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,