ABSTRACT. Using the example of psychosomatic diagnosis, I argue that the clinical context has unique epistemological constraints that limit the certainty of diagnosis and so make meaning indeterminate for sufferer and healer. As a result, forms of clinical truth are borrowed from the therapeutic context to create and authorize meanings for ambiguous or ill-defined conditions and inchoate suffering. Diagnostic interpretation is concerned with classification and legitimation through the production of authoritative truth. In contrast, therapeutic interpretation is fundamentally concerned with the pragmatic problem of "how to continue" and hence, with the improvisation of meaning. These different ends give rise to tensions and contradictions in psychosomatic theory and practice. While authority is necessary to provide a structure on which variations of meaning can be improvised, authoritative meanings may also restrict the possibilities for invention by clinician and patient. The goal of patient and physician is to create enough certainty to diminish the threat of the inchoate while preserving enough ambiguity to allow for fresh improvisation. Accounts of illness meaning must recognize the interdependence of normative rigidity and metaphoric invention.

A RUMBLING: truth itself has appeared among humankind in the very thick of their flurrying metaphors.

– Paul Celan (Hamburger, 1988: p. 263)

Bodily suffering has an urgency and seriousness that lend immediacy to illness experience. Yet, the findings of cognitive psychology and the arguments of social constructivism suggest that all experience is shaped by cognitive schemas and social practices. Illness experience depends on processes of interpretation that impart meaning to sensations, whether these sensations are themselves initially subliminal, inchoate and indeterminate or well-formed and immediately distressing. The meanings given to symptoms and distress can transform suffering. Meaning – any meaning – serves to turn back the tide of chaos and bafflement that confronts us in affliction. Given specific meaning, illness becomes metaphor – a rhetorical resource to be used to explore and communicate the wider significance of our predicament. Even when we are gripped by suffering, we can struggle to put symptoms to work for us: calling on others to help or redress inequity, escaping from harmful or undesirable situations, achieving a measure of control over others through the demands of illness.

Through affliction, people are impelled to borrow or improvise illness
meanings. But to carry private conviction and rhetorical force, illness meanings must be lent authority. Any authoritative interpretation of illness—while it may suggest further metaphoric elaborations of experience—also limits the field of potential meanings available to the sufferer. Tension between authority and invention lies at the heart of the clinical negotiation of illness meanings. This tension exists both between sufferer and healer and within each participant in the clinical encounter, since each faces the problem of clarifying illness meaning. The power disparity in the social roles of physician and patient—and the eclipse of illness by biomedical constructions of disease—may obscure this fundamental symmetry of experience.

In this essay, I will explore the conflict of interpretations in clinical practice in North American medicine and consultation-liaison psychiatry. Biomedicine differs from many other systems of medicine in that it commonly separates diagnostic and therapeutic acts. This separation is possible because disease is treated as a biological reality, independent of any therapeutic relationship or intervention, that is simply waiting to be discovered and correctly labeled. This division of diagnosis and treatment supports role differentiation and specialization within medicine involving different forms of expertise, research questions and personal styles of clinical practice. Of course, this tendency to distinguish diagnostic and therapeutic acts ignores the fact that any diagnostic label is itself an interpretation with therapeutic as well as social, moral and legal consequences.

The practice of psychosomatic medicine and consultation-liaison psychiatry are particularly instructive in this regard because they deal with refractory cases, i.e., those that have no diagnosis, those that have a diagnosis but which fail to respond to standard treatment, those where social and psychological dilemmas are simply too great to ignore, and often those where patients are openly dissatisfied with their care (Kirmayer 1988). The clinical context has unique epistemological constraints that limit the certainty of diagnosis and so make meaning indeterminate for sufferer and healer. To resolve this indeterminacy, clinicians and patients borrow interpretative strategies from the therapeutic context to create and authorize meanings for inchoate suffering. But the goals of diagnosis and therapy are different, and the strategies appropriate in one context become problematic, strange and deforming in the other. Translated from the therapeutic to the diagnostic realm, tentative essays into meaning become constricted and imprisoning realities. Authority is concerned with legitimation and hence with truth, while the therapeutic enterprise is fundamentally concerned with how to continue and hence with the improvisation of meaning. While authority is necessary to provide a structure (themes or modes) on which variations can be improvised, authoritative meanings inevitably restrict the possibilities for invention by clinician and patient. Seen from this perspective, the goal of the clinical negotiation between patient and physician is to create an