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Aspects of Comprehensive Medicine

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■ The heading "Comprehensive Medicine" is really more of an expression of the frustrations of contemporary medicine. The great advances that have been made in the knowledge of *etiology*, the prophylaxis and the treatment of disease leave a space full of the unknown to be discovered. Little by little, the idea has been formed that what exists in this unknown space may be discovered using the same methods of investigation that produced the knowledge stated, yet require another manner of tackling the problems. In reality, it is man that ails and shows two faces, like Juno, the somatic and the psychic, retaining his unity. Psychosomatic medicine casts its attention on the action of the psychic factors of the disease; comprehensive medicine must find in the disease, the study of man as a whole, or as a unit in which the psychic and somatic aspects exist together.

Never has this comprehensive point of view been more necessary than at the present time. A healthy and progressive society increases its hours of leisure; the average age of life is 70 years; and man maintains a more dilated youth, organizes his social security, etc. At the same time competitive society increases his "stress." The fact is that together with these positive notes, other negative ones appear. In any large group, especially if social security exists, every ten years the number of medical consultations increases by 60 percent. The number of medicines required per head increases in cost by more than 150 percent, and in some places out of every ten inhabitants, three take some medicine, either for digestion, for sleep, or for other reasons. The influence of psychic factors in these changes is evident.

The expression of "specifically human diseases" (asthma, obesity, gastric ulcer, vegetative disturbances, etc.) was introduced by Jores, also making it the equivalent to "diseases of civilization," an equivalence that presently does not appear so clear. We find ourselves with two distinct spheres of becoming ill, one the specifically human, and the other, one which is assumed to be the difference between civilized man and primitive man. There is no doubt that human pathology is richer than animal pathology. Not only do I refer to the presence in man of psychic illness, but to the gamut of illnesses. If one reflects momentarily on this difference, it is clear that man falls ill in a different way than do animals.

What we call *symptoms* of diseases are presented on two planes, one somatic and the other psychic. A large theme on general pathology can be constructed in seeing if, besides the two different perspectives—the somatic and the psychic—there exists two different

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structures in becoming ill, and what is common to both. For example, the so-called "defense mechanism" of the diseases and their interposition in the chronic stages of these diseases combine many analogies in both structures. An infection, general at the beginning, becomes local afterwards, and this defensive localization becomes chronic unless there is decisive medical or surgical treatment, and sometimes in spite of it. Analogically, a crisis of general anxiety is localized afterwards as a specific phobia. Always this concretion, in the psychic, is a liberation of the threat experienced in the acute state. The localization of the general infection is also a defense mechanism, even if it is insufficient because it creates new problems. We find ourselves, therefore, with a well-known law of general pathology that is just as valid for psychic as for somatic diseases.

It is evident that animals feel pain and suffering, but it is also true that these phenomena acquire a different significance in man. Pain and suffering open to man the doors of understanding himself and the world around him. Already in infancy there appears the beginning of disclosure of the scheme the child forms with his world, thanks to painful experience. But, apart from the pain and suffering produced by the reality of the world around us which offers resistance, and against which we clash, there exists the pain and suffering that comes to us from our internal world. The efforts to find the "logos" in the "pathos"—that is called pathology—should take us by the hand to discover the texture of human life.

Some authors determine that the human being is potentially immortal. Death reaches him from something outside, and that "something" is insufficient to cover all the etiological field, if you only take into consideration the material causes of diseases and forget the psychic causes. The causes of these diseases —referring to those that appear "specifically" in man—must be found in what differentiates man from the animal and in another sense, in what differentiates primitive man wrapped up in a magic world, from the man that has reached our degree of civilization.

The difference between man and animal radicates, among other things, in the manner of conforming to instinctive conduct. In the animal, the instincts are predetermined, while in man they are subject to his personal freedom; that is, he decides to which he should give free rein and in what way, and which he should renounce. This whole complex system of acceptances and rejections is elaborated during his lifetime, but in a very special way during childhood. It is for these reasons and because of these interlacings between natural impulses and cultural pressures, that the first years of the life of man are so decisive in the shaping of his later life. A frustrated man is one who cannot realize his possibilities. Research in depth psychology show that diseases begin to appear precisely at the moment in life when failure occurs, when he is incapable of making a decision. At that time the disease begins, and after the disease, there is death. The disease is the renunciation of life. The same occurs in animals, except that with them the limitations of life depend solely on external circumstances, since from the point of view of internal development, their instinctive life is always assured. Man, on the contrary, can limit himself from within his intimate self, impeding the development of his life and thereby falling ill and dying, since his life lacks reason.

Thus the conclusion is reached that the cause of diseases which are specifically human is found in two factors: one consisting in the deficient development of the characteristic external possibilities of each man, and the other, in the *progressive weakness of the ego.* Therefore, there also remains outlined the two roads for his cure, and this cure cannot be assured only by means of pharmacology. The illness is converted into a sign indicating that man is on the verge of failing in the realization of his vital design.

These points of view have exercised a certain impact on today's medicine. Specifically human diseases are those that form the core of psychosomatic medicine; the latter, as I understand it, should not be limited to these morbid circles, but should try to discover the specific human element in every patient and his structure.

What can we think of these points of view? As I see it, it is true that those specifically human diseases have something peculiar that differentiates them from the pure somatic illnesses. It is enough to remember, for example,

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how difficult it is to produce an experimental gastric ulcer in a dog by direct action on the gastric mucous membrane, and how easy—or less difficult—it is to obtain it by subjecting any animal to conditions of stress. But the differences in the illnesses of primitive peoples and the civilized ones are not so clear. We, the psychiatrists, are put in a particularly distrustful position, which can be called "Kraepelin's mistake." This great psychiatrist, believing that the study of comparative psychiatry—"transcultural psychiatry" as it is now called—would produce important knowledge about the manner in which mental illness is constituted, organized a trip to Java. As a result of this trip, he pointed out that the frequency in general paralysis was less among primitive people than among civilized people. Beringer, a few years later, proved that this frequency in general paralysis was the same in primitive as in civilized people, a fact which had escaped Kraepelin because of the insufficent information he had gathered on his trip.

The belief that each individual life is in itself eternal and that death only comes from outside is also open to discussion. It is a postulate. Science needs postulates, but its brand of evidence does not appear in all of them with the same clarity. That men are mortal is a reality. That this reality is linked only with the actual event of living and not with something from outside may be accepted or not. The fact is that the curvature of life, biological as well as psychological, points to it (phrases speak of being born, growing, maturing, old age and death). The interpretation of mortality curves in accordance with the progress of medicine would seem at times to encourage the hope of an infinite duration of human life in the future; but these curves take on an undeniably asymptotic character. Life, as a phenomenon, seems to implicitly carry the event of its end, as if life could not be defined without the presence of death. Freud believed in the "death instinct" that was lodged in the human being in strange and fecund unity with the libido. But let us put aside now this meta-psychology and meta-biology for it would take too much time to explain the problem in its entirety. The truth is that it is not evident that the cause of death is always something foreign to the organism and above all, it is not proper to believe in its total disappearance, thanks to scientific advances.

Nobody can deny the intervention of psychological factors in any illness, nor that these may be more visible in the so-called specifically human ones. The difficulty lies in clarifying this relationship and what this step from the *biological* to the *biographical* consists of.

The specifically human diseases appear more akin to the contemporary way of life than others. The word "stress" is a key word in the interpretation of new pathological situations. It is accepted, almost without discussion, that this pathology grows, and it is put in relationship with the present mode of life. Professor Katz told me at the beginning of the last World War, that at that time one did not see hysterical patients in the clinics, only sufferers of stomach ulcers. "Managers' illness" or nervous fatigue are the order of the day. The correlation between this new pathology and the progress of man appears clear to many authors and also to the man in the street. If human progress supposes an enlargement of the historic conscience, the progress of each man within his most intimate and personal disposition supposes a progress in his "realization" of the conflicts and problems that accost him. The decrease in infectious diseases and their like on the one hand, and the increase in psychosomatic disturbances on the other, show that there is a correlation to be established between the more specifically human diseases —including also the neuroses—and the mode of life of Western man.

But although in these and analogous affirmations, there is truth in part, I believe it is our duty as scientists to hold on to this part as solidly as possible, liberating it of the residue of errors that threaten it. Because this relationship between disease and the meaning of life, if established too simply, brings us to the affirmation of Müller-Eckardt of the provocation of a mental illness because of "not being able to be sick," that is, not being able to suffer a somatic illness.

The relation between illness and the meaning of life is not as significant as is presumed, starting from the hypertrophied and fantasied psychogenesis of these disturbances. This does not mean that an illness of any kind is not a *biographic* crisis, specially the serious illnesses. The vital project changes; values that were

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latent surge to the surface and vice versa. Illness is a biographic event, but such a fact does not authorize coming to a conclusion that the illness appears as the upshot of an isolated psychic experience or of a chain from it that turns out to be traumatic. Here lies the error in these anthropological-medical directions. In my book *The Neuroses as Diseases of the Mood,* I have sustained the theory that this does not occur even in the neurosis, or in any diseases, even in those in which trauma appear more clearly as a determining factor. After the War, we were all able to see that many patients with Parkinson's disease said that they had started to tremble right after a bombardment or other analogous emotional trauma. This provoking emotional factor can be seen in the settling of many somatic diseases or in the crisis of decompensation of these diseases; but we can never presume to affirm, for example, that Parkinson's disease in those cases was psychogenetic.

Some time ago I introduced the term "catagenesis" in place of psychogenesis for these cases. For example, a patient suffers from paresthesiae in the right hand, obtained as she grasped a hand rail getting on a train. The trip was the result of the transfer of her husband. The transfer was favorable to him, both administratively and economically since it was a promotion in his career; but she did not wish to leave the town where her parents lived, where she felt protected. The psychogenesis of such paresthesiae seemed clear. Exploration showed that they constituted the first symptom of an acute form of multiple sclerosis which caused her death in a few weeks. It is clear that some would claim that the conflict caused by the separation materialized in the sclerosis, but this affirmation does not satisfy those who with a scientific spirit seek to penetrate the genesis of disease. Although the etiology of multiple sclerosis is not known, what is known about it does not permit its inclusion in a chapter in which, in our current literature, little by little, many diseases are infiltrating: that of psychogenesis. In these cases in which a relationship is established between a psychic trauma and one somatic clinical picture, I propose to speak of "catagenesis." In introducing this neologism I intend to separate this problem from that of the "provocation" of disease. In this latter case the trauma does not hold a *significant relationship* to the symptom, as in conversion-reaction and catagenesis.

The live or animated human body is what we could call *corporality* (or intrabody, as stated by Ortega y Gasset), to differentiate it from the body as an object such as is studied by the anatomist. The differences are so evident as to scarcely be worth the time in pointing them out.

Let us examine now, if only briefly, the structure of this experience of corporality. Speaking about these problems I am always reminded of the proposal that Charcot made to Freud—who had a very good background in neurology—to study the differences between organic paralysis and hysterical paralysis. Freud's conclusion was that in hysterical paralysis, as in the anesthesias, it is the vulgar or popular conception of the organs of the body in general which comes into play. This conception is not founded in a profound knowledge of nervous anatomy. Freud thought this in the years 1885 and 1886.

But, how is that which Freud calls "vulgar conception of the human body" formed? It is evident that there is a conception of the body elaborated culturally. What medicine and its doctors are finding out passes more or less deformed—always more than less—into the popular venacular. The patient approaches the internist and says: "I have a pain in the liver." Others go further in this line and tell him that they have "headaches that come from the liver," etc.

For some years I have been carefully studying the distribution of hysterical symptoms, especially the more striking ones and those full of meaning in relation to the life of the patient. I refer to paralysis and the anesthesias. Clinical experience shows that these are more frequent in the left side than in the right. This fact has already been observed by some classic authors (Janet and Pitres). In the cases where this rule is not followed, it is because the functional predomination of the left brain hemisphere is inverted with respect to the right one. This distribution of the paralysis and the anesthesias shows that the right and left halves of the body do not have the same value nor the same anthropological significance. The right half is more active, the left half is more passive. In the

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right half are localized more frequently the symptoms that belong to what can be called the unexpected reaction or tempestous movements ("Bewegungsturm"), in Kretschmer's sense, and in the left half, those that correspond to the reaction of surrender ("Totstell-reflex").

Also, in the distribution of other hysterical symptoms, one finds certain predominant samples; all of it favors the hypothesis that there exist certain basic archetypes in the manner of feeling the corporality not determined by cultural ways.

I think that from the psychosomatic perspective this "ideagenous" conception should not be enough. There is a corporal psychic experience that is not an ideagenous scheme —to this the notion of "body scheme" corresponds—a direct and immediate experience. We can enter various paths for its study, but for reasons of brevity, I will only choose two: one is that of hypochondria and another that of denial of symptoms, a phenomenon which in some neurological cases is referred to as anosognosia.

In the hypochondriac, the corporal silence of the healthy is transformed into clamorous psychic experience that changes the relationship of the ego with the body. In him there flourishes a fantasy world of sensations. This world seems grotesque at times because it combines with vulgar interpretations. In other patients there even evolves a paranoic development. Leaving to one side these more complex cases, in the most simple hypochondriac the psychic experience is that his body is no longer intact and healthy, as it was before. The word "hypochondria" appeared in medicine to designate discomfort felt in the hypochondrium. Its significant area has been extended and today hypochondriasis refers not to the more localized symptoms of a corporal region but to an attitude. This attitude does not assume—and this is important—a free act of the person, but a structure of psychic experience that is provided by vital or somatic anxiety.

What we could call "denial or repression of the symptom" is one more aspect of the human element of illness. Anton was first to describe the absence of visual perception in organic disease of the nervous system, and Babinski presented to the Neurological Society of Paris two hemiplegics, both of the left side, who ignored in one form or another the presence of the paralysis (anosognosia). Afterwards, cases have been described which are analogous or more complicated, such as the simultaneous negation of blindness and paralysis, of headaches and blindness in a cerebral tumor, etc. The prevalence of anosognosia in left hemiparesia has led to the conclusion of the existence of a center of "body schema" in the right brain hemisphere. Very curious is the description by Fulton and Bailey of a group of patients with tumors of the third ventricle who denied being ill, demonstrating, as these authors stated, a "fatuous equanimity." This fact reminds me of "la belle indifference" of the hysteric.

We psychiatrists have a singular experience: the leucotomy. In the leucotomized obsessive it seems as if the echo of obsession upon conduct and personality was diminished considerably. If they are asked about their obsessions, they remember them, but the patient takes on an attitude of indifference. In a recent case, in my University Clinic, there appeared as a complication in a leucotomy operation a paralysis of the "external rectus" muscle of the right eye which evidently should have produced a diplopia in the patient. Nevertheless, she refused to admit the existence of it, even though we insisted in proving its existence to her. A very interesting case of appearance of a phantom visual field was imparted by me years ago at the Congress of Neurology of Lisbon (1953). It concerned a patient with strabismus who tried to have it corrected surgically. He did not achieve a fusion of the two images of both visual fields, which tormented him very much after the operation. He was operated on again without achieving this fusion and in the end a final operation was decided on only to leave him as strabic as before. The perceptive permanence of both visual fields persisted even in this new situation and the patient accepted as a solution the enucleation of the strabic eye. This was done, but in spite of this mutilation, the phantom visual field not only persisted but increased in intensity, producing such a psychic depression in the patient that he attempted suicide.

This antagonistic pair consisting, on the one hand, of the surrender to the symptom of the

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hypochondriac and, on the other, of the denial of the symptom, is found in the characteristic manner of the perception of corporality. This same duality can be observed many times in the structure itself of the symptoms that are, at the same time, a manifestation of the disorder that constitutes the illness, and the defense against same.

Comprehensive medicine can, therefore, study these specifically human aspects not only in certain determined illnesses, but in all illness. Knowledge of it will permit a deeper penetration into the anthropological structure of the sick man. The doctor will thereby have a more human vision of his activity. He will be a better doctor. His technological progress would be recompensed and enriched by his comprehensive penetration of man. His action will always revolve around the psychotherapeutic atmosphere that will derive from this attitude. Thereby, the doctor will progressively become a better doctor as he becomes more human.

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