, however, in how both ‘good’ and ‘bad’ relationships were defined. A comparison of replies by male and female patients showed some differences, though these were not statistically significant.

In terms of the social ‘onset situation’ (see Alexander et al. 1968), a majority of the asthmatic group (17 patients) saw the ‘stress’ that precipitated their attacks as originating in their pre-existing social networks — such as conflict with spouse, children, relatives, friends, or neighbors. In the GI group, these social etiologies were identified by eleven patients, while five mentioned ‘pressure’ at work.

Analysis of the questionnaires suggested that patients’ explanatory models of psychosomatic disorders are, to a lesser or greater extent, socially constructed. The majority of the sample (thirty-nine patients) indicated that they had learnt about their condition — particularly the etiological roles of stress, emotion and personality — from other people, especially from clinicians. This supports Good and Good’s contention (1981) that illness realities are socially constructed, particularly in the interactions between doctors and patients. They also incorporate, however, patients’ personal experiences, the experience of friends or family, inherited folklore, and information gathered from printed material or
television. In the case of psychosomatic disorders, the social construction involves the 'psychologization' of the condition — redefining physical symptoms as emotional or psychological in origin. This implies, also, a shift of responsibility from clinician to patient — especially to their personality, emotional makeup, lifestyle, or social relationships. In some cases the shift was to the patients' physical predisposition, or 'genetic makeup'. This social construction of psychosomatic disorders is illustrated in the following four vignettes:

(25-year old medical student with ulcerative colitis) Other people were saying there was something wrong with me psychologically. If I'd had appendicitis or a cough, I would have been spared this. Some of these friends were doctors, others not. It's often associated with a psychological component. I searched very hard and for a reason — Why me? Everyone told me it must be psychological, there must be a large psychological component — it's in the medical textbooks. Our society associates the bowel and stomach with nervousness — it's more sensitive to tension.

(33-year old man with ulcerative colitis) It's a kind of strange thing — my parents left about one week before it happened. They left for Florida. I didn't know if that was the cause. I read it in magazines. My girl friend — she's a social worker — she's seen it in books. I've heard it's stress. Maybe because of my background, my Armenian background, my Far Eastern background I've heard it I have a lot of stress. They keep asking me if I have a lot of stress in my life, but I don't think I have a lot of stress.

(29-year old male sociology professor) I had been in analysis and my sense is that my background would predispose me to get an ulcerative colitis-like illness, but there was no reason for me to get one. I'm very perfectionist, oriented towards control of situations — the uncontrollable — and this predisposes me to a colitis-type of disease. But I have no idea why I got it. It came after a period of my life when I was at my healthiest. It's as a result of psychoanalysis, and also from having the illness. I didn't know this before last April. I learnt it from the medical doctors and from the shrink. It was new knowledge, the connection of these types of colitis symptoms and those psychological symptoms.

(34-year old woman with ulcerative colitis) They tell me it's a lot of genetic tendencies to put psychological stress into my body. Until a year ago the doctors were telling me I was crazy. It was my own fault because of what I did. Some said it's because of how you ate. Some said because I was too sensitive. Others said it was because of exercise. Others said because I wasn't taking enough Azulfidine. What I heard from all the doctors was that it was my fault, and if only you did what they said, everything would be OK. Caroline, my (present) doctor, she asked me what psychosomatic meant. She said 'It's not what you think — people think psychosomatic means that it's your fault' — but she says that there's a genetic tendency to put stress in your body, and that's a weakness you have. Before Caroline, they said it was all my fault, and that if only I did things differently everything would be OK.

Another social aspect of these conditions were the patients' beliefs about whether they had control over their social relationships — particularly as to whether the relationship had positive or negative effects on their health. Half the sample (eight asthmatics, thirteen GI patients) felt that they did have control over the types of relationships that they had with other people. Eight (80%) of the men and thirteen (41%) of the women thought that they did have control. When the
two groups of female patients were compared, slightly more GI patients (62%) had control, compared with 42% of the asthmatics.

**COMPARISON OF THE TWO DIAGNOSTIC GROUPS**

As illustrated in Table I, the patient sample had a heterogenous educational, ethnic and religious background. In addition, the GI group consisted of patients with four different diagnoses — ulcerative colitis, irritable bowel syndrome, functional vomiting, and Crohn’s colitis. Despite this heterogeneity, it was possible in analyzing the interviews of the two diagnostic groups (respiratory and gastrointestinal) to isolate common themes within each group. These themes are illustrated in Table IV. I argue that the majority of patients in each group, whatever their background, use a common explanatory image — an emic illness category which condenses the physical, psychological and social aspects of their disorder. In each case this image is a natural symbol — a socially-derived category through which a natural physiological process is perceived and understood (see Douglas 1973: 93). The natural symbols here are the processes of respiration and digestion, and the associated symptoms of bronchospasm, diarrhea, or vomiting. Like 'heart distress' in Iran (Good 1977), this physiological image “draws together a network of symbols, situations, motives, feelings, and stresses” which are rooted in patients’ daily lives and experiences. I suggest that chronic disorders of the respiratory or gastrointestinal tract lead to a pre-occupation with these physiological processes, and that the illness realities constructed between clinician and patient (see Good and Good 1981) link these natural symbols to the wider world of social and moral values. As well as explaining a physical process, the symbol organizes both social and emotional experiences, and helps define certain emotions, thoughts, personality traits, and parts of the body as either ‘self’ or ‘non-self’. Defining some of these as ‘non-self’ can bring the patient’s self-image closer to the normative order of contemporary life — to social values of independence, fitness, youthfulness, contentment, social success, and control over bodily functions and emotions.

The differences in physiological imagery utilized by a majority of patients in each diagnostic category, is illustrated in Table IV. In respiration, the individual has only partial control over the physiological process, in that he can neither ‘choose’ whether to breathe, nor what he breathes in — whether this is dust, odors, or certain allergens. Respiration is a visible physiological process, with immediate response to environmental influences — e.g., by coughing, sighing, speech, or hyperventilation. Expiratory sound, such as speech or crying, is patterned by culture and is part of all social relationships. Bronchial asthma involves a disturbance of this process, often with symptoms of wheezing, cough, or shortness of breath. By contrast, digestion is a slower and more invisible
### TABLE IV
Comparison of the two diagnostic groups

<table>
<thead>
<tr>
<th>NATURAL SYMBOL</th>
<th>Respiratory group (N = 21)</th>
<th>Gastrointestinal group (N = 21)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PSYCHE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotions</td>
<td>Visible, continuous physiological process. No control over what is inhaled. Immediate, visible response to social or environmental stimuli. Expiratory sound, such as speech or crying, patterned by culture.</td>
<td>Visible, continuous physiological process. No control over what is inhaled. Immediate, visible response to social or environmental stimuli. Expiratory sound, such as speech or crying, patterned by culture.</td>
</tr>
<tr>
<td>Personality type or trait</td>
<td>Negative emotions, usually linked to outside events, attack (weak) lungs or bronchi, causing them to tighten up and obstruct breathing. (12 patients) Negative emotions described as an 'it' (12 patients) Too sensitive, nervous or vulnerable to outside events (11 patients) Hold too much in (3 patients)</td>
<td>Negative emotions, linked to outside events, accumulate within the self, and are expelled via (weak) stomach or bowels as anger, 'stress', feces or vomitus. (14 patients) Negative emotions described as an 'it' (19 patients) Too sensitive, nervous, or tense (11 patients) Hold too much in (12 patients) Obsessive, perfectionist or anal (3 patients)</td>
</tr>
<tr>
<td><strong>SOMA</strong></td>
<td>1. Independent of patient’s control. Attack patient’s breathing in response to outside events or to negative emotions responding to those events. (15 patients) 2. Weakened by hereditary, constitutional, or acquired factors – or combinations of these (Hereditary: 14 patients) (Constitutional: 4 patients) (Acquired: 16 patients)</td>
<td>1. Independent of patient’s control Accumulate negative emotions, or respond to outside events by producing vomiting or diarrhea. (4 patients) 2. Weakened by hereditary, constitutional, or acquired factors – or combinations of these (Hereditary: 7 patients) (Constitutional: 10 patients) (Acquired: 9 patients)</td>
</tr>
<tr>
<td>Social relationships</td>
<td>1. Can cause illness (20 patients)</td>
<td>1. Can cause illness (19 patients)</td>
</tr>
</tbody>
</table>
Table IV (continued)

<table>
<thead>
<tr>
<th>Respiratory group</th>
<th>Gastrointestinal group</th>
</tr>
</thead>
<tbody>
<tr>
<td>(N = 21)</td>
<td>(N = 21)</td>
</tr>
<tr>
<td>2. Can cause, maintain, or restore good health (11 patients)</td>
<td>2. Can cause, maintain, or restore good health (17 patients)</td>
</tr>
<tr>
<td>3. Patient has control over their relationships (8 patients)</td>
<td>3. Patient has control over their relationships (13 patients)</td>
</tr>
</tbody>
</table>

**PATHOGENESIS**

- **Exogenous**
  - External social or environmental influences attack (weakened) lungs directly, or in association with negative emotions and/or autonomous organs. Pathogenesis may be aided by personality type (18 patients)
  - External social influences taken into the self, transformed into negative emotions, and allowed to accumulate; must then be expelled via (weakened) bowels or stomach in form of anger, stress, feces, or vomitus. Pathogenesis may be aided by personality type (14 patients)

- **Emotions**
  - Social stresses or environmental factors
  - Emotional stress
  - Physical stress
  - Therapeutic strategy
  - Immediate
  - Delayed
  - 'Unload' or express negative emotions to other people (2 patients)
  - Avoid, or withdraw from, external social or environmental influences (10 patients)
  - Get control over emotions (2 patients)
  - Take medication (20 patients)
  - 'Unload' or express negative emotions to other people (14 patients)
  - Relax (5 patients)
  - Take medication (17 patients)
physiological process, and the conversion of food to feces can take up to 24-hours. Unlike respiration, the individual has some control over what, and when to eat, and the time and place of excretion. All food eaten must eventually be discharged from the system as either feces or vomitus. The preparation and ingestion of food, and the disposal of waste products, are all closely patterned by culture, and are also linked to the maintenance of social relationships. In the gastrointestinal conditions in this group (see Table I), a disturbance of function can involve diarrhea, bloody stools, abdominal pain, and vomiting.

1. The Gastrointestinal Group

Fourteen patients in this group described a process of taking social stresses into the 'self', transforming them into negative emotions — such as anger, tension, hostility, fear, or stress — and failing to release them quickly. These (reified) emotions accumulate within the self, become more dangerous, and must be expelled to the outside as feces, vomitus, anger or 'stress'. In some cases, these two types of socially-unacceptable waste products are used interchangeably, with 'stress' taken in and 'digested' eventually to either anger or feces. The escape of these negative emotions from the self was facilitated by an acquired, hereditary or constitutional physical 'weakness' in the stomach or bowel. In four cases these organs acted, to some extent, independent of their owner's control. Personality, too, played a part in 'taking' or 'holding' too much in. Twelve patients described themselves as someone who 'held too much in', while 11 saw themselves as too sensitive, nervous or tense. Three patients, all college graduates, described themselves as either too 'obsessive', 'perfectionist', or 'anal'.

Examples of this 'digestion/excretion' metaphor for negative emotions are,

(64-year old woman with ulcerative colitis) Stress — physically, or in any other way, can react different with different people. That's how it reacts with our family. We keep it internal. My mother was dealing with my father who had an alcohol problem. She was keeping it all inside. This Irish stoicism is for the birds — our grief has to come out somewhere.

(30-year old woman with irritable bowel syndrome) I tend to hold lots of of things inside. I don't express emotion freely. Anger, tension, hostility, fear, any kind of upset — I think of them as being crammed into my colon.

(30-year old woman with irritable bowel syndrome) Maybe not letting anger out. Even today if I'm angry with someone, I can get an attack. But I can't let my anger out. When I get angry I get pretty violent, I'd really like to smash someone. When you're angry and you can't let it out, it causes tension, and that's connected to your nerve, and it's a way of releasing itself — instead of angry words, it come out like this.

(29-year old man with ulcerative colitis) People who have a short fuse are unlikely to be affected by it. You would just blow up and get all the anger out. Someone who tears himself up (gets it). It's not expressing anger, bottling anger up.
(31-year old woman with functional vomiting) Things build up. You let it all build up till it comes out one way or another, but if you let it out, you let it out. You don't realise you're doing it. You have to find a way of letting it out. Sometimes you can't control your nerves to your stomach. If you hold it in, like with your neighbors – if you dwell on them – it can make you sick.

(34-year old woman with ulcerative colitis) Being the oldest child I had five adoring adults, then two of them died and my brother came when I was two years old. It shook my world upside down. I was raped when I was three, and I stored things inside, inside myself. I put negative feelings inside myself, rather than put them outside myself. Doctors often say anger gets stored in the colon. Someone who's read my chart says my colon's weak. Stress goes to the weakest organ. I let it get to me, and eat me away. Once something gets inside of me it just bounces around inside of me, until I can get rid of it. If I can catch anger while it's fresh and pound something, it'll out of me – or someone will help me get it out.

A large majority (19 patients) of the GI group believed that certain types of relationships with others could cause illness, while 17 felt that some relationships could cause, maintain or restore good health. The predominant image (14 patients) in this group was of the therapeutic value of expressing or ‘unloading’ the negative emotions to another person. For example:

(33-year old man with ulcerative colitis) If you have people you can confide in – can unload on – so that you're not carrying emotional stress along – someone you're concerned about. It can't effect a cure, but it could prevent some diseases.

(36-year old woman with irritable bowel syndrome) A good relationship can make you stay healthy, because you can ventilate a lot of stress, and enjoy them because you can get perspective.

By contrast to this group, a bad relationship was particularly one where one could not ‘unload’ the accumulated stress. When stress or tension did build up in the system, it could attack the organ already weakened by hereditary (7 patients), constitutional (10) or acquired (9) factors. In each case, the direction of the attack was from within – from inside the self, towards the world outside. ‘Good’ emotions were less clearly defined than bad ones; 16 patients in the GI group described these in a more diffuse way – as serenity, calmness, peacefulness and relaxation – and none of these seemed linked to specific types of social relationships.

In the 14 patients (3 men, 11 women) therefore, who utilized the metaphor of digestion/excretion, this image linked together negative emotions, concepts of personality and body image, unpleasant physical symptoms, and notions about relationships with other people.

2. The Respiratory Group

The explanatory models used by most patients in this group differed significantly from those of the GI group (Table IV). The predominant image among the
asthmatics can be summarized as: (1) an excessive permeability to outside influences, both social and physical; (2) a diminished control over one's physical or emotional responses to those influences; (3) only limited control over some emotional states, or parts of the body; (4) an immediate and dramatic response to outer influences, and/or emotional states; and (5) the patient's vulnerability to these influences is increased either by a physical weakness, or by certain personality factors.

The pathogenesis of asthma was seen as an attack from without on the respiratory system, and on the 'self'. This attack, triggered by outside influences, was often aided by pathogenic, uncontrollable emotions, or by semi-autonomous parts of the body. For 16 patients, the 'onset situation' (see Alexander et al. 1968) was a change in the physical environment — such as exposure to dust, pollen, grass, or smoke — while 17 identified a sudden increase in interpersonal tension — such as an argument with a spouse or child — or other sources of 'stress'. In most cases the attack was immediate, though in a few cases the stress took longer to cause the attack. The permeability to outside influences is illustrated in these examples:

(24-year old woman) My lungs are filled with fluid. The chest is congested with phlegm. It constricts the passages and restricts oxygen getting to the lungs. Maybe there's an outside amount of fluid absorbed into my skin. If it's damp and rainy, if there's general wetness, humidity in the air, the water is absorbed into the system.

(73-year old woman) If you have it already, from an infection, emotional things can make it worse. Even talking on the telephone. Like problems with my three children. One is divorced, and she's had a lot of emotional upsets. Even though she's 46 she phones me from New York, and that brings on an attack.

All 21 patients felt that emotional factors were linked with the origin, or exacerbation, of their asthma. Twelve of them spoke of their emotions as separate from 'self', and sometimes acting on their own accord, as illustrated in some of the earlier examples ("The anxiety of not having my medication with me causes anxiety, and that brings on an attack"). These reified, pathogenic emotions often acted in concert with external stressors, to cause an attack to come on. As with the GI group, personality was seen as a potentially pathogenic factor. Eleven patients described themselves as being too sensitive, nervous, or vulnerable to outside stresses, so that they 'took too much in'. Only three 'held to much in'. For example:

(62-year old woman) People who are more sensitive, who take more effect from everyday living get it. Some people can have a fight and it runs off them like water off a duck's back, but it would affect me.

(72-year old woman) A nervous person gets asthma. All through my life I never thought I was a nervous person, but I must have been. Behind it all there must have been a case of nerves.
These personality or emotional factors were particularly potent in the presence of a physical 'weakness' in the lungs, or in the body generally. Fourteen patients saw this predisposition as being hereditary, four as constitutional, and 16 as acquired. A total of 15 patients described their lungs or bronchi as largely independent of their control. For example:

(18-year old woman) The chest tightens up. It hurts when you breath. I'm struggling to get a breath in. They're closing in. Not expanding properly. Hardening up.

As well as using prescribed medication, the commonest therapeutic strategy (10 patients) was withdrawal, or avoidance of the stressful situation or physical environment. Only 2 believed asthma would be relieved by 'unloading' stress, or sharing it with other people. Overall, the respiratory group gave the impression of having less control over external stressors, the social or physical environment, emotional states, and parts of the body. Since 19 of them were female, this may be partly explained by gender (even though their explanatory image differs from that of females in the GI group), and this should be tested further in a larger study.

Like the GI group, a majority of the patients in the respiratory group reified both negative emotions and/or malfunctioning body parts, separated these from the concept of 'self' to a variable degree, and saw them as agents of an 'asthmatic attack' — sometimes in association with external influences. Three of the patients described this attack in anthropomorphic terms — "as though someone was choking me", "like someone's running a knife through it (the chest)", and "my chest is so tight like someone is sitting on it". This image of personal vulnerability, weak or autonomous organs, attack from outside, and immediate physiological response, is different from that used by the GI group. My hypothesis is that part of this difference lies in the differing physiological experiences of the two groups.

DISCUSSION

This pilot-study — although based on a small sample — illustrates the importance of eliciting patients' explanatory models of their ill-health. This is particularly true with chronic disorders, where long exposure to biomedical models may influence the answers to questions such as "Why has it happened to me?", "Why has it recurred now?", "Why am I not getting better?" Clinicians, too, ask these questions of patients with chronic, relapsing disorders. As noted above, psychosomatic disorders are an anomalous category within biomedicine; conditions such as bronchial asthma (Knapp 1975), ulcerative colitis (Engel 1975: 675), irritable bowel syndrome (Drossman et al. 1977), functional vomiting (Engel 1975: 660) and Crohn's colitis (Cheren and Knapp 1980: 1866) are all characterized by a
chronic, relapsing and unpredictable course, often with a poor prognosis. As such, they are less controllable by conventional biomedical treatments. It is suggested that clinicians respond to the uncontrollable aspect by increasingly 'psychologizing' the condition — i.e., by shifting the responsibility for etiology or flare-ups to patients' emotions, personality, or early psychological experiences. This shift matches the contemporary emphasis on social values of fitness, contentment, youthfulness, autonomy, individualism, self-control, and responsibility for one's own health and lifestyle. Clinical encounters between doctors and patients take place within this matrix of social values, and may help reinforce these in the minds of the participants.

This study revealed important agreements between lay and biomedical explanatory models of psychosomatic disorders — particularly on the etiological role of personality, emotions, 'weak' body parts, and social relationships. In this respect, 'personality' can be seen as a 'map' of ideal social values or, as Riesman (1983) suggests, "the expression in a given social context, of one's sense of who one is"; it is "a relational process, a process that relates a person to his situation as he sees it". Riesman suggests further that one should understand "how people perceive themselves to be located in the social contexts they live in, what factors influence this perception of themselves, and how the choice and performance of acts from the cultural repertoire express the sense of self". In the case of the illness realities negotiated between clinician and patient, I would suggest that there is pressure to achieve consonance between predominant social values (as expressed in biomedical categories), and patients' self-perception. In the case of psychosomatic disorders, patients learn to explain their chronic ill-health by defining themselves as too 'obsessive', 'perfectionist', 'anal', or 'sensitive', or as people who 'hold too much in'; their personalities, emotions, lifestyle, or physical weaknesses are blamed for their failure to conform to the ideal social values listed above.

My hypothesis is that, in response to 'psychologization' and the stigma that this implies, patients reify concepts of pathogenic (or 'weak') personality, emotions, and bodily parts, and separate these from the idealized concept of 'self' (cf. Cassell 1976). This shifts responsibility onto these reified entities, which become instead part of the outside world, a more public interface between the self and the environment. In that sense, blame for the loss of fitness, autonomy, contentment, self-control, etc. is shifted to emotions or body parts that are under the control (to a variable degree) of outside forces. Parts of the body, and the personality, are seen as 'non-self', either part of other people or of the natural environment. This is particularly true of socially 'bad' emotions — such as anger, hostility, frustration, and tension — and parts of the body that are 'weak' or vulnerable.

The emphasis on heredity as an etiological factor by half the sample (14
asthmatics, 7 GI patients) can also be seen as shifting responsibility for the 'weakness' to previous generations. Among the asthmatics, especially, the condition was also blamed on factors outside the individual's control – such as the weather, allergies, or infection, or the quality of one's social relationships. By these shifts of responsibility, therefore, patients were able to maintain their idealized concept of the healthy, autonomous self, reduce anxiety and uncertainty, and decrease the social stigma of the disorder. It should be noted that the stigma of a 'nervous' condition is reinforced by diagnostic labels such as psychosomatic, a nervous stomach, or an irritable bowel.

A second hypothesis to emerge from this pilot-study is that physiological experiences may, to some extent, structure patients' explanatory models of their condition. This was particularly clear in the 21 patients in the gastrointestinal group. Despite the heterogeneity of each diagnostic category, the majority of patients shared a common explanatory image – a natural symbol of either respiration, or digestion/excretion. This image explains, and links together, physiological, emotional, and social experiences, and also links these to wider, contemporary social values (cf., Good 1977). For the individual patient, therefore, the physical symptoms condense a range of associated personal meanings, experiences, memories, and expectations. It also helps structure experiences of time ('old anger'), space (environments that trigger asthma), emotions ('get all the anger out'), body parts ('the bronchial tubes close, tighten up on me'), social relationships ('a row can make me tighten up'), personality ('certain personalities, I guess anal, get it'), and physical vulnerability ('stress goes to weakest organ'). This influence of physiological imagery may explain the specific 'attitudes' in psychosomatic patients, noted by Grace and Graham (1952) and Grace et al. (1962). Also, the use of somatic imagery in describing emotions by this sample, tends to contradict Leff's point (1981) that this was only a feature of earlier periods in history.

How patients perceive and interpret their symptoms is obviously of clinical importance. Not only may their 'cognitive set' affect both their emotional and physiological state, but it may affect how they perceive, and are perceived by, members of their families (see Minuchin et al. 1978). In addition, since at least two of the disorders examined in this study have been found to be amenable to psychotherapy – i.e. ulcerative colitis (Karush et al. 1977) and irritable bowel syndrome (Svedlund et al. 1983) – it is important for therapists to understand patients' self-image, and perceptions of emotions and somatic symptoms. This small study was designed as a preliminary examination of these phenomena, and it is hoped that the initial findings of the study will be tested in a larger patient sample in the future.
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REFERENCES

Alexander, F., French, T. M., and G. H. Pollock (eds.)

Barsky, A. J. and G. L. Klerman

Bauer, J.
1942 Constitution and Disease. New York: Grune and Stratton.

Cassell, E. J.
1976 Disease as an "It": Concepts of Disease Revealed by Patients presentation of Symptoms. Social Science and Medicine 10: 143–146.

Cheren, S. and P. H. Knapp

Douglas, M.

Drossman, D. A., Powell, D. W., and J. Y. Sessions

Dunbar, F.

Eisenberg, L.

Engel, G. L.


Fisher, S.


Freud, S. and J. Breuer


Gildea, E. F.

Special Features of Personality which are Common to Certain Psychosomatic Disorders. Psychosomatic Medicine 11: 273–281.

Good B. J.


Good, B. J. and M-J. D. V. Good


Grace, W. J. and D. T. Graham


Graham, D. T. et al.

Specific Attitudes in Initial Interviews with Patients Having Different ‘Psychosomatic’ Diseases. Psychosomatic Medicine 24: 257–266.

Groen, J.


Hendrick, I.


Houck, C.

Anxiety Attacks That Trigger Terror. Woman’s Day. 13 September; 30–35.

Karush, A. et al.


Katon, W., Kleinman, A., and G. Rosen


Kleinman, A., Eisenberg, L., and B. Good


Kleinman, A.


Knapp, P. H.


Leff, J.

Lipowski, Z. J.

Littlewood, R.

Mechanic, D.

Minuchin, S., Rosman, B. L., and L. Baker

Myers, F. R.

Riesman, P.

Sontag, L. W.

Svedlund, J. et al.

Taussig, M. T.

Vaillant, G. E.

Weiss, E. and O. S. English

Wright, J. H. and A. T. Beck