they are now used, are only beginning to be recognized.

How have we come to a crossroads where federal legislation is enacted to protect citizens from their physicians? Will physicians resent the Patient Self-Determination Act for this reason? How are other fundamental principles of medical ethics—beneficence, nonmaleficence, and justice—factored into this new legal equation for medical decision making? Difficult decisions at the margins of life remain the most sensitive issues we face as physicians, individuals, and a society. There are no clearly correct answers. The ideal advance directive does not exist. As noted by Seckler, et al. we need a new "standard which promotes trust between patients and their caregivers (both family and professional) and would return to a recognition that not all of life's events can or should be anticipated." [6] This new standard must recognize the limits of medical knowledge and human foresight. It must combine best-interest considerations, surrogate decision making, and written advance directives. Research into patterns of communication and decision making will bring clarity to the debate. Family physicians must begin to act now within the new requirements of the Patient Self-Determination Act to find techniques that are effective for them and their patients. This act is an important, though imperfect beginning. We must not allow it to become a "medical Miranda warning" [4] distorting our best traditions of helping and healing.

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Any Truth In Psychological Explanations?

. . . most of the public does not believe in the existence of mental illness.

— I.D. Glick, et al.

How's this for irony? The only patient I saw, during a 2-week locum tenens, who mentioned the word "nerves" as a complaint seemed not to provoke in me any need for a psychological explanation. She met criteria for *DSM-III-R* code 296.3 (recurrent major depression), and I prescribed an antidepressant as easily, and with the same confidence, as I would have prescribed an antihypertensive had her problem been essential hypertension. I felt no special need to do what Balint called the "long interview."

On the other hand, the patient who stirred most my interest in a psychological explanation was being treated, without benefit, for Lyme disease. There was disagreement about the diagnosis among her consultants in neurology, rheumatology, and infectious diseases; and her regular physician was at wit's end. Her extensive medical record was full of test results, mostly negative or normal, but contained not a shred of personal information about her life and relationships. I itched to do the long interview.

Each of these vignettes illustrates, in its own ironical way, the ambiguity I have about psychological medicine nowadays. The first, a straightforward mental disorder (which in former times I would have felt obligated to explore psychologically), seemed best treated as an organic disease. The second, a straightforward organic disease, raised psychological questions that expert

Submitted 2 July 1991.
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physicians had ignored. My transformation into an "organicist" is incomplete but further along than I care to admit. There is some small comfort in realizing that my ambiguity is shared alike by professionals and laypersons.

At the "street" level, psychological medicine is not entirely dead and might even be making a vengeful comeback. There have been newspaper stories about a man convicted for having illegal sexual intercourse with a woman who suffered from multiple personality disorder. She charged successfully — 6 of her 46 personalities testified — that he had taken advantage of her most vulnerable personality. More dramatically, another man was accused by his adult daughter of having murdered her childhood playmate, having recalled the event under hypnosis during psychotherapy and claiming that she had repressed the memory for many years. Along the same line, a psychologist I know is counseling a man in his 60s who was presented with a hospital bill by a woman in her 30s who accused him of causing her depression by sexually abusing her when she was an early adolescent. Another Alabama man, charged with murder, accused a former cellmate who appeared to be innocent. When police asked the charged man what motivation the other could have he replied, "He must have had a complex" (a rather sophisticated bit of psychological knowledge).

A visit to any popular bookstore will reveal dozens of titles, like Susan Forward's *Toxic Parents*,[1] supporting the notion that life experiences and human relationships in childhood cause adult distress, dysfunction, and illness. Forward, however, shows some ambiguity about the connections in her choice of metaphor for causality. She wrote:

> As I searched for a phrase to describe the common ground that these harmful parents share, the word that kept running through my mind was **toxic**. Like a chemical toxin, the emotional damage inflicted by these parents spreads throughout a child's being, and as the child grows, so does the pain.[pp 5-6]

Forward believes in psychological explanations but chooses physical language for her bestseller's title.

Contrarily, not many physicians (or laypersons) believe that psychological facts play much of a role in the genesis of diseases that a former generation of researchers and clinicians considered models of psychosomatic medicine—peptic ulcer, asthma, chronic ulcerative colitis, migraine, hypertension, rheumatoid arthritis, and neurodermatitis.

Once known as the "holy seven," these diseases were studied intensively for 3 decades (circa 1930–1960) by distinguished psychiatrists and internists, who believed that the onset and course bore close temporal ties to emotionally troubling circumstances and relationships in patients' lives, as well as to their premorbid personalities and behaviors. They believed also that psychotherapy should be combined with conventional medical treatment to achieve the best and most scientifically satisfying therapeutic outcomes.

Most modern textbooks of medicine mention psychogenesis only in passing, in discussing these diseases, and psychotherapy hardly at all.

The move toward biology and away from psychology is seen most clearly in psychiatry. Hirschfeld,[2] in discussing the diagnosis of depressive illnesses, acknowledges the return to the medical model of understanding by comparing the current usefulness of Kraeplin's descriptive classifications in contrast to the ideas of Adolph Meyer, who saw that psychiatric disorders were primarily the outcome of interactions between the individual and the environment. Natural history and pathophysiology, as in general paresis and organic mental syndromes caused by vitamin deficiencies, are more useful than detailed life histories in understanding the "development and expression of illness."[pp 144-45]

An even stronger statement that shows psychiatry's move toward biology, medicine, and the brain, i.e., toward mindlessness, was made by Terrance Brown,[3] who wrote, in editorializing about the "fences" between psychology and psychiatry:

> In place of the individual subject *whom historical contingencies render unique and*, at least at present, *unknowable* [emphasis added], it (academic psychology) erects the psychological subject defined in terms of mental mechanisms common to every man. This means a psychology that is less complete, but one more certain and more compatible with biology and other sciences.[p 911]

Moreover, psychologizing about illness has become a political liability in the eyes of feminist philosophers, who see psychosomatic diagnoses as misogynistic labels attached to women by a patriarchal medical profession. Apropos of the current debate about chronic fatigue syndrome, Maryann Spurgin[4] wrote:

> To suggest that . . . a type of stress predisposes women to "CFS" commits the psychologizing error to which those of us who are ill stand in protest. Let us put aside psychologizing and concentrate on locating a virus, a toxin, a hormone, a "neck-down" aetiology.[p 137]

Perhaps our dilemma about psychology and disease is captured by the cartoonist Bill Waterson,[5] who draws "Calvin and Hobbes." In response to the question, "What's it like to fall in love?" Hobbes replies:

> Well . . . say the object of your affection walks by. First, your heart falls into your stomach and splashes your innards. All the moisture makes you sweat profusely. This condensation shorts the circuits to your brain, and you get all woozy. When your brain burns out altogether, your mouth disengages and you babble like a cretin, until she leaves.
>
> Calvin says: "That's love?!?"
>
> Hobbes smiles smugly: "Medically speaking."
>
> Then Calvin observes: "Heck, that happened to me once, but I figured it was COOTIES."

The semantic distance between medical jargon and cooties is a measure of our ambiguity about mind-body relations. Medicine has developed a supersophisticated and arcane language about molecular biology, but the public's lexicon of analogs for cooties has not kept pace. Physicians speak about viruses, genes, enzymes, hormones, receptors, and neurotransmitters, but patients still speak, much as they did 50 or more years ago, about pains, fatigue, nerves, headaches, allergy, indigestion, and spells. The big problem is that what physicians know about molecules applies only to a fraction of our patients' complaints. The only acceptable bridging concept we have developed during the past 50 years is stress, and even that has taken on a predominantly biological flavor. It must be immediate, direct, and demoralizing to have any explanatory power.

Authors[6] of a recent review article on improvements in psychiatric treatment made the startling statement " . . . it has been well documented that most of the public does not believe in the existence of mental illness." This despite epidemiological data showing that 10 percent of patients visiting cardiologists suffer from anxiety, that 8 to 10 percent of the population is alcoholic, that 20 percent of patients in a general medical setting have a mental illness, and that 20 percent of us will have a clinically important depression during our lifetimes. On the surface, it would seem that the public should have added anxiety and depression to cooties in their repertoire of complaints.

It is tempting to give up psychological understanding entirely, which is more or less what the mainstream of medicine is doing, but what then is one to do with patients like these?

1. A professional man aged 43 years who is officially disabled by migraine headaches despite an exhaustive array of tests and treatments by several qualified experts.
2. A medical receptionist, still grieving the death of a son 4 years ago, who is rendered unable to work temporarily by her panic over her mistaken belief that another son failed to return home when expected. He was asleep in his bed when she thought he was still out.
3. An accountant with severe "sinus" headaches whose sinuses were normal on physical examination and by radiograph examination.
4. A woman in her 50s who is taking multiple drugs for various symptoms: two antidepressants, a major tranquilizer, a minor tranquilizer, a sedative, two gastrointestinal medications, and two analgesics (Klonopin™, amitriptyline, Etrafon™, Ativan™, Restoril™, Reglan™, Tagamet™, Motrin™, and Anaprox™).

What is wrong with these patients, whose names are legion, and what kind of medical care do they need? Have they simply not found the right physician? Do they need another round of diagnostic tests? Should they go to a world-famous clinic? Should they seek psychotherapy?

Over the years, physicians have offered these types of explanations, which I gleaned from medical records:

- Neurotic worries about things that have no basis
- Has been under a great deal of stress
- Has a good many reasons for being depressed
- Under a lot of stress due to a delinquent daughter
- This unfortunate lady (I thought this observation offered the most hope if the physician understood the ways in which the patient has been unfortunate)

Perhaps a psychologist's explanation[7] would be better. I culled this one from a current journal:

> Manifestations of castration anxiety are legion, particularly fears of injury, loss, invasion of body parts, even the sight of blood. Whereas separation anxiety engenders depression and quiet states of lonely isolation and despair, castration anxiety is phenomenologically identifiable through experiences of terror and horror.[p 254]

Maybe an addictionologist would find evidence that these patients are adult children of alcoholic parents or that they suffer from co-dependency. Forward might find that they were humiliated and abused by their toxic parents.

What is the truth of any such interpretations? Upon what evidence do they rest? What predictive value have they? What are their implications for treatment? None of these interpretations has been verified by the sort of experimental data that we have come to expect in biological medicine, and some have been discredited by research. "Neurotic" is not to be found in official current diagnostic manuals. Most forms of clinical depression have no connection to life events, even demoralizing events; and no physician would be caught dead using a psychoanalytic formulation like castration anxiety. The premises of addictionologists and child abuse theorists rest more on the authority of experience than valid and reliable statistical data. I have seen no studies showing the negative predictive value of having alcoholic and abusive parents.

Where does this leave the family physician (or any other) who wants to be personal, holistic, and humane with patients, and who wants to take into account all the factors — including psychological ones — that might contribute to an illness? It seems clear to me that answers are not to be found in academic psychology or cognitive science, which are no more holistic or humanistic than any other specialized knowledge. It's a dead end to hope for a neat psychological theory that applies to most of the problems that we encounter in practice. We cannot find the meaning of symptoms and illnesses and the stories of patients' lives that comprise the substrate of their meaning in theories of the brain or the mind that omit our common sense and leave us thinking that others are unknowable because their "historical contingencies" are too complex.

Family physicians deal with what Jerome Bruner[8] calls "folk psychology," the shared meanings of life experiences (including illnesses) provided by the culture into which we happen to be born. We appear on life's stage as actors in a drama that has been going on for millennia, and we discover our parts from watching and listening to others as the drama continues throughout our lives. Bruner says that biology does not "direct or shape human action and experience" so much as constrains it and that culture shapes the human mind by accounting for our intentional states and giving us an interpretive system for understanding what happens, even allowing us to go beyond the limits of raw biology.

Folk psychology has the character of a lifelong narrative that must be understood sequentially, i.e., historically. Not only that, the narrative does not always discriminate between fact and fiction; both are interwoven into "drafts of our autobiographies." Nevertheless, our narratives are not merely private and autistic, but public and communal, because culture is prescriptive and moral. Narrative is a device for interpreting experiential deviations from cultural norms; our stories are exceptional but not uncanny, unknowable, or outside the range of social experience. Our individual stories are distinctive in their sequentiality, their mix of fact and fiction, and their departures from norms, but they are still within the human drama.

Bruner's ideas suggest that I have been mistaken in the way I framed the title of this essay. The issue is not the scientific truth or falsity of particular psychological explanations for illnesses, which are legitimate topics for scientific research and therefore can be expected to change with new information. The issue is not

even mind-body relations or the possibility of psychogenesis. I have been hung up on dichotomies when I should have seen that the most egregious failure in medical care is the failure to take patients' narratives into account. Every illness becomes incorporated into a particular patient's life narrative, for better or worse, and the failure to see that is a missed opportunity for a potentially therapeutic interaction between physician and patient.

What I fear is losing the interest and capacity for creating the sort of intimacy in which the patient's narrative can be discovered, at least in part. I do not imagine that I can know each patient's narrative thoroughly, but surely I can do better than structuring my life and work so that I never have to deal with the narrative. If I do that, I am doomed to treating each illness as an isolated event having no relevance beyond itself.

Stanley Hauerwas[9] has suggested that our culture's repertoire of stories about illnesses has undergone attrition and that modern people are likely to see their illnesses as "pointless," that is, having no larger meaning in the drama of human life. In the face of that loss, we are more likely to abandon ourselves and our loved ones to medicine to do with us whatever it can. When suffering, disability, and death become inevitable, we endure them without a cultural narrative that can give them any point. As a theologian, Hauerwas hopes that we can recover the part of our cultural heritage that evokes faith in the larger benevolence of life, without resorting to obsolete theodicies that attempt to read the mind of God.

Whatever the merits of Hauerwas's position, it seems clear that illness and disease of all sorts are dealt with best when patients are supported by a community of belief that gives them meaning as a part of life and that death, too, belongs to the category of cultural narrative. Death is not merely the tragic end of life, but an event occurring within a living community. What we all need is less an explanation for the evil that assails us than a "community capable of absorbing our grief."

Any truth in psychological explanations? That form of the question interests me less now than it did at the beginning. It doesn't matter much when there is a story to be discovered and tentatively interpreted in terms of folk psychology. The clinical problem is that we all need a little help now and again in interpreting our own experiences. Physicians, when they are so inclined, have special opportunities to do that.

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Colposcopy Training For Family Physicians

The technique of colposcopy was originally described by Hans Hinselman in 1925.[1] Although the procedure was accepted in Europe, there was very little interest generated in the United States until 1964, when a small group of interested gynecologists formed the American Society of Colposcopy and Colpomicroscopy. During the next

Submitted 30 July 1991.

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