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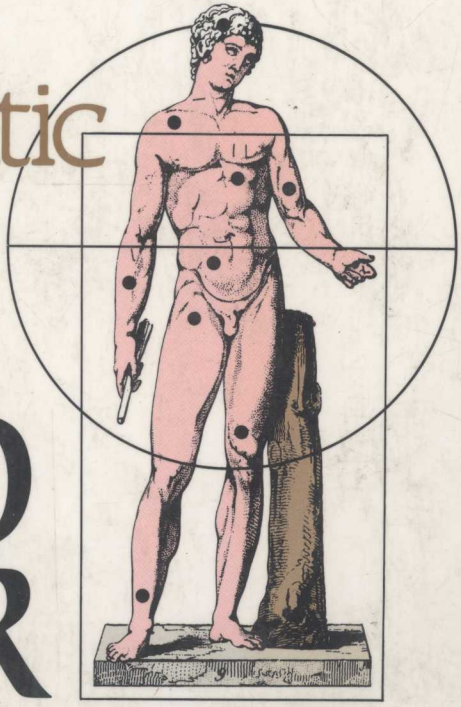
FROM PARALYSIS TO FATIGUE

A History of Psychosomatic Illness in the Modern Era



EDWARD SHORTER

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A History of Psychosomatic Illness in the Modern Era

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To my parents,
Joan and Lazar Shorter,
in gratitude

Preface

The history of psychosomatic illness in the modern era is a complex and sometimes tangled tale. The present work provides the essential narrative of the story, beginning with such notions as hysteria in the eighteenth century, and continuing into our own time with such contemporary disorders as chronic fatigue syndrome. It is a history of shifting maladies as experienced by patients and perceived by doctors, an account of how historical eras shape their own symptoms of illness. (A future work will focus on the social and biological themes in psychosomatic illness, seen in historical perspective.)

It should be emphasized at the beginning that from the patient's viewpoint psychosomatic problems qualify as genuine diseases. There is nothing imaginary or simulated about the patient's perception of his or her illness. Although the symptom may be psychogenic, the pain or the grinding fatigue is very real. The patient cannot abolish the symptoms by obeying the simple injunction to "pull up your socks," for what he or she experiences is caused by the action of the unconscious mind, over which he or she by definition has no rational control. Thus this book does not view patients with "somatoform" symptoms as bizarre objects but as individuals who enjoy the dignity that all disease confers; our task is rather to understand why the kinds of psychosomatic symptoms that patients perceive change so much over the ages.

Because I am a historian, the interplay between culture and the problems of the individual interests me. Here the unconscious mind intervenes. In psychosomatic illness the body's response to stress or unhappiness is orchestrated by the unconscious. The unconscious mind, just like the conscious, is influenced by the surrounding culture, which has

models of what it considers to be legitimate and illegitimate symptoms. Legitimate symptoms are ascribed to an underlying organic disease for which the patient could not possibly be blamed. Illegitimate ones, by contrast, may be thought due to playacting or silliness. By defining certain symptoms as illegitimate, a culture strongly encourages patients not to develop them or to risk being thought "undeserving" individuals with no real medical problems. Accordingly there is great pressure on the unconscious mind to produce only legitimate symptoms.

This cultural pressure is the crux of the book. The unconscious mind desires to be taken seriously and not be ridiculed. It will therefore strive to present symptoms that always seem, to the surrounding culture, legitimate evidence of organic disease. This striving introduces a historical dimension. As the culture changes its mind about what is legitimate disease and what is not, the pattern of psychosomatic illness changes. For example, a sudden increase in the number of young women who are unable to get out of bed because their legs are "paralyzed" may tell us something about how the surrounding culture views women and how it expects them to perform their roles.

Psychosomatic illness is any illness in which physical symptoms, produced by the action of the unconscious mind, are defined by the individual as evidence of organic disease and for which medical help is sought. This process of somatization comes in two forms. In one no physical lesion of any kind exists and the symptoms are literally psychogenic; that is to say, they arise in the mind. In the second an organic lesion does exist, but the patient's response to it—his or her illness behavior—is exaggerated or inappropriate. Culture intervenes in both forms, legislating what is legitimate, and mandating what constitutes an appropriate response to disease. Our late-twentieth-century culture, for example, which values individual dynamism, regards physical paralysis and sudden "coma" (both common before 1900) as inappropriate responses.

Psychosomatic illnesses have always existed, because psychogenesis—the conversion of stress or psychological problems into physical symptoms—is one of nature's basic mechanisms in mobilizing the body to cope with mental distress. People have always tried to achieve some kind of plausible interpretation of their physical sensations. They cast these sensations on the model of well-defined medical symptoms available in a kind of "symptom pool." Only when an individual's act of making sense amplifies the sensations, or attributes them to disease when none exists, does psychosomatic illness come into play.

The two actors in this psychodrama of making sense of one's sensations

are, and always have been, doctors and patients. The interaction between doctors and patients determines how psychosomatic symptoms change over the years. Doctors' notions of what constitutes "genuine" organicity may alter, perhaps as a result of increased scientific knowledge or of new cultural preconceptions. Although patients' notions of disease tend to follow doctors' ideas—a kind of obedience that has started to break down at the end of the twentieth century—patients may also change their notions of the legitimacy of symptoms for reasons that have little to do with medicine. The point remains, however, that the relationship between doctors and patients is reciprocal: As the ideas of either party about what constitutes legitimate organic disease change, the other member of the duo will respond. Thus the history of psychosomatic illness is one of ever-changing steps in a pas de deux between doctor and patient.

This book begins with the late-eighteenth-century status quo and brings the story up to the present. The nature of psychosomatic symptoms changed relatively little before the second half of the eighteenth century. Premodern patients responded not to an official medical culture but to a fairly constant and unchanging body of unofficial medical folklore that was probably a thousand years old. Before 1750 doctors, too, believed in a relatively unchanging core of "humoral" medical doctrines, the basic components of which reached back to the ancient Greeks. Then, after the mid-eighteenth century, the presentation of psychosomatic illness began to vary—changes reflected in the following chapters.

Finishing in the present exposes one to all the risks of writing contemporary history, in which the underlying factors do not stand out from the superficial detail with the clarity lent by remoter times. Still, as a historian, I am attracted by the idea (however illusory and deceptive it might be) of using the past to illuminate today's problems. So striking is the impact of culture on psychosomatic illness, that both doctors and patients today might learn something by seeing medical symptoms, which are considered intensely personal and idiosyncratic, in light of the past.

Some thanks are in order. I owe much to the inventiveness and energy of my library assistant Kaia Toop, and I am happy to acknowledge here the help she has given me over the years. I have been privileged to work in the Science and Medicine Library of the University of Toronto. My friend Walter Vandereycken, M.D., read critically an earlier draft. Joyce Seltzer at The Free Press has been a wonderful editor, and Susan Llewellyn a superb copy editor. I should also like to thank my dear wife, Anne Marie Shorter, M.D., who read each chapter of the manuscript and of-

fered helpful comments. Grants from the Connaught Fund of the University of Toronto and the Social Science and Humanities Research Council of Canada helped support some of the research. Of the many archives and libraries in Europe and England in which I have worked, I must single out the Institut für Geschichte der Medizin in Vienna as a reminder that intense scholarly effort is not incompatible with a setting of warmth and hospitality.

Contents

CHAPTER

1

Doctors and Patients at the Outset

The descent from mind to body is a tricky one. How does the mind interpret the signals the body gives off? A young executive feels a stomachache before an important presentation. There is nothing physically wrong with her stomach. In the absence of any physical lesion, her mind perceives pain coming from the stomach. That pain is psychogenic, unlike the pain of a gastric ulcer, which is somatogenic. (*Somatogenic* means there is something physically wrong with the body, and damaged nerve endings are causing the pain.)

Do psychogenic symptoms have a history of their own? Have they perhaps always been more or less the same, as coughing up sputum, if one has pneumonia, has historically been invariant? One factor that confers a history is the doctor's attitude. Patients want to please doctors, in the sense that they do not want the doctor to laugh at them and dismiss their plight as imaginary. Thus they strive to produce symptoms the doctor will recognize. As doctors' own ideas about what constitutes "real" disease change from time to time due to theory and practice, the symptoms that patients present will change as well. These medical changes give the story of psychosomatic illness its dynamic: the medical "shaping" of symptoms.

Not until the eighteenth century, with the advent of new theories about "nervous disease," does such shaping begin to change. Patients start the narrative by breaking with an age-old pattern of traditional psychosomatic symptoms. And the doctors' part of the story commences just as some important scientific advances occur. But these discoveries about the nervous system led to some unscientific theories about how nervous disease arises—

theories that would suggest to patients a new pattern of psychosomatic symptoms. The symptom shift thus begins with the rise of such "nervous" symptoms. A set of symptoms, such as hysterical paralysis, arose which was quite specific to the late eighteenth and nineteenth centuries. These symptoms would in the twentieth give way to quite different symptoms—those of chronic fatigue, pain, and allergy sensitivity.

Psychogenic Symptoms

By definition psychogenic physical symptoms arise in the mind, in contrast to somatogenic symptoms, which come from organic disease. To the patient, however, both kinds of symptoms *seem* the same: Both appear to result from real bodily disease. There is very little cultural shaping of the symptoms of organic disease, and people presumably turned yellow with liver failure in the fourteenth century just as they do in the twentieth (liver disease causes jaundice, giving a yellowish cast to the skin). Although the mind may still edit somatogenic symptoms, they are mainly shaped by organic disease. But the shaping of psychogenic symptoms is left to the fantasy of the unconscious.

Nevertheless, the unconscious is not entirely abandoned to its own resources. The surrounding culture provides our unconscious minds with templates, or models, of illness. If our unconscious decides, for example, that we are to be in pain, it determines how pain will be dealt with: perhaps with the stoic jaw clenching of Anglo-Saxon cultures or with the tying about one's head of a kerchief, as in Italy. These are examples of culturally determined templates the unconscious uses to instruct itself.

All these templates, or different ways of presenting illness, constitute a symptom pool—the culture's collective memory of how to behave when ill. For Western society since the Middle Ages, the number of potential symptoms in this pool has been relatively unchanging. Symptoms of headache, tiredness, and a twitching left leg are some of its contents, which have been available for centuries. Some symptoms from other cultures—such as "koro," a perception among South Asian and Chinese males that the penis is retreating inside the abdomen—do not form part of this pool.[1] The symptom pool of the Occident has always harbored certain standard items. Until the middle of the twentieth century, people knew about the contents of this pool from popular culture, an oral tradition that communicated from generation to generation whatever individuals told each other about aches, pains, and other bodily woes. Today the media more than any other conduit tell us about the symptom pool.

The contents of this particular symptom pool are psychogenic, in that all may be caused by the action of the mind. (Turning yellow is not part of the psychosomatic symptom pool.) But headache, tiredness, and a twitching left leg may be caused by organic disease as well, and someone has to decide whether they are psychogenic or somatogenic. Perhaps it is the individual, him- or herself, in deciding whether to seek out the doctor for a particular symptom. Perhaps it is the doctor, in deciding whether to operate or to counsel the patient. In historical studies informed retrospection tries to decide. Yet the decision must be made, or the notion of a well-circumscribed psychogenic symptom pool is meaningless.

In some historical periods certain items in the pool are frequently drawn on, in others scarcely at all. How does the culture of a given period decide which symptoms to select? It depends on representations of what is thought to be legitimate organic disease. No patient wants to select illegitimate symptoms, to become a laughingstock or be dismissed as hysterical. Thus any given period will have a predominant notion of what it considers real disease.

Robert Musil makes this point, in a slightly different context, in his novel about Viennese life at the turn of the century, *The Man Without Qualities*. Ulrich, the chief protagonist, is thinking about photographs of beautiful women from decades past, and as he tries to achieve some kind of rapport with the faces in the photographs he notices "a whole number of small features which actually constituted the face, and yet which seemed very improbable. All societies have always had every kind of face. But the standards of the day single out one particular face as the dominant one, the essence of happiness and beauty, while all other faces attempt to imitate it."[2] So it is with symptoms. Our bodies send us the most disparate variety of signals about physical sensations. Under some circumstances, we interpret these signals as evidence of disease, but the symptoms into which our minds cast this disease are just as determined by fashion as was the fashionable face of fin-de-siècle Vienna.

These symptoms fall into four general categories: sensory symptoms, such as prickly skin or tiredness; motor symptoms, such as paralysis; symptoms of the autonomic nervous system, such as a churning bowel; and symptoms of psychogenic pain.

Sensory and motor symptoms, the first two groups, belong to the body's somatosensory nervous system. This is a nervous system with its own privileged pathways. Certain parts of the spinal cord are reserved for it, as are certain areas of the brain. If a young man suddenly developed a loss of feeling in half of his body (and had no organic disease), he would

have a psychosomatic sensory symptom. A young woman who awakened one morning unable to walk because of a paralysis of her legs (and had no neurological illness) would belong in the motor category.

A third group of symptoms are autonomic, meaning they are controlled by the autonomic nervous system, which regulates the action of internal organs and the diameter of blood vessels. Thus diarrhea, blushing, a racing pulse, and all kinds of internal sensations come into this category.

Finally, there is psychogenic pain, which means pain that the patient perceives as real but that is not caused by an organic lesion in the body. The pain arises in the mind. If I get a headache as I sit at my word processor thinking how to make this clear, I am suffering a psychogenic headache.

Of course all these symptoms could result from organic diseases too, which is precisely the point. In somatization the unconscious mind chooses symptoms that will be taken as evidence of real, physical disease and that will win the patient an appropriate response.[3] Thus most of the symptoms in these four compartments of the symptom pool have always been known to Western society, although they have occurred at different times with different frequencies: Society does not invent symptoms; it retrieves them from the symptom pool.

One objection comes immediately to mind. With the exception of those in the last chapter, the patients described in this book are all dead. Is it certain that their symptoms were not caused by an organic disease? Retrospectively, it is not. There is only the presumption of psychogenesis, based on (a) the history of the illness, such as paralysis after seeing a frog on the road, and (b) the response to what was essentially placebo therapy, such as hydrotherapy or administration of a laxative. These two circumstances give certain symptom patterns a flavor of psychogenesis.

An elderly neurologist in Marseilles told me about young Italian female patients, usually from southern Italy, who would be brought to his clinic—much more prestigious than the Italian clinics—in an ambulance, convulsing and thrashing in fits. "It would take four men to hold them down," he said. He cured them with sugar pills. He opened his desk drawer to show the three colors of pills he gave, some "stronger" than others. Of course the patients thought they were powerful medicine.

Were these young women epileptic?

"No, hysterical," he said. "You can smell this quality of hysteria." He gestured expansively to his nose. "*Ça sent de l'hystérie.*"

Whatever the cultural reasons for the illness behavior of these southern Italian women—and one may presume many such reasons on the part of

powerless young women in a patriarchal society—they probably did not have epilepsy. So it is with many of the men and women in this book: They probably did not have an organic illness, although we cannot be sure.

The Symptom Pool

The pool of psychosomatic symptoms, physical symptoms caused by the action of the mind, has a history. Of the various types of psychosomatic symptoms, those attributable to the motor side of the nervous system are the most colorful. Reaching back into antiquity, they include sudden loss of the power of speech (hysterical aphonia);[4] the inability, all at once, to open the eyelids; contractions, incapable of relaxation, of the elbows, wrists and fingers; and failure to get out of bed one morning because the lower limbs are paralyzed. Historically, the commonest of the motor symptoms have been fits, or pseudoepileptic fainting and writhing about. In fits, motor activity is apparently out of control, the limbs twitching histrionically, the eyes turned back in the head, the affected individuals (they do not become "patients" until they see a doctor) often screaming, cursing, and attempting to bite those nearby.[5]

In the domain of pseudoepilepsy there is truly nothing new under the sun. According to a note in the November 7, 1711, *Spectator*: "Mr. Freeman had no sooner taken coach, but his lady was taken with a terrible fit of the vapours, which, 'tis feared, will make her miscarry, if not endanger her life." "After many revolutions in [Mrs. Freeman's] temper of raging, swooning, railing, fainting, pitying herself and reviling her husband, upon an accidental coming in of a neighbouring lady . . . she had nothing left for it but to fall in a fit." Mrs. Freeman was quite accustomed to throwing teacups into the fire and berating the menfolk surrounding her. Whatever the true cause of her unbridled behavior ("this fashionable reigning distemper"), it is unlikely that she had epilepsy.[6]

Far from London in rustic Edale, Dr. James Clegg went to visit his mother on September 14, 1730: "She was seized whilst I was there with a most violent hysteric fit exactly at the time the moon came to the full. I lodged there that night."[7] Again, Dr. Clegg's mother probably did not have epileptic attacks at full moon, though we cannot know for sure. There was Mrs. King, thirty years old, of Northfleet and a patient of John Woodward, a distinguished London physician. In the spring of 1705 "a great grief" affected her, whereupon "she fell into a most violent griping pain of her stomach. In a quarter of an hour she perceived a

tingling, and afterwards a deadness of her left hand, which gradually ascending up her arm, took her head, when she lost all sense, and became finally cold, stiff, and was thought dead." Mrs. King had a long and complicated medical history: "She had once a fit upon a fright, in which she lay as dead for three or four hours." Further: "Upon grief she has had frequently risings in her throat and chokings. A fright affects her back instantly with pain. . . . It also brings on a flight vertigo and pulsation in her back and head, as also palpitation of the heart with a flushing and heat of her head and face."[8] Thus a whole riot of bodily symptoms could accompany an attack of fits, for somatizing patients often experienced all major varieties of psychosomatic symptoms simultaneously.

Mrs. King's case merely hints at another kind of motor symptom: *globus hystericus*, the sensation of a ball rising from the depths of the abdomen and lodging in the throat, whereupon an attack of fits begins. In 1713 a Mrs. Cornforth described to Doctor Woodward what she experienced in such a fit: "First her legs became feeble, so that they would not bear her weight and she could not possibly stand up." Then back pain commenced: "Immediately her heart begins to throb and palpitate, the throbs pointing at, and forcing [radiating] towards the part of the back so pained; they also force to her arms, neck, and head at the same instant, and the pulsations, in all, keep time exactly with the heart and back." She feels nauseated, and then "she sensibly perceives something fluid ascend from the place pained in her back up into her shoulders, the scapulae, arms, neck, and head." At this point Mrs. Cornforth describes much "throbbing" and writhing in her upper body and internal organs. Finally "she feels something descending down her back to her stomach, and the fit is instantly at an end."[9]

"Vapours, otherwise called hysterick fits and improperly, fits of the mother," said London physician John Purcell in 1702, "is a distemper which more generally afflicts humankind than any other whatsoever." Its symptoms? "First they feel a heaviness upon their breast, a grumbling in their belly, they belch up, and sometimes vomit. . . . They have a difficulty in breathing and think they feel something that comes up into their throat which is ready to choke them; they struggle, cry out, make odd and inarticulate sounds or mutterings; they perceive a swimming in their heads, a dimness comes over their eyes; they turn pale, are scarce able to stand; their pulse is weak, they shut their eyes, fall down and remain senseless for some time."[10] These are typical accounts of fits, which dominate the motor hysteria scene until well into the nineteenth century.