

WHY YOUR PAIN MUST NOT EXIST: BIAS & PHENOMENOLOGY AT THE  
ENDS OF MEDICINE

by

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### **Abstract**

Interrupting bias in counselling psychotherapy is critical to ethical practice. This paper demonstrates how the scientific method, for all its utility in health and medicine, also functions as a worldview and a personal bias which is antagonistic to the lived experience of some clients. This personal and individual level of analysis contributes to the critical psychology literature which has typically focused on the historical and institutional roles of science in counselling therapy. Using the case of irritable bowel syndrome it is demonstrated how individual practitioners can become engaged in conflict when client lived experiences take practitioners to the ends of medical knowledge. In this zero sum conflict, the survival of one world view means the other must not exist. I suggest that by acknowledging and attending to the anxieties of this encounter, counselling therapists can enhance their capacity to perform ethical and productive care work. I point to radical empiricism as a methodology that can support less biased client engagement without practice becoming less scientific or less expert.

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## Chapter 1: Introduction

Doing good therapy today is an evolving praxis. It includes certain ways and means of being witnesses to our clients, their inner lives and their surface behaviours, but it also involves significant work tuning our most important instrument: the self of the counsellor. The contemporary psychoanalyst David Wallin (2007, 2013, 2014) puts it most succinctly: “we are the tools of our trade”. This simple fact reminds us that we must not only hone our clinical portraiture of clients, but that we have work to do so that our own attending is as clear and right as we can make it. In contemporary literature such attuning work has many facets, but one of them is reflected in the recognition of bias. Primarily our biases fall upon primary lines of sociocultural ordering: race, gender, age, etc. Ample social justice theory has shown us the multifarious ways in which such biases are both endemic and chthonic in even the most well meaning populations. It has also become something of an undisputed fact that such biases, when in place in a therapeutic relationship without adequate awareness, will have tremendously negative consequences.

This thesis expands on these hidden biases in counselling psychotherapy. In the chapters to follow this paper will demonstrate that the institutional and historical scientism which has been part of the evolution of all of the psy-disciplines (psychology, psychiatry, psychotherapy, etc), which critical psychologists have done so well to document, should also be considered as a personal bias. My purpose in using this term is to couple, in a new way, the scientific imperative with the background functioning of individual practitioners. This paper ultimately aims to show how and why individual practitioners are motivated to hang onto such a bias, first showing what exactly it might be and how it has come to so infiltrate the practice as a whole. I write from a critical perspective, but I acknowledge from the outset that there is something very different between a scientific and, say, racist bias in the

person of the counsellor. The problem with the latter should be as obvious as it is totalizing; but with science it is not so. The scientific method, in the hands of the counselling psychotherapist is not all bad, and not all for naught. The problem, as I hope it is understood through the following pages, is not the existence of the bias per se, but it's status as both unacknowledged and hegemonic. The purpose of this thesis therefore is to examine the ways that the scientific worldview can function as a negative bias in counselling psychotherapy. Like with all our biases the ultimate aim is to understand them so that we can become aware of them in the moment, giving us as practitioners agency and choice in our expression and utilization of worldviews which are not neutral.

To discuss bias and science merely in the abstract would be difficult: this document is primarily about an epistemological problem in counselling psychotherapy. That is to say that it deals with the manner in which counsellors have been building knowledge systems, and it questions the purposes behind particular strategies of gaining knowledge. It suggests that the naked pursuit of truth, by any means necessary, is not the only guiding principle of scientific methods, and seeks to expose alternative goals that we have as researchers and as practitioners. In critically questioning the choices this discipline makes in the production of knowledge, I am also led into philosophical questions of ontology: once we have separated knowledge from the thing-of-which-there-is-knowledge about, we naturally come to questions about the nature of that thing. To ground these otherwise abstract philosophical concepts, I build these arguments on the case of patients who experience irritable bowel syndrome. In this way I hope to concretize and narrate the what, where, how and why of the scientific bias in counselling psychotherapists, in the ultimate interest of developing a methodological path out.

The main argument first proceeds by locating the nature of the scientific bias in the medical exchange between doctor and patient. The evidence shows that when the ends of medicine are reached — when we might expect to see practitioners defer to alternative knowledge systems — there is instead a doubling down of the scientific approach, even when it is unlikely to promote health and healing. Following this, I engage the main challenger to this thesis, the idea that philosophical poststructuralism has already removed the bias from practitioners, at least in counselling psychotherapy. By analyzing the core tenets behind scientific knowledge production — through concepts such as disenchantment and bifurcation — the thesis demonstrates that the poststructural has failed to extract us from this worldview. In the final body chapter I stay with the experience of the biased practitioner to look at how and why such bias is reproduced in daily practice. In conclusion, I compare this bias to historical overcomings of dominant medical perspectives, and point towards some promising methodologies which can support our practices in acknowledgment of this bias.

### **Irritable Bowel Syndrome**

“Is this too much information?”, asks my client, checking in before extending an important narration of a recent episode of painful diarrhea. She is suffering with the symptoms of what is called irritable bowel syndrome (IBS) and the subtext of this question highlights something particular about the phenomenology of the illness. In our clinical relationship she is comfortable telling me, for example, about the suicidal ideations which come at her like arrows shot from some malevolent ghost — demands to kill herself which are gone again like the flicker of a light switch — and yet when it comes to the day-to-day symptoms of IBS, she checks my comfort level before proceeding. IBS is a disorder affecting 10-20% of the world population, with twice as many women as men (Håkanson et al, 2009,

p. 30), that leaves patients with bodies which have become unrecognizable, which do not function as they expect them too. Shame and guilt are common emotions associated with IBS (Håkanson et al, 2009, p. 35). Technically, IBS is a syndrome and therefore characterized by a group of core symptoms. It is described as pertaining to “abdominal pain, a change in bowel habits, urgency to have a bowel movement, flatulence and bloating” (Dancey et al., 2009, p. 487). But this benign description for ordinary experiences disguises the severity and bellicosity with which IBS can impact people's lives, creating significant disruption in work, leisure, and relationships (Dancey et al, 2009, p. 488).

Part of what makes life so distressing for those with IBS is that there is neither a known cause nor a cure. Although for casual observers IBS looks hardly different than, say, Crohn's disease — where there is both cause and cure — it is instead a dilemma which can be called multifactorial, medically unexplained, or idiopathic. The extra pain from the unsolvability of illness is for the most part obvious. We all prefer, in times of dilemma or disability, to be told that our ailment is knowable, temporary, and fixable: cast the broken leg and walk again in six weeks.

What is so rare or difficult about IBS? Have we really no good explanations?

The fact that this question exists at all should be surprising. IBS is the most common experience for which people attend the gastroenterology clinic, and conceptualized more broadly as a somatic expression of relational and emotional illness it is so common that we could call it ordinary. And not just ordinary among the sick, but ordinary among the total population. For many decades there has been good theory on how best to medically understand and treat IBS (e.g. Drossman, 1977). Since the dawn of the 20th century a variety of theory has existed connecting the emotions to somatic complaints and thus supporting centuries of folk understanding of the phenomenon (Van Oudenhove et al.,

2010). We have butterflies in our stomachs and knots in our guts when times are hard, and this is as real as anything else we might experience whether psychogenic or physiogenic. This theory has evolved until we have robust models of a “bidirectional connection system between the gastrointestinal tract and the brain, through neural, neuroimmune and neuroendocrine pathways” (Surdea-Blaga, 2012, p. 617). Since the original publication in the contemporary literature on IBS, Drossman (1977) advised practitioners against focusing their diagnostics and treatments on “the end organ” (p. 817). And anthropological researchers are not surprised— they have long been aware that people express psychological and social dilemmas in somatic terms in the absence of organic disease and that this is the most common global and historical means of communicating illness between patient and healer. (Indeed, the aberration is likely not the somatization of illness but rather the very recent, modern, urban, educated and Western propensity for *psychologizing* pain (Kirmayer, p. 161)). Yet despite all this, there is disdain for the somatizer, the patient from whom relational and emotional distress is expressed through the body.

This brief overview makes it seem quite curious that medical health professionals are so bad at treating IBS. And so the answer to the question of ‘why’ must then go beyond the surface of “medically unexplained” and “idiopathic”, because it is clearly not a lack of knowledge per se which determines this poor outcome. Instead, it is prudent to explore the kind of assumptions and biases might underlie medical health — from general practitioners, to medical specialists, psychiatrists and counselling psychotherapists — which invite those practitioners to exclude certain understandings when in dialogue with IBS sufferers.

This question is important because there are sustained damages one suffers when chronic illness is “medically unexplained”. Biomedical culture specifies a particular relationship with illness; a relationship which is entirely mediated by health care. When that

system fails to maintain certain core ordering processes between person and illness, there is a sociocultural covenant that breaks down into which uncertainty, anxiety, and blame often enter. Anthropologist Jean Comaroff (1982) articulates this secular social contract:

the apparently 'instrumental' acts of modern medical practice have thus become important symbolic foci of *secular ritual* for us, and its techniques and concepts serve as metaphors of our state of being as bio-physical individuals, seeking to enlist 'natural' science in our secular opposition to the forces of disease, decay and death. ... Thus, while scientific knowledge has clearly provided us with important means for the specific control of affliction, it has also come to fulfill a more embracing cultural role. Indeed, 'science' has become our primary symbolic order, in which 'instrumental efficacy' serves as our ritual mode, and 'rational practice' our dominant ideology. (in Crawford, 2004, p. 515)

IBS, along with other idiopathic and medically unexplained illnesses, can thus disqualify patients from the safety of a belonging in established cultural modes of being in the world.

### **Research Questions**

There are a number of questions to ask regarding the experience of IBS in healthcare which lead more directly to the existence and the nature of the scientific bias in counselling psychotherapy.

Numerous studies have described the medical behaviors of IBS clients, and identify various patterns which explain why IBS clients would do the things they do. Susan Johnson (2008) cites "Doctor shopping, disease conviction, [and] aversion to psychogenic explanations" as common behaviours which can be variously explained away by hypersensitivity, suggestibility, and low pain thresholds (p. 23), or as social manipulation, sick role adoption, and overt coercion (Ford, 1997, p. 9). Chang et al (2006) labels these as

societal myths, which include also the triviality of symptoms; their simple cause in stress; their true rootedness in psychiatric disorder (p. 1441). Ultimately these add up to the understanding that those with IBS are difficult patients (e.g. Chang et al, p. 1441). With such a lens it becomes quickly apparent how the uncertainty of IBS can unfold into blame and guilt. But Comaroff serves to remind us that there is more to seeking medical help than the hopeful attenuation of illness. There is at stake one's inclusion or exclusion in one of our foremost cultural means of assuaging pain, and death, and ultimately uncertainty and chaos.

Life in the modern West has been medicalized. Among the expected consequences of this is the internalization of medical conceptualizations of minds and bodies, emotions and sensations, comforts and discomforts. Viewing help-seeking from a sociocultural vantage allows us to see with compassion the naked desire clients have to be brought back into the safe havens of explanation, knowledge, and understanding, if not cause and cure. Those with medical unexplained illnesses like IBS find themselves at a strange crossroads, and the carers for these clients find themselves inducted into that same chaotic space by the presence in their clinics of idiopathic illness.

Functional disorder, hysteria and neurasthenia, malingering and hypochondria, somatization and somatoform disorder; these are just a few of the discursive means by which practitioners separate themselves from their clients. All of them, to a greater or lesser degree, and with more or less malice, carry the implication that "It's all in your head", and that therefore one's suffering is not real. *But why has there been so much effort to eject clients from medical culture, rather than to embrace them?* What is it about IBS that is so destructive to the clinic? Why do practitioners often feel antagonistic towards IBS (e.g. Lipowski, Z. J., 1986, p. 611)? How has theory failed to ameliorate this distance? Though much effort has been spent in identifying the characteristics and qualities of patients which

contribute to this conflict, little research has been done which explores the relationship of health care practitioners to genuinely bio-, psycho-, *and* social- illnesses like IBS. These are the questions set out for in this papers exploration of IBS as an exemplar of the biopsychosocial. Although scores of articles and books have been written on IBS — on the search for organic etiology, the construction of a symptom based syndrome, the management of a fundamentally unexplained illness, and the social effect of taking on the sick role — there is very little research on the questions raised here. The literature review will address the commentary made in the extant literature on the relationship between patients and medics in IBS, but it is readily apparent that although the impoverished dynamic has long been known, the question of “Why?” has been cast aside. It is not, it seems, within the scope of any research.

### **Thesis**

Earlier I hypothesized about the explanatory power of certain chthonic commitments, or biases, of medical practice — I am speaking here towards epistemological structures running below the surface, what philosophers Hubert Dreyfus and Charles Taylor (2015) refer to as the “deeper topology which gives the unnoticed context” (p. 3). Importantly, theorizing in this way is in contrast to more typical rationales pointing to the insufficiency of medical progress (Drossman, 2003) or the malingering quality of the patients themselves (Lipowski, Z. J., 1986, p. 611) . These attempts explain the problem away as merely accidental; e.g. the foolishness of patients (see research associating somatization with lack of education (e.g. Ford, 1997, p. 8; Kirmayer, 1984, p. 173) or a lag in scientific progress which no doubt will soon be remedied.

My thesis is that IBS is deeply threatening to the foundational mores of modern medical culture, and that its so called idiopathy is not an accidental failure on the part of

clinics, researchers, or medics, but rather evidence of a purposive (if unconscious) defense against the legitimization of IBS and other biopsychosocial illnesses. Put another way, my argument is that medical culture *refuses* to legitimate IBS in order to protect its own legitimacy, and that this is demonstrative of the scientific bias enculturated into practitioners. In support of this, I review the knowledge practices in medical culture as they exist across three distinct domains; institutionally (the clinic), theoretically (the university), and personally (the medic), each addressed separately in the three chapters of the body.

This thesis utilizes the concept of medicalization. This is the process by which medical culture, as a form of power, colonizes more and more territories of ordinary experience by “[shaping] the collective conceptual resources through which we interpret and understand our experiences. Medicalization, [Ivan] Illich contends, is able to transform these resources such that we view more and more of our lives through the lens of medical discourse” (Wardrope, 2015, p.342). IBS reveals even more nuanced mechanics at play: that when an illness can not easily, viably and stably be re-coded into medical culture there is a process of refutation *of the very experience itself*. “You don’t feel what you think you feel”. One way to look at IBS is thus as oscillations between offensive strategies for capture and defensive strategies of disclusion. (In Deleuzian terms, as stuck in a liminal moment of deterritorialization without efficient reterritorialization (see Holland, 1991)).

### **Politics and the Stakes of Diagnosis**

This thesis takes as its departure point Edward Shorter’s *From Paralysis to Fatigue* (1992), a social constructionist history of medicine which focuses on the history of psychosomatic illness, “one of ever changing steps in a *pas de deux* between doctor and patient” (p. xi). Shorter recognizes, and I think correctly, that this *pas de deux* is *the* sociocultural practice which serves to confer, or deny, legitimacy to illnesses. As he writes,

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 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, 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" (p. ix-x).

The idea here is that when dilemmas are complex, secret, stigmatized or otherwise impossible to explain or accept within the context of an individual person or a particular culture, people's adaptive unconsciousness will translate that distress into viable symptomologies. In the exchange of symptoms with medics, they are either confirmed or denied and legitimacy of suffering is thus conferred or not. For Shorter it is primarily the patient who is vulnerable in this exchange, only *they* who are at risk of delegitimation in this exchange.

Shorter's theory is largely in the Deleuzian (2006) tradition, speaking to the semiotic value of symptoms, signs which are "named, renamed and regrouped in various ways" and which are grouped together by the clinician to form a clinical picture (p. 15).

With Deleuze, and perhaps in some separation with Shorter, I pay greater attention to the *reciprocal* nature of the semiotic exchange and therefore the reciprocal (if not equal) consequences of that re-ordering. For Shorter, medical culture has little vulnerability to the changing nature of symptoms and interventions. Medical power and its terms of reference

feel relatively fixed, with some room to accommodate shifts through time, and it is the patient only who is uniquely vulnerable to forces of legitimation and delegitimation. But Deleuze reminds us that the stakes of these exchanges are always the potential reordering of the constructs, and in consequence the therapeutic practices these orderings produce. The power of medical culture, though far greater than any one patient, is not absolute. Sufficient change can always unseat the current instance of what Foucault (1978) called biopower: the “numerous and diverse techniques for achieving the subjugation of bodies and the control of populations” (p. 170). Thus, reordering must be defended against, for while power upholds its constructs, those constructs simultaneously uphold power. Therefore, legitimate sufferings which *cannot* be included in medical legitimations of illness, such as IBS, are inherently threatening to medical culture.

This is not a unique risk in IBS, but IBS is a front line in the battle. Put very simply, for Foucault (1978), the making of biopower is defined by the transition from power over death (e.g. the hangman) to power over life (e.g. the doctor): “One might say that the ancient right to take life or let live was replaced by a power to foster life or disallow it to the point of death” (p. 138). Much of this power to discipline bodies is sourced in the ability to construct the very definitions and obligations of health and illness, “propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary” (p. 139): in census and in diagnosis does biopower lay claim. Therefore the exchange of legitimations of illness comes to be among the territorial front lines of biopower. The intricacies of biopower are better read about elsewhere but suffice it to say that acts of disclusion against symptoms that cannot be enfolded within the current regime contain an inherent risk. In defensive acts of disclusion there is always a chance that the lay culture will reject the semiotic maneuver, potentially catalyzing a reordering process in

which the extant therapies (and their entrenched biopower) are at risk of themselves becoming discluded.

It is in this context that the thesis speaks of medical cultures' *defensive interest* in the confrontation with IBS. The biopsychosocial contains an implicit threat to the core ordering knowledges of the current medical culture — it is suggestive of different etiological pathways, it demands alternative therapeutic interventions, it undermines the hegemony of the search for lesion and break. IBS exposes the untenability of core concepts which will be explored in detail in this paper: the bifurcation of nature and the disenchantment of the universe, each of which has underwritten the medico-scientific project from the outset. IBS gravely exposes the limitations of current medical culture, limitations which are commonly advertised as being nonexistent save for the insufficiency of current progress. This threat provokes anxiety, and the resistance is marshalled — exclude and delegitimize threatening illnesses from understandability, exercising the tools of taxonomy and diagnosis of illness in the interests of medical territorialization. Practitioners are thus biased, privileging one worldview over another.

### **Deconstruction and Reconstruction**

I am submitting this thesis in the spring of 2020, in the new era of the coronavirus in which scientific power, public health discourse and the diagnostic, therapeutic, and curative powers of medical culture are more in demand than ever. This paper is a rather excoriating analysis of those very institutions and practices that likely belies the fact that I too await the “cure”. Disease, illness, and death, the isolation of quarantine, the loss and grief and fear and loneliness of plague and pestilence are an important reminder of the value of human machinations against doom, not least of those which include science and medicine. So, how can I write this along with all the rest of this thesis?

This raises a crucial question about the role of critical analysis, and allows space to say exactly what the point of this paper is. My argument is fundamentally about what happens when a particular knowledge structure takes on hegemonic status within the culture. It's about what happens to both the patients and medics who are forced to translate raw experience — as we must always do — into a common language which both *has limitations* and *can not incorporate those limitations*. The semiotics of symptomatology function by zero sum logics. The subsequent problem is obvious. When lived experience fails to conform and confirm the hegemonic order, the patient and medic enter an antagonism. While the power of biomedicine against the patient means the patient is the most vulnerable, conflict always threatens both parties, and so the medical establishment and the medics themselves, are also at some risk.

The purpose of this paper is not to show how IBS can better be treated, or to bring medical attention to these particular interactions. This would be beside the point, because the problem is explicitly *not* in the difficulty of sourcing good information on how to treat IBS — a holistic approach which includes diet, emotional coping strategies, and somatic awareness creates change. The problem is that this information is not incorporated, and so this paper explores why that could be. IBS is used here because of two important qualities: it involves a phenomenological experience that is *sine qua non* biopsychosocial, and a medical picture which is declared “unexplained”. By focusing on an illness experience with these qualities, this paper is able to excavate the processes by which helpful knowledge fails to be incorporated into the treatment of problems. Processes which look a lot like the biases which, in other contexts, have been routed as much as possible from practice.

The arc of this paper ultimately seeks not generalized criticism of institutions or of modernity — this has been done many times by better writers — but rather to show how

the enduring nature of this problem is upheld by *individual* practitioners. This is where I hope it can make a contribution which is reconstructive. The antagonism, the disclusion of experiences of pain and suffering and their social delimitization is fundamentally a relational process. Psychotherapists are at the front lines of the social expression of pain, where the need for agony to be formulated and legitimated unfolds in actual life. If we are to increase our capacity to truly know pain in all its guises — for one must enter the room of suffering before we can find the door to healing — then we need this kind of personal deconstruction of our own motives for not-knowing, for not-seeing. This paper is about identifying the knowledge structures which have hegemonized our experience of suffering under the logics of medicine, and how those have been enculturated into both patients and medics in sometimes disturbing ways.

The hunt for private biases is at the heart of the pedagogy of counselling psychotherapy, particularly in the context of social justice. To do good work we ought to root out enculturated prejudice which infects our thinking and our fellow feeling towards clients and colleagues. Race, gender, sexuality, age, ability, and so on, form the common lexicon of bias, but are not exhaustive. This work of deconstruction is about finding in ourselves as practitioners more of the so-called biases which blind us, biases which here are shown, I hope, to sit at the root of this profession. The experience of IBS within the medical hegemony is thus a vehicle to demonstrate what happens to *us* when truly biopsychosocial pain and suffering enters our offices.

But, we need to do more than criticize if there is a desire for amelioration and expansion in our practices. If deconstructive work is to be creative rather than simply destructive it must not only declare, “Why are things so wrong?” but “What needs happen to make them more right?” Here, the reconstructive question is What do we as practitioners

do when our clients bring us to the ends of medicine? This research sometimes leads to radical calls against medicine, against science, and against expertise. My hope is that by exploring the nuanced mechanics by which these morally ambivalent technologies become pernicious, we can learn how to proceed in ways less biased, but not less expert or less scientific.

### **Chapter Outline**

The body of the text will begin with a brief literature review, highlighting academic commentary on the nature of the relationship between patients and medics with regards to IBS. Few studies have actually been conducted which focus directly on this encounter, though many include brief attention to the topic and the suggestion for more research. This section highlights the current state of the research, the current general opinion on the matter, as well as the gap into which the present inquiry inserts itself.

Chapter's 3, 4, and 5, form the main research and argumentation in this paper. In each chapter a distinct, concrete entity of medical culture is examined in an effort to demonstrate how entrenched is the resistance, and how dominant the epistemological fortification. Each chapter also pairs with the concrete entity with a more abstract, syncretic concept that helps guide the exploration. Chapter 3, *Disenchantment at the Clinic*, maps the Weberian concept onto the daily norms of medical practice. This is largely situated on the bio- side of the disciplinary divide.

Chapter 4, *Bifurcation in the University*, switches modes, from day-to-day medical exchange to the construction of it's theory, and from the bio-medical to the psycho-social. While Chapter 3 exposes hidden epistemologies, Chapter 4 directly confronts their overt constructions in the context of A.N. Whitehead's critique of the bifurcation of nature. This section speaks to the softer side of the medical dyad, critically addressing the

post-structural approaches which have supposedly taken all this into account already, if only medical practice would progress sufficiently to incorporate the new theory.

In the final chapter of the body, *Anxiety and the Medic*, the inquiry turns to the individual practitioner. This chapter investigates the curiously enduring quality of the current medical culture through an examination of its perpetuation in the medic herself. Chapter 5 deploys Paul Tillich's conceptualization of ontological anxiety to anchor a narrative around the very personal motivations for medics to preserve status quo medical culture.

The final chapter concludes the investigation, summarizing these resistances across the Clinic, the University, and the Medic in the maintenance and defence of the modernist epistemology. Chapter 6 highlights some possible alternatives to this approach and how they might be incorporated into medical culture.

### **Transdisciplinarity**

This paper will discuss the interactions between healthcare providers and patients in the construction of illness that is largely felt in the body — the symptoms are diarrhea, constipation, and bloating, and most of the academic discourse on the topic is located in the *Journal for Gastroenterology*. The first question might be, why should we as counselling psychotherapists care about these particular terrains of medical consequence? In short, what does all this have to do with counselling psychology? Well, firstly, it is a reality that IBS clients seek treatment, at least partially, from counselling psychotherapists. There is the simple fact that the physical symptoms are not caused by simple organic disease (such as with an infection which causes stomach distress), but rather involve experiences of emotional and relational distress. In this reading the gastric system is the “end organ”

(Drossmann 1977, p. 817) and understanding “what is the matter” requires the augmentation of a psychosocial approach.

Furthermore, placing IBS within the context of counselling psychology is a deliberate strategy against the disciplinarity which characterizes healthcare, to the detriment of those in dilemma. Going beyond the psychological is already *de rigueur*, and exposing the relational roots and expressions of dilemma is a core component of counselling psychology, because, as Paul Stenner (2017) concisely explains, “the psychological dimension (often discussed in terms such as ‘subjectivity’, ‘affect’, ‘experience’ and ‘desire’) *suffers profound distortion* [emphasis added] when studied in abstraction from its social, cultural and historical context” (p. 1). It is generally considered unethical practice to isolate the psycho- from the social- thanks to logics such as those which have been articulated in the eras surrounding the post-structural turn. This is something of a first step towards what is now commonly understood to be the “biopsychosocial” approach, which returns our biological bodies into the mix of what it means to be human.

Despite this, I argue throughout this paper, there is significant and enduring stratification between the bio- and psychosocial- and these fall along the vocational lines of the doctor and the psychologist. This is not new, of course. In one of Plato’s dialogues a Thracian doctor decries ““This is the reason why the cure of so many diseases is unknown to the physicians of Hellas; they are ignorant of the whole. For this is the great error of our day in the treatment of the human body, that physicians separate the mind from the body” (in Maté, 2004, p. 31). So it is, one for body and one for mind, the old dualism at play, each paying certain deference to the social determinants of health (such as class, gender, race, age, ability, etc) but essentially cocooned within their discipline. This paper will confront this in much more detail in the body of the work, but I address it here to say that the choice to

study IBS within counselling psychology is part pragmatic and part polemic, each challenging the separation of powers which is instantiated again and again when counsellors simply defer physical, biological, or somatic expression of illness back across the line.

### **Terms**

The transdisciplinary character of this paper requires some discussion of terms, because certain words have been captured by the different disciplines to imply “this” and not “that”. *Patient* versus *client* comes to mind at the outset; patients are in doctors care, and in an effort to separate themselves from malicious historical practices of the psychological, counsellors refer to their sufferants as “clients”. In this paper I will resist this custom, recognizing it as an act of discursive reification in which patients are those whose suffering is fully legitimized by organic disease under the auspices of healthcare and clients are those who simply choose to avail themselves of the services of a chosen practitioner. The word patient has an uncomplicated etymology — it is from the Latin for “one who suffers”. In keeping with this tradition I will use the term patient to ensure that regardless of illness, etiology, or chosen practitioner, those who suffer are named with the dignity which they deserve.

Secondly, there is the cacophony of healthcare worker nouns to consider. This paper will consider the roles of general practitioners (GP), nurses, technicians, psychiatrists, psychologists, counselling psychotherapists and others all within a context which considers them to have overlapping terrains of attention. The particulars of vocation make these qualitatively different jobs, and it would be silly not to recognize this. But from the perspective of the sociocultural lens looking from afar at the relations between patients and healthcare we must give this group a name. I use two different clusters of nomenclature in this paper. The first, in the positive register, includes carers, helpers, and care workers. The

second, in the critical register, highlighting their allegiance to the powerful culture of medicine, refers to these practitioners as medics, whether they are surgeons, students, or psychoanalysts.

Finally is the naming of the “problem” itself. This too is at issue, even in popular culture, where there is awareness around languages which are pathologizing or non-pathologizing. The label we give to the problem importantly connotes this. This is an important issue, made first by the invocation of social into the psychological. Where purely psychological terrain *internalizes* problems as features, functions, or dysfunctions of an individual's brain, mind, or personhood, the social awakens us to the ways that an insane world might justifiably lead to insane thoughts, affects, and behaviours. As Don Jackson and Paul Watzlawick of the Mental Research Institute put it over 50 years ago,

At the clinical end of the behavioral spectrum, ‘crazy’ behavior is not necessarily the manifestation of a sick mind, but may be the only possible reaction to an absurd or untenable communicational context. Seen in this light the terms ‘sanity’ and ‘insanity’ practically lose their meanings as attributes of individuals. (Watzlawick & Jackson, 1964, p. 56–57 in Sanders, 2017, p. 248)

In this case words like crazy or insane are both internalizing and pathologizing, concretizing the general problem into a particular, and a problematic one at that. The same problematique is possible when we invoke the biological into the psychological.

Just as expressions of pain and distress in “insanities” become justifiable and legitimated upon recognition of wider contexts beyond the individual, so too do various expressions of dilemma in “somatizations” need a context for their legitimacy. When languages decontextualize and delegitimize certain symptoms at the outset, patients are humiliated and abandoned. Much of this foreshadows the crux of this paper — that many

common means of expressing dilemma, including IBS, are inappropriately de-legitimized — but for the sake of terminology, suffice it to say that the nomenclature we give to the problem connotes either it's inclusion or disclusion within culture legitimacy. Somatoform, psychosomatic, and hypochondriasis are languages which delegitimize, and so this paper uses instead words of problem, pain, dilemma and distress without parsing these by their biological, psychological, or social orientation, and without withholding legitimacy.

Finally, a brief note on the words 'illness' and 'disease'. Simply put, dis-ease refers to structural or functional abnormalities of tissues and organs while illness refers to the patient's perception of ill health (Drossman, 2003, p. 6). This is simple but important because although these are used somewhat interchangeably in lay culture, they are here each technical definitions which refer to very different things. Disease is the landscape of microscopes and laboratory samples, it is either confirmed or denied by medical technology in the search for lesion and break. Illness needs no such thing, it is a phenomenological language of symptoms, of feelings in the world. According to Kay Toombs (1987), the conflation of these terms is not restricted to lay culture but the confusion actually undergirds the patient-care worker relationship itself. She writes,

successful communication also presupposes a certain taken-for-granted congruence in the interpretational schemes of the communicators; that is, the communicator assumes that the interpreter will interpret his communicative sign in substantially the way that he interprets it. In the doctor-patient relationship this assumption is problematic since the communicator (the patient) is intending his sign to relate to his subjective experience of illness and the interpreter (the physician) is interpreting it as a sign relating to disease. (p. 56)

There will be more on this later, but for our purposes here, suffice it to say that illness and disease, as occupying either the phenomenological world of lived experience or the scientific world of the null hypothesis, are highly technical and contrasting terms in which care is taken in their usages in this paper. The term sickness is used as an umbrella term to capture both disease and illness without specification or reduction.

### **Methodology and Prepositions**

#### **Epistemology**

This is largely an epistemological investigation into the nature of the knowledges which underwrite modern medical culture. This includes the manner in which they were developed, how they are maintained and practiced (including their maintenance by systems of power), and ultimately the ways the legitimacy and sanctity of these knowledge systems can be undermined or threatened.

I am applying to medical culture a critique which is typically made against modern Western science more generally; A.N. Whitehead's fallacy of misplaced concreteness. In his 1925 Lowell Lecture series, published as the text *Science and the Modern World*, Whitehead articulates what he sees as

the expression of more concrete facts under the guise of very abstract logical constructions. There is an error; but it is merely the accidental error of mistaking the abstract for the concrete. It is an example of what I will call the 'Fallacy of Misplaced Concreteness'. (p. 52)

For Whitehead this is a kind of good natured and often productive happening in our ordering of the world, but is a mistake nonetheless. In our present context the fallacy of misplaced concreteness begs the question that perhaps what underlies the limited ability of medical culture to survive legitimation of IBS is not the so-called concrete and stubborn

facts of which we speak, but rather the subterranean abstractions which they stand in for. The problem thereby becomes one of epistemological systems at work, and the task for our investigation to reveal what knowledge constructions belie these concrete facts.

Furthermore, as the meaning of this fallacy is expanded on by Paul Stenner (2009), there is a deeper invitation to go beyond fixed concepts of a reality 'out there' awaiting our recognition — e.g. a concrete disease merely awaiting the adequate observation technology. Stenner (2009) writes:

The fallacy of misplaced concreteness that we inherited from seventeenth-century physics lured us into thinking of process as some irrelevant epiphenomenon to be explained away, and staked its claim on a cosmology grounded in the idea of a brute material reality existing with its 'simple location' in the immediate present and enduring through time. (p. 19)

This leads us to a constructionist preposition as a corollary to our epistemological focus.

### **Constructionism**

A constructionist assumption grounds this investigation, in this case a social, or discursive constructionism. In this mode of thinking, reality is understood as different from an objective system "out there" that is observed in classical Humean empiricism and described by representational language (language which does its best to capture by representation what's going on elsewhere). Rather, to a greater or lesser degree depending on the strength of one's constructionist view, reality is *constructed*, as it were, in conjunction with the so-called observers, who may better be named participants. Stenner, following Whitehead, is open to a deeper constructionism than just the social, and this idea will be developed later in the paper, but that discussion can remain for later.

For now, suffice it to say that discursive and social constructionism is an understanding of the world as one in which reality is embedded with “language and communicative action” and so “are locally determined through dialogical exchange” (Anderson and Goolishian 1988, p. 373). One way to think of this is to see that our options as actors, or the potentials available to us, are constrained by our imagination in language. In this case, access to increased vocabularies of affect, emotion, and action, similarly increase our capabilities as persons, now grasping more of reality (see, for example, Bloom, 1999).

But discourse goes beyond representing reality to actually and actively construct that reality. Speakers, in the words of Judith Butler (1990), *performatively* create reality. This occurs by “linguistic declarations that perform actions including calling into being the objects they name”, and performativity is “the discursive mode by which ontological effects are installed” (p.112). Consider a representative declaration such as “The leaves are green”, in comparison with a speech act, “I now pronounce you man and wife”. In the latter case, the world is shaped according to the utterance. As philosopher Catherine Wetherell (2007) notes, “this is a rejection of the view that language is a 'do-nothing domain', transparent, neutral, non-intrusive, a reflection of activity rather than activity itself” (p. 663). For Berger and Luckman in their famous book *The Social Construction of Reality* (1966), “The child learns that he *is* what he is called” (p. 152).

Importantly, two differences between constructionism and naive realism are in play. First, this process lacks fixity and generalizability. It is localized, anarchical, and untethered. Indeed, “[T]he construction of human systems, is a constantly changing, creative, and dynamic process” (Anderson and Goolishian 1988:376). This is the quality of reality which

makes space for this paper to speculate that the rules and roles of the patient-medic dynamic are not fixed, and therefore the medical culture is not invulnerable.

That this paper treats the exchange between medics and patients as both precarious and genuinely casual in the very articulation, expression, and becoming of sickness is predicated on these understandings of a constructionist reality in which discursive practice is an ongoing negotiation that has emergent, unpredictable outcomes. Indeed, “Deleuze insists on the impossibility of controlling change and of predicting the flow immanent to life. There is no one method that will do the trick, and there is no one ending to the story” (Nicherleain, 2017, p. 154) and so positions must be defended, for even the powerful are at risk in a constructionist universe.

### **Phenomenology**

The phenomenological lens is critical to this investigation for several reasons, but primarily because it is the language of illness, in the same fashion that biomedicine is the language of disease. To put it simply, it is not a diagnosis *per se* which is bothersome about illness, but rather the way that it manifests in one’s life; it is the pain, the discomfort, the reduced capacities. Indeed, Fredrik Svanaeus’s (2000) phenomenological approaches to the medical encounter describes “how being ill is essentially characterized as a state of unhomelikeness in which we are alienated from the way we feel at home in our bodies” (in Hakanson et al., 2010, p. 1117). In some basic sense illness is about symptoms, and therefore these are “the means by which patients communicate their problems to physicians at first presentation (Drossman and Sperber, 2012, p. 388). Symptoms are different from diagnoses in important ways; they have their own consequences, and they are not merely markers in a diagnostic process.

For Kay Toombs in her dissertation *The Meaning of Illness (1987)*, phenomenology exposes and explains much of the discord between medic-patient relationships in general, and exhorts the researcher to pay adequate attention to the patients lived experience of illness. This contains an ethical imperative given the power imbalance between medics and patients which ought to be heeded, if only because it makes treatment more effective. She writes, “if therapeutic goals are to be optimally effective- and suffering is to be relieved- attention must be directed to this perceived lived body disruption rather than being exclusively directed towards the objective pathophysiology” (p. 10). But more importantly for the purposes of our paper, in Toombs’ analysis the lived experience of illness gives unique information about sicknesses. According to Toombs’ we must recognize that the “lived experience of illness is quite *distinct* [emphasis added] from the phenomenon of the disease state and that the two cannot be identified with one another” (p. 10). Accessed via the phenomenological lens, experiences of the lived reality of illness improves our access to the ontological reality of sickness *in toto*, which is more-than and incommensurable to disease considered alone.

### **Limitations**

Perhaps the most important limitation of my thesis is in the manner in which I collapse the variegated institutions and cultures into a monolith. As I argue for in the Terms section above, this is important for the purposes of my thesis in order to demonstrate the existence and function of a central epistemological framework. Having said this, it may, like other theses of its ilk seem to be “too bald and exceptionless to be true” (Taylor, 2009, p. 19). And in the specific context of this paper, this argument has been well made. Here, Maria Nichterlein is evocative and compelling:

Certainly, medicine itself has suffered significant transformations as Foucault has described (1973), transformations that seem to have been ironed out, to have been erased, in the current image of a monolithic and natural-scientific medical discipline. This reduction of the profession of medicine to a monolithic idealisation seems to be mirrored by the often clichéd critiques of the medical model, critiques that unfortunately seem to dismiss the complexities of the clinic (Barney, 1994) as a space that offers ongoing resistance to systems that have tried to capture it.

(Nichterlein, 2017, p. 146)

I have no sufficient defence against this critique, save to say that the initial argument in a longer conversation is served by simplicity. If my thesis holds water then future research should most certainly include greater sensitivity to difference in medical exchange. I suggest that it would be useful to consider medical practices as containing an internal plurality containing the same kind of hegemonic and subordinate blocs that we have learned to apply in more sophisticated analyses of gender (e.g. Connell & Messerschmidt, 2005). There are no doubt competing hegemonic and non-hegemonic practices and this paper narrowly focuses on orthodox, dominant medical power.

It would be of great interest to explore the interaction of alternative / non hegemonic medical cultures. For example, some progressive counselling psychotherapy clinics have recently incorporated somatics more and more into their practices, reterritorializing the bio- into the psychosocial. Indeed, over the past quarter century, significant changes in the talking cure have been in the direction of the body; as counselling psychology expands on cognitivism, behaviorism, and unconscious representation, new theories around affect, emotions, sensations, and the agency of the body in conjunction with the mind have shifted the terrain of what counsellors attend to. Whether or not these

transcend the bifurcation, disciplinarity, and disenchantment which this paper argues is at the heart of the issue would require nuanced investigation in a future work.

## Chapter 2: Selected Literature Review

The literature review asks of the case of IBS, what is it that leads to such antagonistic encounters between patients and medics? And why is there considered to be no therapy for IBS? We might assume that perhaps it is ‘incurable’ due to the insufficiency of current medical progress — that with more funding, and more research then better answers would be on their way. Surprisingly, only some of the readings suggest as much. There is indeed a core of biomedical researchers who simply believe that either IBS will eventually be organified (thanks to scientific progress) or else common sense will prevail and it will be declared ‘all in the head’, and they are working diligently in pursuit of such ends.

However, widening the context of the research to include sociological and anthropological accounts of somatized distress, a different picture emerges in which these bodily expressions seem to be neither organic nor imaginary. They contradict the account of the biomedical authors with a strange ease, as if nothing could be more obvious. It was this strangely *obvious* knowledge around the aetiological mechanics underlying IBS that appeared to be simply unintegrated by medical culture that fomented the research project

as it came to be organized. The obvious and accessible quality of knowledges which could ameliorate decades of patient-medic conflict are the qualities which point to bias.

This brings us to that research which pertains directly to the question; What is the nature of the interaction between medicine and IBS; between medics and patients? The literature here is generally unanimous in two things; that the exchange is abysmal for both parties, and that there is a lack of research excavating this phenomena. It is precisely in this gap that the present inquiry hopes to be of use.

### **Brain-Gut Axis**

The following chapter will take a tour through some of the most relevant papers in the extant literature, paying particular attention to those emergent themes as described here. However, there is a potentially important new literature on the topic which is largely absent from the themes of this review, regarding what might be best called the brain-gut axis. There is some tremendous research happening here which is linked with polyvagal theory (Porges, 2011) in both its character and its potential to transform dualist thinking on the topic. In these theories the assumption of a traditional, unidirectional flow of information and causality (Stern, 2003, p. 177) — from either the brain to the body (psychosomatic), or from the body to the brain (somatopsychic) — is replaced by a reciprocal pathway. The specifics of the brain-gut connection are explained by Van Oudenhove et al (2010) “as the bidirectional connection system between the GI tract (with its enteric nervous system) and the brain (central nervous system) through (autonomic) neural, neuroimmune and neuroendocrine pathways” (p. 202). As Drossman (2005) puts this in concrete terms, writing “The combined and integrated effects of altered physiology and the person’s psychosocial status via the brain-gut axis will affect: 1) how the symptom is experienced, 2) the individual’s illness behavior, and ultimately 3) the outcome.” (p. 252).

This intervention significantly amplifies the complexity of the system and is a powerful explanatory model, so why leave it out?

Firstly, it waits to be seen how this will be integrated by medical culture.

Understood as a new theory it is best considered to be in its infancy. Perhaps the most authoritative voices on the matter come from self help and popular science writing, where provocative subtitles include “How the Hidden Conversation Within Our Bodies Impacts Our Mood, Our Choices, and Our Overall Health” (Mayer, 2016) or “Unleash Your Body's Natural Ability to Heal Gut Sensitivities, Inflammation, ... ” (Habib, 2019) etcetera. Though cynical of such early promises, I am sincerely encouraged by this kind of work, and I am curious as to how it can be integrated into medicine and theory in ways which support deeper constructionisms of reality than our current knowledges recognize. But the truth remains that it simply has not yet been really picked up by the culture, and unfortunately this cannot only be ascribed to its novelty. In fact, this is really just a sophisticated version of very old theories on connection between the mind and body as mediated by sensation and emotion, theories that came prior to the domination of parsed and reductionist biomedical perspectives. Indeed, nearly 150 years ago William James (1884) was articulate on this very thing in his oft-quoted passage :

Our natural way of thinking about these standard emotions is that the mental perception of some fact excites the mental affection called the emotion, and that this latter state of mind gives rise to the bodily expression. My thesis on the contrary is that the bodily changes follow directly the Perception of the exciting fact, and that our feeling of the same changes as they occur IS the emotion.’ [1884, p. 189–190 in Van Oudenhove et al., p. 203)

And what is more, in the clear terms of a simple mechanics, by the early 1900's the abstractions of James and Lange had been translated into understanding of reciprocal interactions between the psyche- and the soma- specifically in the gut. Walter B. Cannon (1909) discussed how

‘An emotional disturbance affecting the alimentary canal is capable of starting a vicious circle; the stagnant food, unprotected by abundant juice, naturally undergoes bacterial fermentation, with the formation of gases and irritant decomposition products. These in turn may produce mild inflammation or be absorbed as substances disturbing to metabolism, and thus affect the mental state ...’ [p. 5, in Van Oudenhove et al., p. 203)

As will be seen to be a common story in the medical interaction with IBS, the mere presence of sound theory and etiology which integrates directly the biopsychosociality of IBS is discluded by medical culture.

### **Organic Etiology**

The standard biomedical research on the topic has innumerable articles in the search for the organic cause of IBS. The researchers pursue the same agenda as the medics, starting “with the question Are the patient's symptoms "real" — that is, warranted by the presence and nature of objective medical findings - or unsupported and hence functional and imaginary?” (Lipowski, 1986, p. 613).

Because there is no lesion, no break, these articles take on a familiar format in which they highlight new beginnings, things to come, spaces to watch for. This form echoes the critical scholar Ivan Illich's (2003) observation of medical research in general, that It “ is overwhelmingly oriented towards unattainable “breakthroughs”” (p. 921) . This discipline is at once mystified by IBS and entirely confident that medical progress will soon

bend IBS into its domain. They echo the triumphant tone of a passage cited by Gabor Maté (2004) in evidence of this narrative: “A 1985 editorial in the august *New England Journal of Medicine* could declare with magisterial self-assurance that “it is time to acknowledge that our belief in disease as a direct reflection of mental state is largely folklore” (p. 29). In keeping with this, Douglas Drossman (2003), perhaps the most committed scholar-practitioner of IBS, observed overhearing at an international conference for gastrointestinal disorders,

“At last we have ‘organified’ IBS’, ‘Now that we have an animal model, we can find a cure,’ and , “Surely it will now be easier to get research funding.’ Implicit in these statements is an assumption that knowledge of the basic mechanisms underlying neuroenteric reactivity or symptom generation is all that is needed to understand our patients with functional GI disorders” (p. 6)

Drossman here addresses the crucial assumption of the bloc, that the organicity of IBS is both necessary and sufficient.

Normally a literature review would highlight the exceptional as the exemplar, but given how little movement there appears to be in this particular literature I think it more representative to choose some rather typical articles. For example, consider Abdullah (2008) in his *Current Review on Pathophysiology and Diagnostic Aspects*. His story unfolds like this: “Until now...IBS [has] not been fully understood.... Nowadays, such paradigm [sic] has been challenged by various evidences indicating organic abnormalities... Better understanding on IBS pathophysiology hopefully will provide better diagnostic methods and treatment.” (p. 218). The narrative of explainability awaiting medical progress is clear to see, but what of the existence of that paradigm-shifting evidence? Abdullah notes that “Clinically, there are some findings that indicate the role of inflammatory process in pathogenesis of IBS; such as,

the onset of IBS that occurs after an episode of gastroenteritis (post-infective IBS (PI-IBS)) (p. 218). Whether or not this is paradigm shifting is perhaps for the biomedical bloc themselves to decide, but Sperber and Drossman (2012) take an account of this:

In 2007 Kellow wrote in a paper in support of the Rome III criteria that 'Other potential biomarkers in the functional GI disorders include mucosal histology, cardiovascular reactivity, gut permeability and blood, stool, and genetic markers. Unfortunately, none of these have as yet proved reliable or accurate enough to supplant, or form part of, the symptom-based criteria' [Kellow, 2007]. Five years later we see no new support for a change to this statement. (p. 387).

A most recent article by Hadjivasilis et al (2019) in perhaps the most popular IBS journal, the *Annals of Gastroenterology*, is less jubilant but nonetheless indicative again of the resolute search for evidence of pathophysiology. The authors identify food intolerance, infection, inflammation, genetics, neurotransmitters, and microbiota, among other locations of potential pathophysiology. These authors are perhaps less partisan than the example article above, hunting merely for physiological correlates and expressions of IBS rather than a fully physical cause. Their research evidences the potential for therapies for specific symptoms of IBS which are likely to be helpful to patients (although the overall efficacy of symptom based approaches is commonly questioned in the literature, e.g. Drossman et al., 1977). This is worth acknowledging with some positivity. However, as will be discussed in Chapter 3, there are unconsidered risks to this approach, and at the least they should include a weighing of the balance between the possibility of symptom management and the iatrogenic costs of protracted hunts for pathophysiology in actual patients (Fink, 1992).

### Psychosocial Etiology

There are many excellent explorations of the psychosocial etiology of IBS. However, there does still exist in this literature a tendency toward reification, though of course in the opposite direction of the biomedical camp. Here, there is the distinct psychologization of the illness, to the point that it can sometimes become articulated, or misunderstood, as essentially a proxy illness for depression. As if the patient actually has depression if only medical culture could help them see that, and then their IBS may disappear and a therapy for depression could be undertaken. Ford critically addresses this issue, writing “These syndromes ... cannot be simply viewed as misattribution of depression or anxiety, due to "hysteria", or malingering, or to any other reductionist theory... They are simultaneously medical, psychological, and social phenomena. (p. 14) Again, like above, this is summative of the mood of this literature rather than evocative of any one piece, but it is nonetheless a danger of the parsed disciplinarity from which IBS is approached. I am more sympathetic to a psychologized approach than the somatic reifications which were sought above, but each has their own significant failings. Nonetheless, the psychosocial camp reveals important qualities of IBS.

For example, Chang et al (2006) observe that across many studies 40-60% of patients with functional gastrointestinal disorders (FGID's, of which IBS is one among) have “high rates of psychiatric disorder and psychological distress” (p. 1439). Both early life traumas and more banal daily stressors have been implicated as being life events which contribute to IBS, along with other psychosocial variants such as “generalized and gut-specific anxiety, somatization, abuse history, poor coping skills, and inadequate social support” (Sperger and Drossman, 2012, p. 387). Of serious note is that the prevalence of sexual and emotional abuse in the life history of IBS patients is between a quarter and a half of the population,

despite the fact that underreporting of abuse always make this kind of accounting a challenge (Surdea-Blaga, 2012, p. 618). Certain personality traits and qualities have also been integrated into psychogenic analysis of the illness, including problem avoidance, self blame, and alexithymia (Surdea-Blaga, 2012, p. 620, Muscatello et al., 2016, p. 6406), people pleasing and self-silencing among women (Chang et al., 2006, p. 1440), as well as anger (associated with constipation), and passivity (associated with diarrhea) (Drossman et al, 1977, p. 816). Emotional conflict was prevalent in a study of 60 women with IBS in which 80% experienced difficulty maintaining satisfying romantic relationships, and two thirds described their sexual relations as unsatisfactory (Brook, 1991, p. 39).

Given these relatively general, rather than gut specific life-dilemmas, Stern (2003) notes that “It is unclear why some patients with an abuse history ‘choose’ (unconsciously) one organ system rather than another through which to express distress” (p. 177). Numerous psychodynamic theories are invoked in this literature to try and mechanize the movement from trauma, conflict, and stress to bowel specific illness.

Sexual abuse, whether involving the genitalia or the anus, may culminate in shameful, negative feelings and thoughts towards the gynaecological / sexual apparatus or the lower gastrointestinal tract or, commonly, both. The additional need (real or imagined, heightened by shame and fear) to keep ‘dirty’ secrets ‘inside’ (a precursor to constipation) conspires towards directing the somatic symptoms towards the abdomen, pelvis, perineum, genitalia, rectum and anus, i.e. towards the two twin tracts (in women): gynaecological and the gastrointestinal (Stern, 2003, p. 177)

Alternatively,

The work of [Melanie] Klein contributes to our understanding of the anxieties of the women in this series. As a result of very detailed child analysis she has described the differences between the leading anxiety situations of the boy and the girl and has shown that because of her unconscious concern for her imaginary babies the girl [sic] has a much deeper dread than the boy of destruction of her internal organs." (Brook, 1992, p. 42)

Whether or not one appreciates, in 2020, this kind of deeply gendered psychoanalytical summation is debatable. Nonetheless, these mechanics have secured a position in the literature, and may aid in the explanation of the 2:1 prevalence of IBS in women compared to men (Håkanson et al, 2009, p. 30). They may also be at least partially validated by phenomenological evidence that women with IBS avoid children, believing the illness may harm the foetus or prevent them from taking care of the child ((Håkanson et al, 2009, p. 36).

Although the specifics vary as to just how important various traumas, stressors, personality traits, or psychodynamic coping strategies are in IBS, it is essentially unanimous that they are the leading force in its etiology. Exactly how these play out is largely speculation, but there is a track record of utility for therapeutic intervention which goes beyond the individual symptoms to target the person in psychosocial context.

### **Symptoms in Anthropological Context**

While the psychosocial bloc works out the specific mechanics of interactions between experience and gut distress, anthropological evidence suggests that the causal arrow itself could hardly be more obvious and true. This literature, while sometimes referring to IBS specifically, or the FGID's as a group, or just psychosomatic illness in general, attests to its outright ordinariness. (For the purposes of this section, the term psychosomatic is taken at face-value to indicate illness which interfaces between the

biopsychosocial without any attributions otherwise.) In Laurence Kirmayer's (1984) seminal pair of articles, he reports that "Worldwide, somatic symptoms are found to be a common way of presenting to both Western-style physician and traditional healer even when emotional and interpersonal conflicts seem *dramatically obvious to all concerned* [emphasis added]. (Kirmayer, 1984, p.175). For Kirmayer, it is not psychosomatic patients whose plight needs a "special explanation", but rather one is needed for those working with dedication to parse illness into specifically psychogenic or physiogenic categories (Kirmayer, 1984, p. 161).

Reinforcing this, the social historian of medicine Edward Shorter writes that "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" (Shorter, 2008, p. x). Gabor Maté's *When the Body Says No* (2004) is a book length treatment on the apparent commonality of this transmutation from very real psychosocial dilemma into very real illness. For Maté, serious illnesses which do also have distinct pathophysiologies, such as cancer or ALS, must be included in our understanding of psychosomatic illness and its prevalence.

Within this literature I would also include analyses of the so-called 'sick role' which investigates the social function of illness. Ford (1997) delineates the social utility of being visibly, physically sick (in ways that, for example, a trauma history does not explicitly create): accessing medics as a support system, rationalizing failure, seeking gratification for nurturance, create power in interpersonal relations, provide a cry for help for those with limited abilities of articulation, avoid stigmatization of alternative dilemmas, and secondary gains such as resolving interpersonal conflict (p. 8-9). The sick-role is a well known construct and one that is often used to inform castigations of malingering — e.g., feigning illness to

escape responsibility. A quality of this disparaging language is evident in Ford, but nonetheless it is still evident that illness confers certain rights and dignities to the person that they do not have in wellness. Goldberg and Bridges (1988) are evocative in their telling of it:

We are now in a position to see the adaptive advantage of somatisation, painful though it is in other ways: it is a great way for not seeing oneself as mentally ill, and not seeing oneself as responsible for the life predicament that one happens to be in. A man need not ask himself whether he has been a good husband, has done as well as might have done at his work, or made a mess of bringing up his children: it is enough that he is in pain. If anyone is to be responsible for his predicament, it is surely his doctor, who has either not made the correct physical diagnosis, or has at any rate not stopped his pain. (p. 142)

Taken out of the pejorative context and understood in functionalist and discursive constructionist terms, it becomes obvious that the expression of distress in socially visible ways is a productive means of managing dilemma. Turning again to Kirmayer (1984), "Every language grants us eloquence when it is time to cry for help. Every culture has a rich set of idioms for the expression of distress aimed at mobilizing an effective social response" (p. 159). Not only does it mobilize the soma to help with coping, it mobilizes the social too.

### **Medic-Patient Exchange**

Given these enormously differing approaches to IBS, the question arises as to how this all plays out when patients seek help from medics. This is commonly addressed throughout the literature on IBS, and on psychosomatic illness more generally. There is also a literature specifically on "difficult patients" (e.g. Sharpe et al., 1994) which could have further informed this research, but I restricted my analysis to that pertaining more

specifically to the topic at hand. Perhaps not surprisingly, the IBS literature is filled with reports of the unsatisfactory quality of the medic-patient exchange. This is particularly unsettling given the conclusions of one of the earliest assessments of a biopsychosocial IBS: that “there was little difference in the medications used for these patients. The doctor was the treatment” (Drossman et al., 1977, p. 818).

On the benign and sincere end of medic-patient relations, the psychoanalytic-psychotherapist Brook (1984) describes a collegial conversation about a mutual IBS client with their GP in which the two medics each confessed to the feelings of “frustration and helplessness she roused in us” and concluded that such commiseration was necessary with such a client with whom no one doctor could cope alone (p. 41). On the other hand, we have this collection of less than generous (and perhaps, hopefully!, outdated) descriptions collected by Lipowski (1986):

Patients with persistent somatization are not only well known to physicians but are also singularly disliked by them. Their widespread unpopularity is reflected in the mostly derogatory labels they have acquired, such as “crocks”, “gomers”, “turkeys”, “hypochondriacs”, “hysterics” and “the worried well”. They have been called the “disliked” and even the “hateful” patients. (p. 610-11)

A more contemporary, and certainly more reasonable account of the medics side of the story is recounted by Drossman (2005) who drierly relates that ““There [remains] a sense that these disorders are not as “legitimate” since physicians view patients with functional GI disorders (FGIDs) less supportively than those with organic disorders” (p. 252). Seven years later, Drossman along with Sperger (2012) describe little change in this orientation toward the patient:

[the biopsychosocial] perspective contradicts the medical education that most of us have received... Eventually we feel confused and 'drained'. After giving up, we may then come to view these patients as 'difficult' rather than 'challenging' and often discharge them from our care with the statement that 'nothing is wrong with you' or 'it's all in your head'. (p. 388-389)

Unfortunately, the literature tells us what is likely obvious: that little of this escapes the notice of the patient. While very little research has been completed on the experience of IBS patients in healthcare, a masterful piece of patient centered phenomenological research was conducted by Håkanson et al (2010). They describe the medic-patient exchange as a "critically important opportunity" (p. 1117) but that patients were found to be "exposed to humiliation, insignificance, and abandonment" (p. 1123). I can think of no more damning language than that characterization of the experience. And what is more, the patients were aware that the source of their delegitimization was the absence of "visible bio medical evidence of disease" (p. 1123).

### **Research Gaps**

The extant literature paints the story of a relatively ordinary somatic expression of a dilemma which is denied important legitimations by medical culture in an antagonistic and humiliating exchange between medics and patients. There are very few attempted explanations as to why this remains the case, and it is from here that the present investigation is launched. In 1992, Fink called for a discussion of this in the context of the serious iatrogenic consequences of this dynamic, concluding his paper with a call for "discussion as to why physicians repeatedly look for organic possibilities and attempt medical and surgical treatment, instead of recognizing somatization (p. 446). In his paper titled *Psychiatry, psychotherapy and gastroenterology—Bringing it all together*, Stern (2003)

suggests that some of the answer lies in the very personal qualities of medics themselves, but that was of course beyond his scope to address (p. 176). Drossman (2005), who has been oft-quoted so far in this review, suggests future research towards “reducing physician maladaptive attitudes toward patients” with IBS (p. 2005).

All of these inform the research questions of this paper, and are specifically addressed in the following chapters, each exploring how a different facet of medical culture — the clinic, the university, and the practitioner — navigate IBS, and why that navigation seems always to disclude it from experience, and reject it from a position in medical territory.

### Chapter 3: Disenchantment in the Clinic

We now reach the point where the story can be told of the medical exchange itself, the moment of interaction between patient and medic which has been reported so frequently as unsatisfactory. How can this be understood? And why is the clinic so threatened by illness not captured by their knowledges? This chapter locates the fundamental tension of IBS at the clinic as one between the phenomenological reality of the lived experience of pain and illness and its *incommensurability* with the singular hunt for organic etiology and pharmacological cure. Although the tension between the phenomenological and scientific worldviews are present in every encounter between medic and patient (Toombs, 1984), I argue that what makes IBS special, along with other so-called idiopathic illnesses, is that particular quality of incommensurability. In the context of the functional disorders, of which IBS is included, this has been observed as a tension in medical practice for at least 100 years, such as in this illustration by R.S. Boles (1928), among the originators of the “functional” category:

Unfortunately scientific progress has been so dramatic that the study of the disease overshadows the study of the patient ... the clinician of today concentrates his endeavors on the search for something organically wrong; and if their best efforts are not rewarded, interest in the patient lags; he is simply labeled a neurotic ... (p. 64, in Van Oudenhove, 2010, p. 207)

I define this quality of the exchange by the inability of medicine to viably territorialize the illness, unlike with most other illnesses in which having the cause and cure is interpolated (by both medic and patient) as a total conceptualization of illness; overcoding, erasing, or replacing other knowledges. It participates in getting rid of illness; to

say that is equivalent to understanding illness is to say, without being too trite, that the ability to cut down trees is equivalent to understanding them.

The process of medicalization is not one of brute force, *per se*. It is not a colonization of violence (for a wonderfully documented and non-polemical history of an instance of medicalization, see Gollaher, 1994). Medicine asks us to believe that by its access to cause and cure it therefore holds the keys to reality, and by monopolizing discourse implies that it *alone* has that key. This is what the German philosopher Marcus Gabriel (2017) calls the false ideal of “scientism”: “the belief that only the natural sciences understand the fundamental level of reality, namely the world in itself, while all other knowledge claims are always reducible to the sciences or, at any rate, should be measured by these” (p. 103). In medicine this hegemony of scientism relies on that interpolation of the ability to cure disease with the ability to understand the phenomenological and ontological realities of illness. This is made possible by certain epistemological biases of the modern era.

Two of these biases are instrumentalism and naturalism. With respect to the former Gabriel (2017) again is parsimonious, explaining that, according to naturalism, “only that which can be ontologically traced back to the domain of the natural sciences can exist; everything else is mere illusion” (p. 106). By this logic the phenomenological is reconceptualized. Not now the subjective experience of lived reality, but as a mediocre observation, a “competing explanation” (Gabriel, 2017, p. 108) of something better addressed by the medic. Because of this hierarchical bias towards naturalist knowledges the two viewpoints of patient and medic are not actually awaiting the construction of a hermeneutical meeting point — a gestalt of illness and disease — but are rather awaiting the overcoding of the experience by the explanation. The near monopolization of medical discourse in the modern era has thus transformed the helpers act of legitimating illness into

an act of translation into the dominant register. This is evidenced, at least partially, in patients seeking diagnoses, even extremely serious and damaging diagnoses, in preference to pain left unnamed by medicine.

### **Instrumental Knowledge and Modernity**

This is characteristic of the fully scientific perspective — the “view from nowhere” (Nagel, 1989) — and matches the epistemic position as it was originally conceived and purposed. As Hannah Arendt (1958) writes it: “Modern natural science owes its great triumphs to having looked upon and treated earth-bound nature from a truly universal viewpoint, that is, from an Archimedean standpoint taken, wilfully and explicitly, outside the earth” (p. 11). We should make no mistake here, although we establish this in the interests of a critical position, the fruits of this effort have been unprecedented, though perhaps not unimaginable. This “courage to follow the ancient and medieval principle of simplicity in nature- even if it led to the denial of all sense experience” (Arendt, 1958, p. 259) led Descartes (1637) to the observation that

it is possible to attain knowledge which is very useful in life, and that, instead of that speculative philosophy which is taught in the Schools, we may find a practical philosophy by means of which, knowing the force and the action of fire, water, air, the stars, heavens and all other bodies that environ us, as distinctly as we know the different crafts of our artisans, we can in the same way employ them in all those uses to which they are adapted, and thus render ourselves the masters and possessors of nature. (in Taylor, 1992, p. 149).

We can see in Descartes, the modern eras pioneering epistemologist, the idea that instrumental knowledge ought function *instead of* rather than alongside other ways of knowing. But we can also see his foreknowledge of a new ability to become masters of their

universe. From our vantage point in 2020 the fruits of instrumental reason are not in question, but what remains for our consideration is a reckoning with the cost. Arendt (1958), having borne witness to a World War in which technology (i.e. instrumental science) scaffolded a new era of atrocity and horror, writes of this cost with a mournful elegance:

[instrumental reason] proved in demonstrable fact that both the worst fear and the most presumptuous hope of human speculation, the ancient fear that our senses, our very organs for the reception of reality, might betray us, and the Archimedean wish for a point outside the earth from which to unhinge the world, could only come true together, as though the wish would be granted only provided that we lost reality and the fear was to be consummated only if compensated by the acquisition of supramundane powers. (p. 262)

### **Disenchantment**

Taylor (1992) explains that this new mode of knowledge has implications for both our picture of the universe — “the dissipation of our sense of the cosmos as a meaningful order” (p. 17) and our picture of ourselves — “the ideal of the disengaged self... and the framework of self-mastery through reason” (p. 21). For Max Weber (1917) this “means that in principle there are no mysterious incalculable forces that come into play, but rather that one can, in principle, master all things by calculation. This means that the world is disenchanted” (in Gabriel, 2017, p. 148). If we hear echoes of this “mastery by calculation” in the triumphant optimism of the biomedical research we reviewed in Chapter 2 it is not erroneous. This is precisely the underpinning for that great myth of progress. This famous assertion is sometimes taken — as it is by medical culture— to mean that the disengaged selves of modernity in fact *successfully* occupy that Archimedean seat and therefore have in

fact conquered mystery through sheer reason. Reading Weber's disenchantment as veridical, however, is a mistake. As Gabriel (2017) tells it:

Modernity is almost completely unmanageable and opaque. Nonetheless we assume it is rational, that the foundations of our social order are secured through scientific procedures, which in principle each one of us can learn and understand. The idea is that everything is in perfect order, an order that one could ascertain if only one had the time and inclination. We have the impression that society is in the hands of experts. It is precisely this *illusory or ideological assumption* [emphasis added] that Weber calls the "disenchantment of the world" (p. 148)

Though we often think of the Weberian critique as focusing on such hyperobjects as the state or the economy, the opacity of health and sickness are equally implicated. Illness — though not disease — is an epistemic event horizon beyond which there is no claim to rational knowing. This is the source of the major threat IBS, that the chaos and opacity of idiopathy has the capacity to expose the illusory quality of disenchantment upon which modernity has partially constructed itself. There is mystery, meaning, and an *engaged* self in these patients.

### **Zero Sum Exchange**

Understood within the context of the foundational epistemology — disenchantment — which the scientific bias both rests upon and maintains, we can look again at the exchange between illness and disease, between the phenomenological and the medical. What we see is that the crucial incommensurability is *structural*, it can be no other way. In disease the objectifiable universe enters the body, and so the self becomes for the moment objectifiable. When a good patient comes in they "complain in measured terms and in reasonable proportion to demonstrable pathologic disorders, should report physical distress

in somatic terms and emotional distress in psychological terms and should accept a doctor's opinion and treatment gracefully and compliant" (Lipowski, 1986, p. 611).

What they are doing when they are good is helping the project of mapping the subjective onto the objective in the interests of, yes, marshalling social resources and ameliorating their distress, but also in ensuring that their experience conforms to the epistemic condition of our time. They arrive already "[self-mastered] through reason" (Taylor, 1992, p. 21), and when the two worldviews conform as hoped the patient is led to no crises of trust in either themselves or medicine. But a bad patient — of whom we have discovered includes those with IBS — stops the process before it can start. They present illness which refuses to map onto disease and express a subjectivity which cannot viably be overcoded by an objectivity. This is a problem in a world with a new methodology in which our natural senses are deemed unreliable — "the sun does indeed seem to "go down"" (Dreyfus and Taylor, 2015, p. 23), but that does not make it so. And because the exchange is structurally zero sum, this becomes a problem for medicine, which returns us to the thesis of the investigation. The stakes of their potential loss are too high. Biopower tells some of this story, but disenchantment tells even more. To let Archimedes lever come smashing down out of the sky and back onto the senses of the lived experience is, to the scientific mind and ergo to medical culture too, an untenable threat.

Rather than back away from the mystery of non-physiogenic illness and leave room for the personal and social meanings of illness, the demands of disenchantment place a burden on medicine that is especially strong. When health and ideology come thusly into conflict medicinal bias always must prioritize the upholding of a social order grounded in the illusion of disenchantment.

### Testing and Iatrogenesis

The question thus comes to land back in the concrete realities of the clinic. Do the actualities of the exchange in the clinic lead us to this same conclusion? In the following section we investigate tactics of the clinic in their encounter with IBS, asking the question: is this for health or for disenchantment? What is shown here is that medicine does not yield to the phenomenological experience and perform the interventions that are long proven to help people with biopsychosocial dilemmas that express in the bowels. What is evidenced instead is a relentless pursuit of organification and territorial capture playing itself out again and again with new patients. The clear and known iatrogenic consequences tell a story of epistemic victory valued over health.

In the following I investigate the use of medical testing, however, there is an important caveat that must be stated. The use of medical testing at all does not *de facto* support the thesis. Medical testing is valuable in those cases in which it serves twin goals: upholding epistemic disenchantment *and* enhancing health. Where testing might become evidence of a more predatory rule of engagement and is therefore in support of the thesis is when those goals are not in alignment. Our social expectation of medicine would have it defer always to health when other priorities interfere. The thesis of course is that IBS exposes the way that medicine in fact defers elsewhere than health when under threat. Therefore, the following argument speaks towards that subjugation of the health priority as it is demonstrated in invasive, fruitless, and ultimately iatrogenic clinical tactics when the phenomenological will not map to the scientific. This is particularly relevant given our findings in the literature review, that IBS and other somatically expressed biopsychosocial illness are rather ordinary and well understood.

Testing for IBS is essentially both common and contraindicative. As early as 1915 Dr. Alvarez, who coined the term ‘irritable colon’ is quoted as saying that “The great thing in handling these persons is not to reinforce their fear that there is something seriously wrong with the colon’ (cited in Sperber and Drossman, 2012, p. 389). What Alvarez is speaking towards, and I think correctly, is the propensity of the clinic to pay excessive attention to somatic symptoms, reinforcing the epistemic hierarchy, to the detriment of a more holistic picture. His thinking is backed up again and again by more contemporary scholars. As we move forward in this analysis, it’s worth imagining what that “IBS patient” arrives at the medics office with: complaints of persistent diarrhea or constipation, bloating, etc. There is context for this.

Drossman (2003) reminds us that, in general, “[most] clinical symptoms that patients bring to physicians are not explained by specific diseases” (p. 7). Nonetheless, according to Goldberg and Bridges (1988), there is a belief that pain “presages serious organic illness” (p. 140), a belief which “tends to be encouraged by doctors — who differentially reward somatic symptoms” (p. 143). This is despite the fact that studies have shown that between 68 and 92 percent of patients [in primary care] are without serious physical disease” (Kirmayer, 1984, p. 168). It is also in spite of the fact that for three in four patients who ultimately receive a *psychiatric* diagnosis it is physical symptoms that were the chief complaint (Lipowski, 1986, p. 610). All this points in a direction which suggests less prioritization of the organic rather than more.

Nonetheless, the mode of engagement for IBS-type symptom presentation in the clinic is clear. Below is a standard operations procedure for diagnostic evaluation from 1977. Although this is surely outdated, given the enhanced specificity of symptom focused treatments in modern biomedical approaches to IBS such as those discussed in Hadjivasilis

et al (2019), it seems unlikely that testing could be substantially reduced. Regardless, this is an evocative snapshot of the search for organicity 60 years after Alvarez' warning against it:

**TABLE 5.** *Diagnostic evaluation in the irritable bowel syndrome*

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- A. *Initial work-up.* History and physical examination, pelvic examination, sigmoidoscopy, stool (3 times) for occult blood and ova and parasites, complete blood count, urinalysis, electrolytes, trial of milk-free diet.
- B. *If symptoms persist.* Barium contrast studies to include barium enema and upper gastrointestinal series with small bowel follow-through, evaluation for malabsorption (stool for fat by Sudan IV stain, serum carotene, calcium, alkaline phosphatase, prothrombin time), lactose tolerance test.
- C. *Specific tests—Pain:* Oral cholecystogram, intravenous cholangiogram, angiography, radionuclide scan, abdominal sonogram, 5-hydroxy indoleacetic acid, C' esterase inhibitor assay, Watson-Schwartz test.  
*Diarrhea:* 72-hr quantitative stool fat, D-xylose, duodenal aspirate for *Giardia lamblia*, small bowel biopsy, serum immunoglobulins, hemagglutination inhibition assay for amebiasis.
- 

(cited in Drossman et al, 1977).

What are the results of such testing? Sometimes, certainly, organic illness is revealed and IBS is taken off the table. However, given that IBS and other functional, nonorganic illnesses are the most common reasons for visits to the gastroenterology clinic (Stern, 2003, p. 176) this successful end to invasive testing can not be the norm. For these biopsychosocial patients, whom the literature sometimes calls “somatizers”, the testing and intervention for organicity is not productive of health. Although somatizing can in this literature be pejorative or pathogenic (e.g. suggestive of a somatoform psychiatric disorder), I reinterpret the language here as a neutral descriptor of those with non-physiogenic suffering that is expressed somatically.

In Fink's (1992) review of invasive procedures with somatizing patients he observes that they in fact receive *more*, not less, procedures including “uterine curettage, GI

operations, appendectomies, and laparotomy/ laparoscopy" (p. 443), data which confirms "the impression of many authors that persistent somatization patients are exposed to extensive surgery" (p. 445). He reports that "a medical or surgical treatment was used in nearly half of the admissions in which no objective evidence of organic dysfunction or pathology was detected" and that the patients "did not benefit from such treatment" (p.445). For Fink, this repeated pursuit of organic aetiology in favor of recognizing somatization is distinctly and explicitly harmful to patients. This approach overemphasizes the somatic element of the biopsychosocial dilemma, entrenches patients within the clinic instead of seeking help elsewhere, and of course the high volume of invasive surgery poses imminent and explicit risk to the health of these patients (p. 446). It also limits the therapeutic relationship in serious ways, as was evidenced in the literature review. In this way the clinic fails to adhere to the maxim that "the treatment should never be more dangerous than the disease" (Drossman et al., 1977, p. 818).

### **Reification or Rejection**

At the surface level this approach is explained away by appeal to the "Type 1 error". But in illustrating this, I want to keep it in the context of the epistemic structures of disenchantment because this contextualization reveals the deeper commitments which we have charged them with. Stern (2003), explains how diverse priorities and risks are organized in the clinic:

The first fear is that of 'missing something organic', a fear drummed into medical students and compounded by 'scandals' in the national press of negligent or careless practitioners. Therefore, the diligent doctor leaves no stone unturned, and investigates each patient thoroughly. (p. 181)

Goldberg and Bridges (1988) echo this sentiment:

Doctors often increase the likelihood of somatic symptoms forming the centre-piece of the medical interview by differentially reinforcing somatic symptoms: often because of their own fear of missing organic disease when it is present (i.e. making a 'type 1 error'). The high technology surrounding medical training encourages doctors to seek reductionist explanations of pain and distress. (p. 140)

There is a demand here to be both sympathetic and concerned. The type 1 error perhaps ought to be the primary concern of the medic, and we should desire them to do their job well. However, as is repeated throughout this investigation, the problem is what occurs when the priority of the discourse comes into conflict with health. And what is apparent is that medical practice time and again fails to go beyond organicity, caught instead in recursive loops intended on instrumentalizing and objectifying an enduring experience of illness. Toombs (1987) makes clear what is relatively obvious, that "if therapeutic goals are to be optimally effective- and suffering is to be relieved- attention must be directed to this perceived lived body disruption rather than being exclusively directed towards the objective pathophysiology" (p.10), but it cannot be said that medical culture inclines toward this. The work of disenchantment is too strong.

Underpinned by this epistemology they are caught in a zero sum game with the null hypothesis at its center. They have only two choices; reification or rejection. If reification is successful, the illness is captured overcoded into disease. If such efforts at reification fail — whether the patient or the medic finally gives up on the fruitless search — there is no deferral to the phenomenological but rather, as with IBS, the illness is either; 1, diagnosis by exclusion with a "medically unexplained illness" (a phrase fully in line with disenchantment narratives and actually denoting something like, 'in expectation of explanation by medical progress'); 2, labelled with a reductionist psychiatric disorder which ignores the somatic, like

“masked depression” (Ford, 1997, p. 14); or 3, as we saw is common in the literature, the patient is simply rejected for being “objectively well” (Lipowski, 1986, p. 611). In all cases the construction of idiopathy serves to protect the integrity of biomedicine. It declares that whatever remains unknown after the calculation of medical experts is in fact not real, discrediting alternative knowledges — such as the phenomenological — in the process. In this way, modernist disenchantment keeps the full picture of IBS from view in medicine, and so medicine keeps IBS from legitimation.

#### Chapter 4: Bifurcation in the University

At this stage it is time for the investigation to make a shift. Although I have collapsed medical cultures disciplinary split into a single behemoth, critics of the thesis are left with several openings. This investigation so far implicates a modernist ideology and points to its presence in the clinic, which has so far included mostly doctors on the biomedical side of the disciplinary line. Critics should be shouting that of course this is the case *over there*, but what about on the side of the psyche where a critical approach has long ago swept through the discipline.

For Paul Stenner (2009), “a key problem for the philosophy of psychology is the problem of how to articulate the distinctness of ‘the psychological’ from the organic and the physical whilst simultaneously allowing for interrelations between these domains” (p. 197). Concerning all of this, I will pursue directly the critics who would remind me that the lessons of the Frankfurt School — which push back against that instrumentalism — are evident deep in the construction of contemporary therapies. Long ago Horkheimer and Adorno (1987/2002) wrote, “For Bacon as for Luther, “knowledge that tendeth but to satisfaction, is but as a courtesan, which is for pleasure, and not for fruit or generation.” Its concern is not “satisfaction, which men call truth,” but “operation,” the effective procedure” (p. 23), so what is new under the sun here? Critics so far might argue that the investigation has cherry picked from the *least* progressive elements of my fictitious medical behemoth, and that the poststructuralist advances in counselling technologies have incorporated phenomenology and hermeneutics into a deep humanism which rejected the hunt for organicity 50 years ago. So, the investigation must swing far to the other side, from the practicalities of the clinic to the abstractions of the university, diving deeper into these epistemologies, with particular attention now to the radical and progressive aspects of medical culture.

What remains of the modernist epistemology in medicine after the post structural turn? Does what remains uphold the thesis, and collude with disenchantment against IBS and other biopsychosocial expressions of illness? Or has the poststructural turn been a success that simply has not yet been translated into the practicalities of the clinic? Or has it been a success that is suggestive of the necessity of that disciplinary divide, where the biopsychosocial is alive and well with *psyche* who guards against the predators of instrumental science? (For this last is perhaps the argument of the last great critics, who won a revolution and now protect a new status quo). These questions are set out after in this chapter, but to explore the post-structural and its aftermath we have to start again with a newly situated picture of modernity. I propose to show in this chapter that the most structural turn has been insufficient in accomplishing its stated task.

### **Structuralism and Mediationism**

There are a variety of terms for the mid-20th century turn, including postmodernism, liquid modernity (Bauman, 2000), and post-structuralism. Post-structuralism is the most specific of these phrases and addresses, in multiple ways, a belief in moving beyond grand central narratives, or central structures. To understand the nature of that turn, we need to have a sense of what structuralism was in the context of the psydisciplines so we can ask whether or not the post-structural truly brought forth the post-modern.

Near the beginning of modern, urban psychologizing work, Freud had his patients (the neurotic), tell him (the analyst, the impartial and expert observer) their private tales of woe (with speech as a felicitous *representation* of reality). With his objective expertise, Freud would locate within this pantheon the heretofore hidden structures of the mind by which this person is made to suffer. As Parry (1991) sums it up,

Freud listened to the person ... for the underlying structure, part science, part mythology, that purported to explain the experiences, both the ones highlighted and those forgotten. The power of the structure to explain and complete the story was, for Freud, the important thing. (p. 37)

By insight and catharsis the sick might regain some foothold to exert their will again upon these now-revealed deep structures. What does this method tell us about the world? To believe in this approach we must live in the world of structuralism; a world where entities contain deep, whole, coherent, independent, stable structures, foundations of being upon which to stand and to live up to, not dissimilar to Platonic essences. This structural construction of reality, beginning in language and sociology and extending into the human mind, are described by Lynn Hoffman (1990).

[T]he idea of the "system" was first introduced by Ferdinand de Saussure who founded structural linguistics. De Saussure proposed that one could discern an organized set of rules for language that not only accounted for its evolution across time, but also for its coherence at any moment in time... De Saussure's use of the term "system" became part of a contagion of ideas... Freud, an early structuralist, had already contributed a psychic version in his theory of the ego, superego, and id. Psychologist Jean Piaget had posited "structures" in the cognitive development of the child. (p5)

And as we have seen in disenchantment, and as is echoed above, the world is apparently such that these objective structures of reality, *out there*, are accessible to us through expert, objective observation. Instrumental control is surrogate for knowledge of the ontological

whole. But disenchantment does not reveal for us even deeper assumptions about the world that allow for such a perspective in the first place. There is in fact a very difficult philosophical problem at play: If things are out there, and we are in here, what connects us? In what way can we determine whether the things our eyes or telescopes show to us have much correspondence to the actual nature of things? Charles Taylor (2015) explains:

To sum it up in a pithy formula, we might say that we (mis)understand knowledge as "mediational." In its original form, this emerged in the idea that we grasp external reality through internal representations. Descartes, in one of his letters, declared himself "certain that I can have no knowledge of what is outside me except by means of the ideas I have within me"... I have knowledge of things only through ("by means of") these inner states, which we can call "ideas." (p. 15)

In this way instrumental and structuralist biases shifted what can be thought of as the line between self and world. In modernity the self becomes bound in a new way and we begin to uphold what Paul Stenner (2012) calls "the self-contained 'subject' beloved of liberal humanism" (p. 4), so persons are cut away from the world. But we can see from Whitehead (1938) that the world is also cut away from us: "Scientific reasoning is completely dominated by the presupposition that mental functionings are not properly part of nature" (p. 156, in Stenner, 2008, p. 96). Turning again to Taylor, this time in his opus *The Secular Age* (2007), we are told that science and disenchantment requires us to "make the rigorous distinction between mind and body, and relegate all thought and meaning to the realm of the intra-mental. We have to set up a firm boundary, the one, as we have seen, which defines the buffered self" (p. 131). If all of this sounds familiar, it is indeed that old mind-body dualism.

### **Bifurcation in Modernity**

The achievement of representational, instrumental knowledge comes at the cost of our alienation from the wider world around us. Nature is bifurcated, meaning itself cleaved from raw matter, and the world is disenchanted. Stenner (2009) is clear on the nature of bifurcation as it casts beyond the *cogito*:

It was Hume who demolished the concept of an essential relatedness to nature that featured in the accepted philosophy of his day. This demolition was a profound influence on subsequent philosophy. Both the British Empiricist tradition, and the German tradition inspired by Kant and Hegel can be read as attempts to restore some sense of the fundamental relatedness of things. The concept of relatedness demolished by Hume, however, was part of an accepted philosophy ... that, at base, the universe is composed of subjects (rocks, trees, gusts of wind, flows of fluid, electrons) which are implicitly conceived as substances (subjects) qualified by predicates (a hard rock, a brown tree). The problem with this assumption as to fundamental fact is that it begins with the supposition of a multiplicity of disjointed subjects. Any relatedness must then overcome this initial state of disjunction: conjunctive relations must be forged. (p. 13)

From substance comes separation, a world of subject and object, of inner and outer. This is the world found and reified by the medics in the clinic, along with Freud and the modernist therapists as they engage with persons as alienated, individuated objects of analysis. But what else could they do at the turn of the 20th century, “working at the high-water point of the modern era's belief in the saving power of science” (Parry 1991:p37). Indeed, in the wake first of Bacon, Descartes, and Hume, and then of Newton

and Galileo the advances of modern science and philosophy had ‘discovered’ a reality in which humans could view themselves no other way.

Marcus Gabriel (2017) adds to Arendt's critique of the Archimedean perch. Here, in the aftermath of the scientific revolution in which the ancient and medieval worldview had been sundered, the moderns found a newly ordered world based on

insights into space and the mechanics of the heavenly bodies... [and] in this new order, there was no special place for man [sic]... Modernity begins with the decentralization of humanity and its life environment, the planet earth. Humanity grasped that it was located in a much larger context than it had previously dared to dream, and that this context was in no way tailored to human needs. Yet, from this, a scientific worldview was prematurely inferred in which humans are no longer to be found.” (p. 100).

This stance cuts us off from the world because bifurcation cleaves apart the “social” from the “natural” (Stenner, 2012, p. 8). Our pictures of the cosmos becomes what philosopher Wolfram Hogrebe calls our “cold home” (in Gabriel, 2017, p. 97) and we become “divided beings needed to be healed” (Dreyfus and Taylor, 2015, p. 26). In bifurcation the commitments against the phenomenological we witnessed in Chapter 3 are significantly deepened and the tensions between illness and disease are seen to grow stronger. Meaning and matter, inner and outer, subject and object, human and nature, persons and each other — we cannot bridge these gaps in the bifurcated cosmos of modernity. Under a bifurcated epistemology the biopsychosocial is entrenched as a *terra incognita* because it defies the critical boundaries by which the cosmos is conceptualised. For poststructuralism to effectively refute this thesis of the threatening nature of IBS, it must obliterate bifurcation along with structure. Does it?

### Poststructuralism

These modernist estrangements are the consequences the poststructural hoped to resolve. Holism, structure, progress, and objectivity together form an arrogance of authority that could, and did, lead to atrocity and its justification. The horrors of the twentieth century forced upon us an acknowledgement of these totalizing qualities of modernity. No longer crusading in the name of God, the twentieth century would find parade and massacre in the name of science; the grand and totalizing systems which arose from the deep laws of structure, from Marxism to Nazism, posed terrible risks. The poststructural can be read as the response to this arrogance. Marci Shore (2017) summarizes Continental thinking on this transition:

I define postmodern as incredulity towards meta-narratives,' wrote the French philosopher Jean-François Lyotard ... Postmodern philosophy was in large part inspired by the moral desire never again to fall prey to those grand narratives, to those seamless reconstructions of reality that enabled totalitarianism...

Modernity, explained the Polish philosopher Zygmunt Bauman, aspired to replace the pre-modern solids with something still more solid and lasting. Postmodernity (which Bauman calls 'liquid modernity') aspires to melt the solids. This second-wave modernity no longer searches for firm grounding, but embraces ephemerality, slipperiness, uncertainty, liquidity. 'Flexibility,' Bauman wrote, 'has replaced solidity as the ideal condition to be pursued of things and affairs.' All the while, God remains on His 'protracted leave of absence. (para 11-12)

Alongside these maneuvers the tectonic plates of theory in the psydisciplines in general, and counselling psychology in particular, have also shifted, and we now purportedly do therapy in this post-structuralist age, working against the wholism and the deep

structure and the oppression of the previous paradigm. In theory, this new exchange looks tremendously different than the picture of Chapter 3.

The medic now engages with the patient in a relational connection which breaches the hard boundaries of the self, equal partners in a project of co-creating a new reality through conversation. There is not problem and analysis per se, but rather, healing involves the shared reconstructing of one's life narrative, not only as thought-of but as lived, as lived in ordinary time within the particular family, community and society in which they do, and of which the counsellor is also a part. Although both counsellor and therapist (and sometimes others) sit and talk, there is little here that bears resemblance to that structuralist point of view and is in many ways antithetical. In his manual for collaborative counselling, David Paré (2012) underscores the poststructural counsellors "profound faith" in clients' preexisting knowledges, skills, and abilities (p. 48). Here, the therapist does not sit outside the room, as it were, with some view from nowhere, assessing and diagnosing with expertise. Rather, this approach begins in a different place than modernism's psychologist-as-cartographer, charting foreign lands of difference from above; it begins with the therapist now in the room, a participant in a sociality which is not the confrontation of subject and object, nor even the meeting of subject and subject, but as a participant in a communion of sorts, working to co-create a third, a center which is new.

### **Knowledge and Language**

Bakhtin (1984), in his analysis of the poetics of Dostoevsky, captures a fundamental innovation of the poststructural:

A plurality of independent and unmerged voices and consciousnesses, a genuine polyphony of fully valid voices... not a multitude of characters and fates in a

single objective world, illuminated by a single authorial consciousness; rather a plurality of consciousnesses, with equal rights and each with its own world" (p. 6)

That single structure of the objective, outer world is dismissed in this new social order, and in the exchange of science for the social, the poststructuralists discard Galileo's telescope for a new tool, language. Ludwig Wittgenstein becomes the philosopher preeminent, and the opaque declarative statements which form the *Tractatus Logico-Philosophicus* (1921) became a kind of methodological aphorism: thus, the new social discursive polyphony declares "The limits of my language mean the limits of my world" (cited in Sanders 2017, p. 15). Hermeneutics, taken up by Gadamer, leverages this new model until language becomes, in the poststructural era, both the font and limit of epistemological pursuit. David Linge, in his introduction to *Philosophical Hermeneutics* (2004) explains that "language and the understanding of transmitted meaning are not two processes, but are affirmed by Gadamer as one and the same." (Gadamer, 2004, xxxvii).

For us as living persons we are no longer individuals with a bounded consciousness; we are psychosocial beings, permeable to society, actively complicit in culture. As educator, activist, counsellor, and author Colin Sanders connects the dots, "Social constructionism...amplified the earlier ideas of Mead (1934), arguing that selves, persons, psychological traits and so forth, including the very idea of individual psychological traits, are social and historical constructions, not naturally occurring objects" (Sanders, 2014, p. 2). Lynn Hoffman echoes this sentiment, writing that "The big deception is the biological package; that people give you a name and you have to take responsibility for it" (p. 2). And for Davies and Harré (1990), knowledges emerge "through the processes of social interaction, not as a relatively fixed end product but as one who is constituted and reconstituted through the various discursive practices in which they participate" (p. 46).

Importantly, this construction of reality and personhood happens not by any individual agent, but truly in society, between people and not just within one person.

In many ways this approach tells a story of humanness that is far more liberating than the structuralist ideals of the early 20th century. This social constructionism helps in defenestrating the myths of neutrality and objectivity, instrumentalism and naturalism. Indeed, in this era we are unable to forget what Markus Gabriel (2017) reminds; "We always peer at reality from some standpoint or other. We are always somewhere and never view reality from nowhere" (p. 105). This positionality, crucial to much of the progressive political agenda today, is co-extensive with the post-structuralist project. This creates a space in which the phenomenology of illness can be heard. Indeed, in many counselling clinics across the globe the method is towards Gadamer's (2004) hermeneutic ideal, the fusion of horizons.

In these ways it certainly seems that post-structuralism successfully created a non-totalizing ethics of engagement with enough muscularity to compete with disenchanted modernity. Many of the old ways could no longer in good conscience be upheld, as Gergen (1985) contends:

To the extent that psychological theory (and related practices) enter into the life of the culture, sustaining certain patterns of conduct and destroying others, such work must be evaluated in terms of good and ill. The practitioner can no longer justify any socially reprehensible conclusion on the grounds of being a "victim of the facts"; he or she must confront the pragmatic implications of such conclusions within society more generally. (p273)

But what of bifurcation, which upholds and deepens the modernist commitments as much as disenchantment?

### **Bifurcation in Postmodernity**

In the analysis so far, the poststructural appears still to be a metaphysics of *distance*. There was liberation here, and empowerment, because what once appeared to be stable, non-manipulable structures out there were transformed into constructions open to change (Stenner, 2013, p. 3). But it is limited by putting humans in the separate, special container that is the social. Through anthropocentrism and the special classification of language we are made to believe that what constitutes our being and our relations is non-natural. This stance ultimately reifies the chasm between meaning and matter, between persons and the world. It upholds the bifurcation, though, as a pendulum swings, now emphasizing the other side: the social rather than the biological. We have this new space carved out for ourselves in the universe and yet we remain apart, down to the very roots of knowledge. Rollo May writes of those 'would insist that the Western absorption in conquering and gaining power over nature has resulted not only in the estrangement of man [sic] from nature but also indirectly in estrangement of man [sic] from himself' (May, cited in Sanders 2017:p248). And as Sanders highlights, Erich Fromm (1960) perceived a Western 'spiritual crisis', saying: 'It is the crisis which has been described as "malaise," "ennui," "mal du siècle," the deadening of life, the automatization of man [sic], his alienation from himself, from his fellow man and from nature' (p. 78, cited in Sanders 2017, p. 249). The estrangement continues when we understand our personhood, via social construction, as 'not naturally occurring' (Sanders, 2014, p. 2)

Stenner (2009), in a critique pointed specifically at Rom Harré, captures bifurcation in the poststructural era:

In hardening the distinction between the physical/chemical/organic and the psychological, Harré has deliberately blurred the distinction between the psychological and the socio-cultural, thus allying psychology with the social sciences and humanities (an understandable strategy given the hegemony of the natural science vision of psychology). He has thus long argued for a fundamental ontological division between things material and things to do with persons: “Realism in the physical sciences and realism in the human sciences are not the same” (Harré 1997, 174).

We can witness the degree to which bifurcation infiltrates even some of our best theory, and on both sides of the divide. On the side of the social, certain thinkers, notably Judith Butler (1993), struggle to insert the material fact of our animal bodies back into their theory. And on the other hand, there are materialists so dogmatic that they run into what David Chalmers calls the “hard problem of consciousness” (Chalmers, 1995, p. 201) in which thinking cannot be brought back into theory! The pendulum swings too far. The poststructural movement, fighting as it did against atrocity, against Hegel and the Holocaust, needed distance more than integration. But as long as we remain steadfast inside the bifurcation, polarizing nature and culture, our epistemologies remain insufficient to the problem of the biopsychosocial.

Of course, on this side of bifurcation the commitments appear radically opposed: an illness such as IBS is no longer defended against by relentless testing in pursuit of organification — or bio-fication we might say in our present context — but is rather reduced

into a purely psychosocial affair. Goldberg and Bridges (1988) explain what happens in this encounter:

Enter a research psychiatrist....to make diagnoses of anxiety state, depressive illness, and mixed anxiety depression. The research psychiatrist does this by ignoring the somatic symptoms; just as the other doctors have tended to handle them by confining their attention to the somatic symptoms. Each side has paid a heavy price for the divorce between psychiatry and general medicine. (p.141)

The maneuvering away from bodies buries the material, corporeal pain of IBS as some sort of regrettable but inessential epiphenomena. Ford (1997) echoes the impact for biopsychosocial patients of a bifurcation which persists in the poststructural era of the psychosocial, *sans* bio:

These syndromes, like the process of somatization itself, cannot be simply viewed as misattribution of depression or anxiety, due to "hysteria", or malingering, or to any other reductionistic theory. Furthermore, these syndromes do not fit into an either / or category in reference to medical versus psychological illness. They are simultaneously medical, psychological, and social phenomena.

The poststructural movement, fighting as it did against atrocity, against Hegel and the Holocaust, needed distance more than integration. But as long as medicine remains steadfast inside the bifurcation, polarizing nature and culture, illness which traverses — and therefore transcends — the mind body dualism remains contested ground. For all it's immense good, the poststructural does not take us beyond the modernist epistemologies continue to shape us and plague us.

### Chapter 5: Anxiety in the Medic

Having looked at the epistemologies which undergird standard operating procedure in the clinic, and the efforts of theory to escape the limits of modernity, this investigation finally turns its attention to the practitioner themselves. In part, this section is guided by the questions raised in the literature review, such as by Stern (2003) who notes that “although the description of the mental state and temperament of individual physicians is outside the scope of this paper, these are powerful factors which should always be borne in mind” (p. 176). Given the depth of the epistemological constructs which appear to play out on surface interactions between patients and medics, it seems that these individuals must carry that particular burden on behalf of medical culture. In what ways might this be true? How might medics become defenders of an epistemology that they have, likely as not, never heard of? What would motivate them to play their role in this bitter agon between the phenomenal and the scientific (whether social- or natural-)?

Firstly, it’s important to identify how it may be possible to live out and even defend a philosophy that may have never entered conscious thought. Again we turn to Charles Taylor (1992), who explains

We could conclude from the fact that some people operate without a philosophically defined framework that they are quite without a framework at all. And that might be totally untrue (indeed, I want to claim, always is untrue)... [T]heir lives may be entirely structured by supremely important qualitative distinctions, in relation to which they literally live and die. This will be evident enough in the judgement calls they make on their own and others' action. But it may be left entirely to us, observers, historians, philosophers, anthropologists, to try to formulate explicitly what goods, qualities, or ends are here discriminated. (p. 21)

Following this logic, this Chapter sets out to excavate in what ways these subterranean epistemologies inform the medic themselves, focusing as in Chapter 4 on the psychological side of the bifurcated coin, with specific attention to counselling psychotherapists.

### **Disqualified Knowledges**

This focus is useful because of all the medical disciplines, counselling psychotherapists are not strangers to the means by which technologies of knowledge — like those so far investigated — have been dangerous forces over the past century and a half. Foucault was too clear on the means by which epistemological domination drove the civilizing forces of colonialism, of science, of modernity *in toto*. By 1980, he had pointed a way forward:

I believe that by subjugated knowledges, one should understand something else ... namely, a whole set of knowledges that have been disqualified as inadequate to this task or insufficiently elaborated; naive knowledges located low down on the hierarchy, beneath the required level of cognition or scientificity. I also believe that it is through the re-emergence of these lowranking knowledges, these unqualified, even directly disqualified knowledges ... that criticism performs its work. (p. 83).

Many authors, particularly in the critical psychology period, are clear-eyed on the multifarious ways that epistemological domination has been so insidious a force on the citizenry in general, and on the users of medicine in particular — the patients and their phenomenologies. In response to this, White and Epston, perhaps more than any other, have shown a way to walk this path within counselling psychotherapy specifically, teaching both a paradigm and a technique for highlighting acts of resistance to that will to knowledge, and uncovering non-hegemonic knowledges of patients.

In 1997 Michael White authored a paper which put the focus of this uncovering work on therapists themselves, emphasizing the discovery and expression of the therapists “preferred knowledges and skills” (p. 152). This contrasts to the evaluation of the therapists knowledges as on a spectrum of fidelity to expert knowledge (White, 1997, p. 151) and in so doing resists the demands of disenchantment. No doubt such an approach is a positive one, reaffirming ethics against epistemological domination. The suggestion here is that medical experts ought to defenestrate themselves of the instrumental knowledges through which they dominate exchanges with their patients. But what this chapter argues is that the epistemological hegemony under discussion is actively maintained by the medics themselves. They too, as individuals, are threatened by illness which speaks to knowledges beyond the extant paradigm — illness which delineates the ends of medicine — and they too are in active defence of expertise, of disenchantment and bifurcation, and therefore the reductivist project.

### **Knowledge and Apocalypse**

So far, in analysis of the knowledge of both social- and natural- science there is what appears to be the earnest pursuit of ontological reality. That is to say, the search for truth in science, philosophy and art is genuine: whatever is to be found, let it be known. This is our common sense understanding of this pursuit, even if we recognize that various methodological and epistemological barriers might hamper our access to that reality. In this conceptualization, things (like illnesses) which expose the limitations of knowledge constructs ought to be celebrated as that which marks the boundary and shows the path beyond. The myth of progress suggests that knowledge evolves in this way, rather than becoming fortified and static as this thesis has described it. But there is another, albeit more cynical, analysis of the pursuit of truth. Understood differently, the will to knowledge is not

absolute. Rather, entrenched in a tension between the discovery of useful truth and the discovery of awful truth, the pursuit is always truncated, constructing agreed-upon realities which are adequate to the task of getting by but which yet preserve a veil of ignorance.

Consider the word which ordinary language has come to take as the destruction of the world, *apocalypse*, which means:

disclosure of knowledge. In biblical Greek, “apokalypsis” means “uncovering” or “unveiling.” It refers to the moment when a long-buried truth is finally exposed...What actually ends the world as we know it is the revelation itself, being shown the thing we had agreed not to see. (Chocano, 2017p. 11)

This is more than merely suggestive of the destructive powers of that unconcealment — what Heidegger calls *aletheia*, a conception of truth as disclosure instead of correspondence (Wrathal, 2013, p. 208) — and speaks to organized social effort towards protection from apocalypse. Dominant discourse, while certainly accumulating political power, more importantly captures those subjugated experiences and knowledges which might incite apocalypse and therefore defends itself against knowledges which always contain an internecine potentiality. Seen in this way, and given the foundational import of the modernist epistemologies this investigation has highlighted, the destructive potential of IBS phenomenologies becomes increasingly clear.

From what do we need protection? Chaos, disorder, the abyss on one hand, and the collapse of social cohesion on the other. In consideration of the latter, Berger and Luckman (1966) explain that the measure of veridicality of human knowledge is not its correspondence to ontological reality, but rather its correspondence to other human knowledges. Put differently, in my understandings of trees, what matters less is how much this corresponds to the *true nature* of trees compared to whether my ideas correspond to

*your* ideas of trees. In *The Social Construction of Reality (1966)* Berger and Luckman demonstrate that society, and even our very identities, is built up upon these shared knowledges:

We now not only understand each other's definitions of shared situations, we define them reciprocally. A nexus of motivations is established between us and extends into the future. Most importantly, there is now an ongoing mutual identification between us. We not only live in the same world, we participate in each other's being.

Confusion and collapse is therefore a very real risk in *aletheia*, and not the collapse of abstract philosophical projects like modernity, but our actual conceptions of self and the relatedness between each other are at risk. This is why this Chapter points towards the personal as a source of lasting defence against the imprecation of illness without disease.

### **Knowledge and Chaos**

But what about the risks of chaos? For the Romantics and the German Idealist philosophers it was the calling of the abyss which more than anything else requires the defence against *aletheia*. The pursuit of knowledge is truncated by what Nietzsche says is the fear that “one might get a hold of the truth *too soon*, before man becomes strong enough” which initiates “the will to the inversion of truth, to untruth at any price” (Nietzsche, 2000, p. 261). But the pursuit of truth is never fully stopped, rather, knowledge systems become dominant which best allow for control *without* revelation, an advance of power without approaching that constant possible apocalypse. This is resonant with Heidegger’s critique of science and technology, that it “threatens to sweep man away into ordering as the supposed single way of revealing” and “drives out every other possibility of revealing” (in Glazebrook, 2001, p. 373).

Again, Nietzsche (1872), this time critiquing disenchantment in the Ancient Greek context, is evocative of this twin demand as it becomes psychologized in the individual:

the unshakeable faith that thought, using the thread of causality, can penetrate the deepest abysses of being, and that thought is capable not only of knowing being but even of correcting it. This sublime metaphysical illusion accompanies science as an instinct and leads science again and again to its limits ... Anyone who has ever experienced the pleasure of Socratic insight and felt how, spreading in ever-widening circles, it seeks to embrace the whole world of appearances, will never again find any stimulus toward existence more violent than the craving to complete this conquest and to weave the net impenetrably tight. (Nietzsche, 2000, p.97)

For Nietzsche then, our so-called will to knowledge is anything but pure. It is saturated with the same tension that exists between the phenomenological knowledge of illness and the scientific knowledge of disease. Our seeking is for strict purpose, for an order to assuage chaos using hierarchically arranged knowledges. And just as commonly, what we call the drive to knowledge is more like masquerade, a deal we make with each other to agree to call certain ways-of-seeing as true and right not because they are *complete*, but because they are serviceable and stable and so declared complete.

Umberto Eco is far more generous in his estimation of the limits of knowledge, yet he advises that what is made present in the encounter with those limits is the gravity of death. ““What does culture want? To make infinity comprehensible. It also wants to create order.... And how, as a human being, does one face infinity? How does one attempt to grasp the incomprehensible?... We have a limit, a very discouraging, humiliating limit: death” (Beyer & Gorris, 2009). He invokes the methodology of the list as a means of grappling with

the “topos of the inexpressible”, and uses Homer’s *Catalogue of Ships* as a means of lodging this methodology — compatriot to diagnosis — all the way back to antiquity.

[T]ake Homer, for example. In the "Iliad," he tries to convey an impression of the size of the Greek army. At first he uses similes: "As when some great forest fire is raging upon a mountain top and its light is seen afar, even so, as they marched, the gleam of their armour flashed up into the firmament of heaven." But he isn't satisfied. He cannot find the right metaphor, and so he begs the muses to help him. Then he hits upon the idea of naming many, many generals and their ships. (Beyer & Gorris, 2009)

For Eco there is an enduring and beautiful human frailty and yearning evident in the construction of the list, which we would be remiss not to see along with him. Yet, we must also recognize in the list is always less-than what is there, and in our frail dependence on the list there is a desire to not-see that obscuring. This listing is of particular relevance to examination of medical culture, because the same motive is present in the description and documentation of symptomologies; in the work of taxonomy. Maria Nichterlein (2017) points to this in the context of psychiatry’s own great Catalogue, the *Diagnostic and Statistical Manual (DSM-5)*, writing, “It provides a stable opinion – instead of chaos – that provides a steady platform for the construction not only of a unified ‘normal science’ but of *reality full-stop* [emphasis added] (p. 148).

### **The Map and the Territory**

<sup>1</sup>Looking at this Janus-headed system of information and ignorance is to witness the real and fatal flaw of expert knowledge: that is masquerades as truth, as the real, when it is merely a map. That is to say, after Baudrillard (1994), that we have so long ago replaced the

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<sup>1</sup> Korzybski, 1933.

signs-for-things for the things-themselves that we've forgotten they ever connected to the real in the first place. This bait-and-switch of signs for things happens at all levels of psychology and culture and not only via top-down mechanics. Individuals participate. There is too much world out there, too much reality, it is always a "topos of the inexpressable" (Beyer & Gorris, 2009). To think of it or talk of it we must shrink it down and, once constructed, the map becomes indispensable.

But of course with fidelity to the map we partially let go our grip with reality — the tool which allows us to navigate reality also disconnects us from it in a final dialectic. Disconnected to change and time, the map, like all printed word, seeks to cast in stone what is always in flux. So even the perfect map (e.g. Borges' map of the empire whose size was that of the empire in Eco, 1995) erodes with time, and not just in the long run' but right now with the ticking of the clock. Consider the folly of Ernest Pudding in *Gravity's Rainbow* (Pynchon, 1973):

He started in on a mammoth work entitled *Things That Can Happen in European Politics*. Begin, of course, with England. "First," he wrote, "Bereshith, as it were: Ramsay MacDonald can die." By the time he went through resulting party alignments and possible permutations of cabinet posts, Ramsay MacDonald had died. "Never make it," he found himself muttering at the beginning of each day's work—"it's changing out from under me. Oh, dodgy—very dodgy." (p. 77)

Desiring a scientific source rather than these purely literary, we might turn to Whiteheads' supposition "The Fallacy of the Perfect Dictionary: We experience more than we can analyze. For we experience the universe, and we analyze in our consciousness a minute selection of its details." (in Segall, 2013, p. 12). Yet the scientific project continues, as it must. But let us recognize that whenever we prioritize the map over the real we are always

at risk of exposure. Experience which will not be mapped, which will not overcode, as in illness without disease, is one of these threats.

This is felt particularly by medics because they are among Weber's class of experts. It is upon their shoulders that the map is upheld, and it is fidelity to the map which, literally by definition, is the measure of one's success. This internalization of the technologies of expert knowledge is the crucial consequence faced by individuals who themselves become, through vocation, the actors upon which the illusion of private and collective disenchanted security is maintained. For Nietzsche (1873), the scientific investigator both builds the house of science while simultaneously seeking protection inside it:

the scientific investigator builds his hut right next to the tower of science so that he will be able to work on it and to find shelter for himself beneath those bulwarks which presently exist. And he requires shelter, for there are frightful powers which continuously break in upon him, powers which oppose scientific "truth" with completely different kinds of "truths" which bear on their shields the most varied sorts of emblems." (On truth and lies, p. 2)

The frightful "truths" threaten not just the expert in their vocation, but the very concept of expertise itself. That is to say that what Weber, Foucault and White and Epston might have called 'expert knowledge' performs two different functions. First, it serves as genuine knowledge, useful information for getting the job done, the more specialized the job, the better the function. Second, it serves as a safeguard against knowledge of the real — that is, the fluxing, processual world of ontological insecurity and constant apocalypse

The great illusion of modernity is unconcealed in these moments of conflict between incommensurable epistemologies, threatening the maintenance of order, and order itself in

an aletheia of chaos. The so-called secular age is exposed to be reliant on a great and secret faith, and for the medics, their own staggering fragility and complicity shine in silhouette.

### **Anxiety**

Personally, vocationally, when individuals enter adulthood and take on the mantle of expert in some corner of life, we take on these dual projects. Explicitly, we do the job as stated; birth babies, clear garbage from the streets, sell cars, counsel patients. But implicitly, there is a silent covenant that we will uphold these grander expectations and be the bearers of disenchantment; we will be good Weberian managers. Caught between chaos and death on one side and participation in order on the other it would be naive to imagine doing otherwise. The Spanish philosopher José Ortega y Gasset (1929) is eloquent in his articulation of this very position:

You will hear them talk in precise terms about themselves and their surroundings, which would seem to point to them having ideas on the matter. But start to analyze those ideas and you will find they hardly reflect in any way the reality to which they appear to refer, and if you go deeper you will discover there is not even an attempt to adjust the ideas to this reality. Quite the contrary: through these notions the individual is trying to cut off any personal vision of reality, of his own very life. For life is at the start a chaos in which one is lost. The individual suspects this, but he is frightened at finding himself face to face with this terrible reality, and tries to cover it over with a curtain of fantasy, where everything is clear. It does not worry him that his "ideas" are not true, he uses them as trenches for the defense of his existence, as scarecrows to frighten away reality.

What is highlighted here is the anxiety regarding the medics' very existence and a defence organized through a distancing from the real in favor of the orderly. The path by

which the revelation of a reality beyond epistemological limitations becomes a threat to existence is well understood in Heideggerian terms, notably his sense of the ontic and the ontological: that is, the worldly reality of death, say in a hospital bed from metastatic cancer, and the metaphysical significance of death, that is, an awareness of ourselves and the world “as being essentially “nothing and nowhere”” (Jacobson, 2016, p. 77). The chaos behind order contains that “unbearable awareness and knowledge of death” against which, the Polish sociologist Zygmunt Baumann tells us, societies erect culture, philosophy, and science (Jacobsen, 2016, p.1). In this way medics themselves are positioned to defend and deceive against the threat of sheer nothingness which epistemological revelation might inculcate. This penumbral space provokes anxiety. Paul Tillich (1980) explains this relationship:

The first assertion about the nature of anxiety is this: anxiety is the state in which a being is aware of its possible nonbeing. The same statement, in a shorter form, would read: anxiety is the existential awareness of nonbeing. "Existential" in this sentence means that it is not the abstract knowledge of nonbeing which produces anxiety but the awareness that nonbeing is a part of one's own being. (p. 35)

This problem leads towards a functionalist understanding of myth and ritual. This is a deceptively simple analytical lens, which suggests that these cultural rituals can be found and described via their function, and, in this case, their identification as death rituals can be ascribed via their role in the mediation of the problem of death. In functionalism, if you find something having a function (or outcome), then one must conclude that this is that thing's purpose (or among that thing's multiple purposes). This is important in viewing the medical culture in particular, because the culture does not view or label their own mediations as

rituals at all, but rather asserts itself as a direct competitor to traditional ritualistic mediations against death. The functionalist methodology suggests otherwise and leads me to treat medical science not merely as a realist, instrumental construction for the prolonging of life, but also as a procession of rituals which have as their catalyst the same psychosocial needs as traditions now considered outdated, folksy, or absurd. It is now worth revisiting the passage from Jean Comaroff that is presented in the introduction of this paper:

the apparently 'instrumental' acts of modern medical practice have thus become important symbolic foci of secular ritual for us, and its techniques and concepts serve as metaphors of our state of being as bio-physical individuals, seeking to enlist 'natural' science in our secular opposition to the forces of disease, decay and death. It is this metaphoric role, then, that accounts for the perpetuation and effectiveness of a host of medical beliefs and practices whose specific efficacy is almost impossible to establish. Thus, while scientific knowledge has clearly provided us with important means for the specific control of affliction, it has also come to fulfill a more embracing cultural role. Indeed, 'science' has become our primary symbolic order, in which 'instrumental efficacy' serves as our ritual mode, and 'rational practice' our dominant ideology. (in Crawford, 2004, p. 515)

This special quality, that they do not function as ritual *qua* ritual, but rather as instrumental ends-in-themselves with a buried, secret, or chthonic ritualism is a crucial point. This is what allows the faith of science (which cannot openly stand beside the rationality of science) to be performed without apparent faith, without belief, and thus retain the illusion of disenchantment.

### The Medic

So where does all this leave the medic in their confrontation with difficult patients and illnesses which will not map? This chapter exposes the very troubling nature of this position. Medics are the experts operating out on the boundary line of modernist epistemology and biomedical bias. The biopsychosocial which will not be reduced into instrumentalist and bifurcated boxes of experience and knowledge is an enormous threat to the person managing the line. It is not merely a hypothesis of organicity or psychopathology which are at risk of being disavowed, but the entire enterprise by which the modern west maintains social cohesion and keeps chaos at bay.

The medic themselves is confronted with deep sensations of anxiety in the face of collapsing expertise and the recognition of the secular faith. It is up to the individual in these moments of possible apocalypse to do the duty that is truly ascribed to them — to uphold the social order through secular ritual — whether or not this is for or against the health of any given patient. The ends of medicine must not be recognized. IBS patients are encountering medics whose frustration, hopelessness, and derisiveness is only apparently the result of the insufficiency of medical progress. What lies under the surface is the anxiety brought about by the extraordinary threat of alternative knowledges, grounded in patients' lived experience, which are beyond what medical culture can tolerate. Practitioners are thus biased.

### Conclusion

What I have tried to show so far is that there are really very distinct and compelling reasons for therapists to abstain from their duty to listen, and it takes the form of a scientific bias. That when clients bring material which is too threatening to the nature of the therapist's reality, they enter into an antagonism, a zero sum game in which one worldview or the other will come out on top. Medical expertise is wielded to gain power, and the raw experience of suffering which clients arrive with is reduced into known and tolerable explanations.

There is a history in psychotherapy of this kind of epistemological domination. An incredible example comes from Judith Herman's (1992) reading of Freud. Here, she speaks to something which I think psychotherapy has learned to absorb over the past century: violence, atrocity, and trauma. At the outset of her important book *Trauma and Recovery* (1992), she writes that "The ordinary response to atrocities is to banish them from consciousness. Certain violations of the social compact are too terrible to utter aloud: this is the meaning of the word unspeakable" (p. 1). As more and more therapists take a trauma-informed approach, violent narratives have become palatable and integratable by therapists, if with a very human uneasiness. Dori Laub (1991) interviewed a great many holocaust survivors and provides a compelling, articulate, and extremely moving sense of what it means to approach life's terriblenesses alongside others:

My function in this setting is that of a companion on the eerie journey of the testimony. As an interviewer, I am present as someone who actually participates in

the reliving and reexperiencing of the event. I also become part of the struggle to go beyond the event and not be submerged and lost in it. ... I observe how the narrator, and myself as listener, alternate between moving closer and then retreating from the experience — with the sense that there is a truth that we are both trying to reach, and this sense serves as a beacon we both try to follow. The traumatic experience has normally long been submerged and has become distorted in its submersion. The horror of the historical experience is maintained in the testimony only as an elusive memory that feels as if it no longer resembles any reality. The horror is, indeed, compelling not only in its reality, but even more so, in its flagrant distortion and subversion of reality. Realizing its dimensions becomes a process that demands retreat. The narrator and I need to halt and reflect on these memories as they are spoken, so as to reassert the veracity of the past and to build anew its linkage to, and assimilation into, present-day life. (p. 76)

But in Herman's take on Freud, she goes beyond this uneasiness to speak towards the clash of worldviews that some client material brings forward, echoing the kind of ontological dissonance characterized in this thesis. In Herman's (1992) telling, Freud initially approached his clients — primarily 'hysterical' women — as "a man possessed of such passionate curiosity that he was willing to overcome his own defensiveness, and willing to listen" (p. 8). But when he found a horror that could be integrated, he made the shift to denial of women's experience for which he is now so famous. Herman writes:

Within a year, Freud had privately repudiated the traumatic theory of the origins of hysteria. His correspondence makes clear that he was increasingly troubled by the radical social implications of his hypothesis. Hysteria was so common among women that if his patients' stories were true, and if his theory were correct, he would be

forced to conclude that what he called “perverted acts against children” were endemic, not only among the proletariat of Paris, where he had first studied hysteria,

but also among the respectable bourgeois families of Vienna, where he had established his practice. This idea was simply unacceptable. (p. 9)

Freud, faced with the antagonism of worldviews, was left between a rock and a hard place. His choice has been for history to judge, although Herman (1992) is clear to articulate that the blame does not lie solely with him, but in the context of hegemonic knowledge systems. The context and the individual are intertwined, which is why these chapters have surveyed the intellectual and practical environment, and the impact on the medics themselves.

Therapy has worked very hard over the past century to incorporate more and more of clients' raw experience into the fold of tolerability. The social justice approach prioritizes practitioners disabusing themselves of typical biases towards race and gender, etc, in which prejudice might manipulate clients' experiences. The trauma-informed approach asks them to be sensitive to their own triggers wherein the needs of private affect regulation might block the ability to see and hear. What I hope this paper demonstrates is that the lessons of critical psychology are not simply historical, systemic, and institutional concerns, but once enculturated into practitioners they become themselves a source of willful blindness. For Nietzsche, this is precisely the existentialist predicament, which he foreshadowed so clearly at the end of *The Birth of Tragedy* (1872/2000), writing:

In this sense the Dionysian man resembles Hamlet: both have once looked truly into the essence of things, they have gained knowledge, and nausea inhibits action; for their action could not change anything in the eternal nature of things; they feel it to be ridiculous or humiliating that they should be asked to set right a

world that is out of joint. Knowledge kills action; action required the veils of illusion: that is the doctrine of Hamlet, not that cheap wisdom of Jack the Dreamer who reflects too much and, as it were, from an excess of possibility does not get around to action. Not reflection, no - true knowledge, an insight into the horrible truth, outweighs any motive for action, both in Hamlet and the Dionysian man. Now, no comfort avails any more ; longing transcends a world after death, even the gods; existence is negated along with its glittering reflection in the gods or in an immortal beyond. Conscious of the truth he has once seen, man now sees everywhere only the horror or absurdity of existence; now he understands what is symbolic in Ophelia's fate; now he understands the wisdom of the Sylvan god<sup>2</sup>, Silenus; he is nauseated" (p. 60)

Perhaps it may be true that what I call raw experience is always *too much*. This is true for Arthur Kleinman (2016), writing pragmatically about medicine in the 21st century:

Here a considerable part of the problem of giving due acknowledgment to or providing an adequate redress for the social experience of suffering resides in the extent to which it always transgresses the bounds of formal representation. As experience, it is made in the damage done to an entire person in his corporeal and social being, and where this is disaggregated for refined professional analysis into discrete medical or social problems, too much of its reality is obscure. (p. 108)

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<sup>2</sup> The myth of Silenus: "There is an ancient story that King Midas hunted in the forest a long time for the wise Silenus, the companion of Dionysus, without capturing him. When Silenus at last fell into his hands, the king asked what was the best and most desirable of all things for man. Fixed and immovable, the demigod said not a word, till at last, urged by the king, he gave a shrill laugh and broke out in these words "Oh, wretched ephemeral race, children of chance and misery, why do you compel me to tell you what it would be most expedient for you not to hear? What is best of all is utterly beyond your reach: not to be born, not to be, to be nothing. But the second best for you is - to die soon" (p. 42)

But would it still not be the case that we can put ourselves on a journey towards more; more than the knowledge we can yet see, if never all of it? Perhaps in the same way that other biases have come under management, and denial and domination are held back, should not the same be true for the preoccupations which this paper traces? With this hopefulness, I want to conclude this paper by inquiring what it means to enhance our will to seeing along this axis of medical authority and the expert halo. What of our fidelity to the real, alluded to above, the will and ability to see the other *qua* other?

### **The Will to Seeing**

The real is filled up with experience at a bandwidth greater than what we reduce it too in our crisp, clear, shrunken interpretations and the real is often what our clients are in confrontation with when they come to our offices. Their logics that have organized their life, whether the social compact that Berger and Luckman (1966/1991) discuss, the private logic of Alfred Adler (1964), or, say, the working models of emotionally focused therapy (Johnson, 2019) have been in some way cracked by experienced reality and are in demand of a new formulation (Stern, 1983).

The scholar Walter Kaufman (1955) explains the stakes for those who, like Nietzsche and Rilke, are willing to shirk order and expertise in favor of an “honesty [that] does not permit any such security”:

Whoever does not affirm at some time or other with a definite resolve — yes, jubilate at — the terribleness of life, never takes possession of the unutterable powers of our existence; he merely walks at the edge; and when the decision is made eventually, he will have been neither one of the living nor one of the dead. To

show the identity of terribleness and bliss, these two faces of the same divine head  
(p. 9-10)<sup>3</sup>

Rilke echoes here the Latin poet Terrence, who's message the pre-eminent Jungian therapist James Hollis (1993) declares is "one of the wisest utterances by any human.... "Nothing human is alien to me"" (p. 78). Indeed, Nietzsche (1872) shows a path forward in his observation that when the Ancient Greeks used their Gods to interpolate Reality, there was less suppression and denial and translation, and the search for truth was a little purer than in our modern world:

Whoever approaches these Olympians with another religion in his heart, searching among them for moral elevation, even for sanctity, for disincarnate spirituality, for charity and benevolence, will soon be forced to turn his back on them, discouraged and disappointed. For there is nothing here that suggests asceticism, spirituality, or duty. We hear nothing but the accents of an exuberant, triumphant, life in which all things, whether good or evil, are deified. (p. 41)

In this passage Nietzsche first presages his future coinage of "beyond good and evil" but importantly, locates it not in a world-that-ought-to-be, but rather in a particular history and culture which already was. This is a very possible world, and one which a counselling epistemology must consider.

If our clients come to us seeking change, seeking to process, or alleviate, or simply mediate some experiences of the terribleness of life, then we do them no service if we are not able and willing to look at that with them with Rilke's definite resolve. To merely find

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<sup>3</sup> And see Nietzsche in the same timbre: "“Anyone who, in intercourse with men, does not occasionally glisten in all the colors of distress, green and gray with disgust, satiety, sympathy, gloominess, and loneliness, is certainly not a man of elevated tastes; supposing, however, that he does not take all this burden and disgust upon himself voluntarily, that he persistently avoids it, and remains, as I said, quietly and piously hidden in his citadel, one thing is certain: he was not made, he was not predestined, for knowledge” (p. 227)

historical patterns, or silver linings, or solution focuses, is to look along with them in pretend; if it is not the desire to weave an impenetrable net then it is fluttering around the flame of vanity. This is not what Rilke or Nietzsche means, and if it is all we bring to our clients as the real bestows upon them (and us) some scene that does not incorporate, then we reproduce disenchantment, we fake Weberian management, we reconstruct an interpreted world that is reliably safe for both ourselves and our clients. Wendy Farley tells us, ““The struggle toward truth ... requires a practice or practices that order one toward others in their unique beauty and suffering, *practices that permit the exteriority of reality to be acknowledged*” (in Freeman, 2013, p. 117).

### **Alternative Affordances**

So how might we proceed then? There is an eerie dread we must face as we are to see beyond the orderings of our culture, history, and science. How can we open ourselves more to the raw experiences of our clients which defy categorization? What needs to be presented here then is an affordance which let's us — if only occasionally — abandon our sense of the interpreted world and be willing and able to see with fresh eyes the real-reality that our clients brings to them. But, we also have to acknowledge that for the most part, it seems we need some mediating or at least attenuating force between ourselves and the truth. For Nietzsche (1872/2000), this is art:

Here, when the danger to his will is greatest, art approaches as a saving sorceress, expert at healing. She alone knows how to turn these nauseous thoughts about the horror and absurdity of existence into notions with which one can live: these are the sublime as the artistic taming of the horrible, and the comic as the artistic discharge of the nausea of the absurdity. (p. 60).

We are presented with a means of translation or interpolation; a way to deal. That, too, is what science and knowing-practices present us with. But in *knowing* there are severe consequences, not least of which is the ease by which the capture of knowledges leads to power, and the ease by which those powers create hegemonic discourses. These not only oppress peoples but oppress what I might call vulnerable epistemologies; possibilities of being are discluded before they ever come into being. Knowing-systems, in their particular translation of reality, have strong tendencies towards what Miranda Fricker describes as hermeneutical injustice, “the injustice of having some significant area of one’s social experience obscured from collective understanding owing to hermeneutical marginalization” (in Wardrope, 2015, p. 342).

Perhaps even more problematic, traditional knowledge systems movement towards order is inherently backwards looking. Ralph Waldo Emerson, in his time, wrote that “Our age is retrospective. It builds the sepulchres of the fathers” (1836/2000, p. 3). The collection of data that has been is in the interest of eternal truths, laws of physics, predictive hypotheses. This is how understanding and ordering provides for the illusory promise of control. As Whitehead (1938) phrases it, “Science is concerned with the facts of bygone transition” p. 105). And because of this, it is by its nature a force of exclusion, not merely of other epistemologies, but of other possibilities *in toto*. What doesn’t fit cannot be, the new must remain concealed. I know of no greater articulation of this will to power than in Cormac McCarthy’s *Blood Meridian* (1985), in which a character unfolds the logic and sequelae of the list:

He looked about at the dark forest in which they were bivouacked. He nodded toward the specimens he'd collected. These anonymous creatures, he said, may seem little or nothing in the world. Yet the smallest crumb can devour us. Any

smallest thing beneath yon rock out of men's knowing. Only nature can enslave man and only when the existence of each last entity is routed out and made to stand naked before him will he be properly suzerain of the earth... This is my claim, he said. And yet everywhere upon it are pockets of autonomous life. Autonomous. In order for it to be mine nothing must be permitted to occur upon it save by my Dispensation. The man who believes that the secrets of the world are forever hidden lives in mystery and fear. Superstition will drag him down. The rain will erode the deeds of his life. But that man who sets himself the task of singling out the thread of order from the tapestry will by the decision alone have taken charge of the world and it is only by such taking charge that he will effect a way to dictate the terms of his own fate. (p. 160)

That Nietzschean web, taken to its outer limits by methodologies of inventory and ordering have tremendous power to assuage the anxiety of the abyss, but they bring shocking costs.

### **Modes of Seeing the New - Empiricism**

At last then, we come to see some of the quality of engagement that is needed if therapists are to be expected to hear and see beyond the map: the capacity for novelty. I want to conclude this paper with the suggestion of a methodological branch which might be explored if counselling psychology is to insert more novelty into its context of medical meaning making. Deleuze (2002) offers us strategies to consider if we are to do more than find in our clients what is also everywhere, and to formulate with them the raw experience which is theirs alone. He writes:

I have always felt that I am an empiricist, that is, a pluralist. But what does this equivalence between empiricism and pluralism mean? It derives from the two characteristics by which Whitehead defined empiricism: the abstract does not

explain, but must itself be explained; and the aim is not to rediscover the eternal or the universal, but to find the conditions under which something new is produced (creativity). In so-called rationalist philosophies, the abstract is given the task of explaining, and it is the abstract that is realized in the concrete. One starts with abstractions such as the One, the Whole, the Subject, and one looks for the process by which they are embodied in a world which they make conform to their requirements ... Empiricism starts with a completely different evaluation: analyzing the states of things, in such a way that non-preexistent concepts can be extracted from them. States of things are neither unities nor totalities, but multiplicities," (Dialogues, vii)

This particular brand of empiricism is indebted to the early American psychologist and philosopher William James, who was largely passed over at the turn of the century by the European advances of Charcot, Janet, and Freud. In 1911 James wrote that empiricism recognizes "reality is created temporally day by day, concepts ... can never fitly supersede perception.... The deeper features of reality are found only in perceptual experience" (p. 100, 97). I believe that it is precisely this kind of methodology which is expressed in the work of French sociologist Pierre Bourdieu.

In *The Weight of the World* (2000) Bourdieu explores suffering through oral history, presenting on the page in stark, unedited fashion the phenomenology of everyday misery as experienced by everyday people. We might think of this as unfiltered, untranslated, and, in the context of psychotherapy, somewhat unformulated (Stern, 1983). There is something unsettling to the clinician's eye when reading this material, not that the initial utterances were made as such, because that is what we expect, but that they were *allowed by the expert to be considered a finished product in that state*. As clinical therapists attending to

suffering there are tasks of healing, or at least amelioration, which call us to some sort of work. We reforumulate, we restory, if we don't diagnose. Bourdieu, in his social role as researcher, allows these expressions of misery to sit as completed statements, empiricism honoring haecceity.

### **Radical Clinical Empiricism**

I believe the challenges and lessons from James, Deleuze and Bourdieu can be integrated into our own thinking. Can we sit that moment longer with the unformulated, (perhaps better understood as under-formulated) before we intervene? Can we consider that material which is particular, specific, and non-integratable as more complete than our medical instincts suggest? Can we ask ourselves if what this client or that client is now presenting is not yet-another expression of something eternal, but includes within it something brand new?

In the encounter with experiences of suffering like IBS I believe that such a radical empiricism can allow practitioners to provide care that avoids the humiliating disavowal or overcoding of idiosyncratic symptom expressions. This paper excoriates a fundamental antagonism between client and practitioner which arises when the map does not reproduce the territory, but a radically empiricist approach that acknowledges the fact that the new is always potentially present (literally) for actualization is a profoundly *collaborative* clinical position. If we are not afraid of the disavowal of our maps (with all the attendant anxieties and consequences this paper has described), then we need not defend them. Rather, we can track the expressions of suffering with our clients in an active process of creating new maps of multiplicities which make sense in the here-and-now and which do not require explanations from the abstract, but which themselves explain.

Earlier I quoted Emerson's appeal against the backwards facing traditionalism by which we view our universe, but I excluded his exhortation. Emerson (1846) wrote, "Why should not we also enjoy an original relation to the universe? Why should we not have a poetry and philosophy of insight and not of tradition, and religion by revelation to us, and not the history of theirs" (p. 3). We also need a medicine of insight and revelation, one which incorporates the limits of its own ontologies and interventions so that it can work both within and beyond them. Radical empiricism contains within it both an epistemology and an ontology which is profoundly different from the instrumental monism of biomedicine as described in this paper, but it is also uniquely different from the discursive constructionism by which the post-structuralists antagonized early modernism.

A Jamesian (or Deleuzian, or Whiteheadian) clinical method stands on the shoulders of approaches already integral to contemporary counselling: Buber's hermeneutics (1937) and Anderson and Goolishian's "not knowing approach" (1992). Regarding the former, hermeneutics and phenomenology are always constrained by matters of bias, hence Husserl's methodological crux as bracketing and Heidegger's focus on situatedness or historicity (Lavery, 2003). The radical empiricist viewpoint helps identify the source and quality of bias as predilections towards orderliness and away from novelty. Regarding the latter, radical empiricism helps thicken the epistemological and ontological frameworks upon which such not-knowing stances rest. They are here lodged back into a mainstream of scientific praxis, and I think become both more practical and teachable. Compared to the relational construction of knowledge *contra* the scientific method, Brown (2018) explains what is occurring when such exchanges are viewed in the Jamesian universe:

Sense and sense-making is often treated as the outcome of individual or collective efforts to make order out of the disorderly – the 'aha!' moment of sudden

realisation and clarity. Yet we may think of it, on the contrary, not as something added to the world, but rather as the 'actualisation' or 'conrescence' of a specific experience that is already of the world, albeit as a 'potential' or 'virtual' set of relations .... The field of forces out of which particular experiences are actualised also goes beyond any particular experience. It opens up onto experiences that are as-yet-un-actualised, experiences that are currently 'impossible', in the sense that they are not part of the grammar of self-relations that are pointed out by signs within the experience ecology, but which nevertheless are beginning to emerge, or at least becoming imaginable...As psychologists, our role is to act as cartographers of extant experience ecologies, but we also have a responsibility towards engaging with the emergence of the un-thought, the experiences-to-come, towards life in the making. (Brown, p. 61, p. 63)

Psychologists as well as practitioners I should say. Clinicians are on the front lines of the phenomenal world, listening to stories being told almost *because* of the fact that they do not conform to known modes of ordering, listing, and sorting. What is revealed by radical empiricism is that, in a differently understood world, this exposure to the new, to the unsettled, to the unintegrated, is not a threat at all if we use our tools as tools and not as proxies of realities totality. As Umberto Eco (1989) writes,

This world is ruled by an original ambiguity which existed before and lies beneath the distinctions later introduced by a science that must work by rigid categories. It is in the presence of the *Lebenswel* before it vanishes into the shadows of reason, that our origin and nature, as discovered by contemporary phenomenology, must be sought. Against this presence operative and provisional distinctions — useful tools of organized knowledge which we have converted to idols

out of laziness — crumble. Rational means are indispensable to cope with the world on rational terms. Yet, *they are not the world*. (p. 57)

When we reach the end of medicine is the moment of our highest calling. To accept what disconfirms our world views does not make us less scientific or less expert. If we understand the meaning of the new in human affairs we recognize that wherever *experience* is in collision with *order* we are in participation with the creative force of the world.

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