The "hypochondria" is a term with scorn and derision, not demands on attention and credibility but needing to be suspected of by people who suffer from health anxiety, or of suspecting they are suffering from a disease while having their symptoms dismissed as baseless.

A Condition of Doubt seeks to understand hypochondria, and how our thinking about health and disease should be in particular patients that have a condition emerging from patients' expectations of medicine.

The book's four parts explore the biology of medicine, the wealth of texts from the history of medicine, psychiatric and popular culture, A Condition of Doubt, and a case for, the place of medicine in understanding medicine and medicine thinking about medicine.

This book argues that the condition of hypochondria has become more common, and that hypochondria — as it is addressed by the medical profession — should be addressed by rethinking medical expectations. This means, and more broadly, rethinking our approach toward the unknown.
Despite this, the authors conclude that the hypochondriacal patients, those showing a more appropriate and realistic appraisal of risk, should be subject to "cognitive restructuring."

The study effectively uncouples mental health from the accurate perception of reality (at least to the extent we accept the estimation of probabilities to be part of such perception). The patients who manifest greater cognitive distortion are the ones considered mentally healthy. It is adaptive, then, to be somewhat deluded about our invulnerability. Despite this, the realistic pessimists are the ones that doctors seem reluctant to engage with in any ongoing exploration of fears that, in the aggregate and the long term at least, are quite well founded. Could it be that this most rationalist and evidence-based practice is so deeply invested in the shared illusion of stable good health that the realist hypochondriac has to be pathologized out of fear that he will bring down the whole fragile structure? What this study suggests to me is that medicine's unquestioned reliance on objective evidence as the grounding for rational medicine and for mental health is potentially harmful, to patients and also to practitioners.

We can define hypochondria as a condition of biology to the extent that we define "biology" as Donna Haraway does in the epigraph to this chapter, as "discourse on the body." By opening up the space between objective evidence about material bodies and subjective experience of selves, hypochondria exposes the epistemological fragility of a medicine that sees itself as primarily a science. Hypochondria may appear to be cultural or psychological rather than biological, and visceral and emotional rather than rational, but, in evincing the fact that illness can and does persist in the absence of identified disease, it also reveals the need for medicine itself to recognize its own foundation and practices in the biocultural, the subjective, the visceral, and even in the adaptively irrational.

Of course, medicine's attitude to objective evidence about biological conditions has not been historically consistent. In the next chapter we turn to the problem of tracking historical changes in the status and meaning of hypochondria as a medical condition that has no natural history.
to be called hypochondria—a 'real' disease which has lost most of its symptoms over the course of several centuries—and that of a mental illness—a prodigious variety of imaginary disease.' Setting out to write a history of hypochondriasis as a clinical condition, German Berrios asks, "From the Greeks on, what is the history of hypochondriasis about? We can now say that it is unlikely to be about some stable behavior related to some tenebrous brain structure. It is far more likely that it is just about the avatars of a fascinating term." The transhistorical constant of hypochondria is the term's indeterminate reference—and thus its inescapable self-reflexiveness. As has already become clear in my own work, to study hypochondria, whether historically or synchronically, is inescapably to study terminology, discourse, and medical epistemology.

Because of its self-reflexiveness, a relative constant in the naming of certain states as "hypochondria' has been a tension between what the patient and the doctor understand and experience regarding this state and how it applies to the patient's physical condition. Hypochondriacs have long been defined at least in part by their apprehension of things and events within their bodies that doctors cannot find, though the modes of imagining and seeking such things has changed repeatedly. For instance, an eighteenth-century physician lists clear physical symptoms of the condition he names hypochondria—'fatality, dyspepsia, palpitation, tremor, and sense of pain'—but nonetheless classifies the condition primarily as "error respecting a person's own health or form.'

Contemporary psychiatry relies, too, on the hypochondriac's being wrong. The grounds for diagnosing hypochondria as pathological are not simple; that it is maladaptive and causes suffering but also, according to psychiatry's taxonomy of mental illness, the Diagnostic and Statistical Manual (DSM-IV), that it arises from a flaw in cognition, a specifically hermeneutic one. According to the DSM-IV, the hypochondriac's preoccupation with disease is based on the misinterpretation of somatic symptoms that continues despite "appropriate medical evaluation and reassurance." The manual relies, then, on the assumption that the interpretation of subjective symptoms can be both conclusive and conclusively—verifiably—wrong, and that "appropriate medical evaluation and reassurance" is a stable and consistent entity, something one must be mentally ill not to be persuaded by. The manual grounds its criteria, then, on the assumption that somatic medicine's own epistemology—even regarding subjective sensations—is reliable and secure, since misinterpretation as a psychological symptom of hypochondriasis can be recognized as erroneous only if the medical doctor's interpretation of somatic symptoms is trusted to be correct and conclusive. Yet we all know that there are many situations where this is not the case.

This reliance on error as a criterion explains the extreme historical fluidity of other aspects of hypochondria, for such error—often, more accurately, the error of not completely believing the doctor's assessment—is always relative to what medicine at a particular moment trusts itself to know for sure.

Putting it more vividly, Brian Dillon calls the history of hypochondria "an X-ray of the more solid and familiar history of medicine." Not only does the condition expose the "underlying structure of our hopes and fears about our bodies," in Dillon puts it, but like an X-ray is also potentially diagnostic, revealing fractures and lesions in the powerful armature of medicine on which most of us, sooner or later, depend for our lives. But perhaps hypochondria's history is even more like a photographic negative of medicine, revealing the outlines of what medicine can know in ghost form, thereby calling into question its practitioners' authority over what we think we see.

Hypochondria is the shadow self of medical knowledge, its always-doubting alter ego, calling into question—but never, ever entirely rejecting—every science and theory and therapy that most of us wish were omniscient and infallible. And like every alter ego, individual hypochondriacs haunt their particular doctors, faithfully seeking medicine's eventual recognition of what they have within, perpetually and miserably skeptical when told it is no matter.

Hypochondria's shadowy history casts into bright definition the problem of bodies, both as objects of knowledge and loci of experience. As states called hypochondria migrate, from anatomy to physiology to neurology to psychiatry, that trajectory replicates clinical medicine's struggle to negotiate a place for the thinking, feeling, and potentially doubting mind of the patient. Without clear evidence of a concrete and objective condition coming from somewhere other than the mind, hypochondria turns back on itself at the point where mind and body meet—or rather where they cease ever to have been fully separate.

The Anatomical Hypochondriion and the Physiology of Melancholy

Hypochondria begins in the stuff and space of the body: Hippocrates used it as an anatomical term, a collective noun for the contents of a region called the hypochondriion, literally below the chondros, the cartilage of the ribcage. The Oxford English Dictionary retains this first meaning of the noun as those "parts of the human abdomen which lie immediately under the ribs and on each side of the epigastric region" and "viscera situated in the hypochondriosis; the liver, gall-bladder, spleen, etc., formerly supposed to be the seat of melancholy and vapours." As a biological space it was, from the first, a place where things could go wrong.

In the systemic humoral physiology that dominated Western medicine at least until the sixteenth century, anatomy alone could never explain pathology, for health was constituted by a subtle balance of heat and moisture conveyed and maintained in the mobile fluid substances of the body rather than within static organ systems. The humoral, precirculatory, body was not a controlled and
selective system of nutrient use and recycling; it was permeable to and continuous with the substance of its environment, and its matter was continuous with and co-constitutive of the subjective mental experience of the person. Hypochondria might, in this physiological paradigm, be thought of as beginning in the anatomical region of the hypochondrium, in particular the spleen where black bile was generated out of part of the blood. Any imbalances of the humors were, though, by definition rapidly metasatistic, throwing off kilter the entire psychosomatically integrated system.

Aris in the spleen, cold, dry, black bile—melancholy—was the humor most predisposed to pathology, for it was the opposite of the healthiest humor constituted by the energetic heat and moisture of the blood. In hypochondria, excess black bile would thicken and decay, causing stoppages and toxicities especially harmful to both the gut and the mood. The melancholic humor was the one most likely to clog up the pre-circulatory system of fluids and spirits whose equilibrium had to be so carefully maintained. Spirits, in particular, traveling in the tubes we now know as nerves, were as determinant of the mind’s good governance as the body’s.

Undue anxiety about the fragility of one’s body and despair about its mortality were consistent with melancholia, understood as an entirely integrated disorder affecting patients regarded as psychosomatically whole (which is not, of course, to say that mind and body were not recognized and named as different aspects of the person). Hypochondria was, from Galenic medicine through the early eighteenth century, associated (in various shifting ways) with a physical and, in theory at least, measurable excess of black bile. The mental agonizing produced by such excess was accepted alongside physical complaints as another manifestation of disorder in a body whose health was equally subject to the actions of, for instance, diet, ideas, climate, and emotional provocations on an unbreakable feedback loop of bodily matter and subjective experience. As a result of this psychosomatic coherence, practitioners and theorists of humoral medicine found hypochondria to be a challenge but not a threat.

In his compendious encyclopedia of morbidity, the 1621 Anatomy of Melancholy, Robert Burton classified hypochondria as the most common manifestation of melancholia and associated it specifically with physical symptoms and thence with the patient’s relentless need for doctors and medication. The personification of “hypochondriacal melancholy” is pictured on Burton’s frontispiece surrounded by medicine bottles, and Burton calls it “a disease so grievous, so common, I know not wherein to do a more general service… than to prescribe means how to prevent and cure so universal a malady, an epidemic disease, that so often, so much crucifies the body and mind” (76).

Burton specifies its pathology as a “splenetic hypochondriacal wind” (78), quoting Melanchthon on its physiological etiology: “black blood drawn from the spleen, and diffused under the ribs, on the left side, makes those pernicious hypochondriacal convulsions, which happen to them that are troubled with sorrow.” (163). In summarizing the effects of hypochondria, Burton does differentiate between the physical and the mental. Its symptoms are, “in body,” “Wind, rumbling in the guts, belly-ach (sic), heat in the bowels, convulsions, crudities, short wind, sour and sharp belchings, cold sweat, pain in the left side, suffocation, palpitation, heaviness of the heart, singing in the ears, much spittle, and moly, &c.” (84). Mental symptoms include “fearful, sad, suspicious, discontent, anxiety, &c. Lascivious by reason of much wind, troublesome dreams, affected by fits, &c.” The “et cetera” at the end of each list suggests the extensiveness and fluidity of hypochondria as a diagnostic category; Burton quotes Crato on the difficulty of producing a finite list of characteristic effects: “the symptoms are so ambiguous… that the most exquisite physicians cannot determine the part affected” (248). The spleen may, then, be the source of black bile, but the disease melancholia is caused by the influence of black bile throughout both body and mind.

Yet some of Burton’s examples reveal affinities with contemporary hypochondria. For instance, he tells of a man who fell into water containing frogs. The man believed he had swallowed frog-sap and, predisposed by hypochondriacal melancholic pathophysiology, his dark unhealthy mind jumps to dire conclusions: “with that conceit and fear, his phantasy wrought so far, that he verily thought he had young live frogs in his belly” (249–250). The man responds—just as Molière’s Argan later would—by becoming a doctor: “If studied physic seven years together to cure himself, travelled into Italy, France, and Germany to confer with the best physicians about it.” Repeatedly told he had wind, not frogs, in his belly, he asked the doctor whether he could not hear them croaking. The placebo approach was ruled out because the patient, like so many hypochondriacs, already knew too much: “Platerus would have deceived him, by putting live frogs into his excrements; but he, being a physician himself, would not be deceived” (250). Eventually, after another seven years, he was liberated from his fantasy (“se phantasia liberates est”). Burton does not give a cause for this cure.

The characteristics I derived from Little Ninja’s account of her hypochondria are quite evident here: the patient is afraid that something terrible is happening hidden inside his body; he resists the doctor’s reassurance that all is well, and he is well informed (perhaps dangerously so) about medicine. But the content of Little Ninja’s hypochondria, a possible but hypothetical cancer, hypothetically caused by her smoking, is distinct from—at odds with—the hypochondria itself. In Burton’s humoral typology of melancholy, no such clear distinction between the fear and its bodily object is possible. The fear itself is as physical as the content of the fear it causes; a gut full of frogs is an unsurprising preoccupation in a disorder associated primarily with abdominal symptoms.

Humoral treatment of hypochondria thus tended, in Burton’s account, to involve evacuating the matter produced by inefficient functioning of the organs in the hypochondrium, and in particular reducing wind in the belly, by clysters (emesis), laxatives, and wind-reducing foods. Bloodletting was not recommended. A particularly creative treatment was, according to Burton, practiced
successfully by Amatus Lusitanus: "Put a pair of bellows end into a clyster pipe, and applying it into the fundament (rectum), open the bowels, so draw forth wind, nature non admittit vacuum. He vaunts he was the first invented this remedy, and by means of it speedily eased a melancholy man" (419). Along with this "flatous" "abundance of wind," sexual frustration was also responsible for the "strong imagination" and "violent and furious passions" of the hypochondriacal melancholic (454). In early modern pathology, mental apprehensions, physiological processes, matter itself, and symptomology could thus form an unbreakable cycle.

Also in the seventeenth century, this imbriication of anatomy and psyche enabled English physician Thomas Sydenham to establish a resilient gender distinction. He claimed that hysteria and hypochondria were gendered analogs of the same disorder, with the uterus inflecting the condition's presentation in female patients, whereas in males it was determined entirely by the action of the organs of the hypochondriac.13 Partly because of this expansion of its demographic base to include women, the epidemiology of hypochondria became more extensive. No longer simply the commonest form of melancholia, it was coming to be a characteristic national condition: when Scottish physician George Cheyne published The English Malady in 1733, he estimated it to be present in a third of English people—but he defined it broadly, including anxieties associated with now recognizable diseases like syphilis and tuberculosis. Significantly, though, Cheyne also associated hypochondria with social conditions, and he connected its physical and psychological aspects with what we would now consider environmental stressors. At this time, then, hypochondria was democratized; as a result, it became both more widely diagnosed and a good deal less respectable than it had been.

A treatise published in 1766 by physician John Hill may mark the last widely known argument that hypochondria was primarily an organic disease—at least until twentieth-century psychiatry replaced humors with neurotransmitters. But Hill's terms show that he was reacting to and resisting a gradual psychologizing of hypochondria: "To call the Hypochondriasis a fanciful malady, is ignorant and cruel. It is a real, and a sad disease: an obstruction of the spleen by thickened and distempered blood; extending itself often to the liver, and other parts; and unhappily in England very frequent:physick scarce knows one more fertile in ill; or more difficult of cure."12

Hill's somatic account of this "real disease," however, included the mental and spiritual. As he goes on to say, "Real grief has often brought it on; and even love, for sometimes that is real." Emotional stress led to physical effects, as we still know. What is less familiar is the entanglement of body and mind in Hill's account of the role of reading in hypochondria: "Study and fixed attention of the mind have been accused before; and add to these the stooping posture of the body, which most men use, though none should use it, in writing and in reading."13 Reading is not a purely mental activity. Its typical posture physically compresses the organs of the hypochondrium but also exacerbates melancholia as a mood through affinity with its (cold, dry, dark) material substance: "of all other things night studies are the most destructive. The steady stillness, and dusky habit of all nature in those hours, enforce, encourage, and support that settled gloom, which rises from fixed thought; and sinks the body to the grave; even while it carries the mind up to heaven."14 This is only one of a great many texts that associate hypochondria with the habit of reading—I will return to this connection later.

Hill concludes by offering, triumphantly, a pharmacological cure: powder of spleenwort, which will gently break down the blockages in the spleen and allow them to be safely evacuated via the bowels. (A more violent attack on the obstruction, he warns, runs the risk of distributing the melancholic blood into the bloodstream, where it will do serious damage.) In a few lucky individuals, he concludes, the body will then cure itself by evacuating the bad blood of hypochondria via the hemorrhoids, which were sufficiently ubiquitous to be considered a physically normal means for the body to discharge excess blood.

**Morbid Anatomy Finds Nothing There**

With the rise of pathological anatomy in the eighteenth century—now familiarized in the humanities by the work of Michel Foucault in *The Birth of the Clinic*—the integration of mind and body in pathology was, to some relief on the part of medicine, nominally untangled. Morgagni and Bichat both developed accounts of morbid anatomy that would narrow diagnostics down to material lesions affecting particular tissues, so that disease could be visualized, isolated, and potentially excised.15

With pathology identified as material lesions in the stuff of the body, objectively visible at least on autopsy if not before, the invisible subjective experience of the patient was separated from disease itself, becoming the discursive sign or performance of an unquestionably material referent. This meant that if, as in hypochondria, no referential lesion could be found, the patient's account of symptoms was called into question. This is the point at which hypochondria becomes an epistemological, rather than purely a diagnostic or therapeutic, problem for modern medicine.

Unsurprisingly, in the early nineteenth century, the diagnosis of hypochondria as mental illness began to dominate. Moody obsessions with one's bodily health would be called hypochondria and described, as Jean-Pierre Palfrader did in 1822, as "madness" with "moral and intellectual causes" rather than pathological, humoral ones.16 These causes could still be situated in the body to the extent that hypochondria was thought of as a disease rather than a charade, but it was no longer a condition of the hypochondriac or the guts. Hypochondria was now positioned, along with the mind itself, securely in the brain and came to be
associated primarily with symptoms like headache and insomnia, its primary causes "mental overwork, strong emotions, and masturbation."

Cheyne's recognition in *The English Malady* (1733) of the social causes of hypochondria can also be seen taking more overt form. George Grinnell, in his recent study of hypochondria in writings of the Romantic period, the late eighteenth and early nineteenth centuries in Europe, observed that the "malady became a somatic expression of a culture fascinated by well-being like never before as it increasingly targeted the healthy body as an object of regulation." Grinnell sees hypochondria, with its etiologic indeterminacy, becoming a site of resistance both to the objective medical gaze of morbid anatomy and to the consequence of that gaze, the disciplinary social control projects of public health. For Grinnell, the hypochondria's knowledge of his own condition was "haunted by invisible specters that mark the uncertain prospect of ascertaining his health or illness"—haunted, that is, by the insistent return of the subjective into a more firmly scientific modern clinic. Grinnell observes that to this extent hypochondria is "as much epistemological as it is personal, persistently marking the presence of irrationality for a post-Enlightenment age of reason." Even more potent, I suspect, was hypochondria's presence as an *alternative form of reason*, marking the resilience of the authority of subjective bodily experience in the face of its denial by the reductive logic of the clinic.

Romantic hypochondria was rebellious and resistant, a complex condition of mind and nerves interlinked in undermining the dictates of new health regimes. Nonetheless, with the rise of psychoanalysis and its more decisive separation of mental from physical disorders, hypochondria became an orphan hybrid, at once both and therefore neither somatic nor psychological, and as such a condition that neither domain of health care was obliged to take on as its own. The result of this indeterminate move from disease to madness was that hypochondria became a very undesirable diagnosis—for clinician and for patient.

With its emphatically somatic content, hypochondria would not fit into Freud's linguistic and nonsomatic model of the unconscious: "hypochondria floundered between mental confusion and physical illness." Freud was clear that hypochondria was not the same as somatization, the bodily expression of purely psychological issues. Its somatic perceptions and symptoms would not map onto, or explain, past psychic traumas: frankly about the body, hypochondria could not be assimilated into a psychoanalytic model. For Freud, hysteria, which he considered a "psychoneurosis," an unconscious conflict expressed by the body, was eminently analyzable. But hypochondria, an "actual neurosis," had its roots in the flesh and not the unconscious, and so fell outside his purview.

Psychologist and historian Susan Baur nicely captures the paradox that followed from this particular solidification of Cartesian dualism: "Being unanalyzable, hypochondria was of little interest to psychoanalysts, and being resistant to medical treatment, it was not a disorder that medical doctors wanted to treat either"—and so, "just as psychoanalysts were rejecting the disorder as unprofitable (insufficiently neurotic, if you will), the splenetic man in the street and the medical doctor were also rejecting hypochondria, but for the opposite reason: it was too 'mental.'" The area that would then take up the problem was psychiatry, the branch of biological medicine that manages the experiences of the mind. It would classify hypochondriasis as one of the "somatic disorders"—illnesses of the mind expressed, in terms of form or content or both, through the body. This might seem a perfect solution, but psychiatry's balancing of the mind–body relationship has been as troubled as Freud's efforts were in dealing with the corporeality of hypochondria.

**Psychiatry and the Somatoform Disorders**

Thus, hypochondriasis appears to be a paradigm of psychopathological complexity and interrelatedness.

—Vladan Starcevic and Don R. Lipsitt, *Hypochondriasis: Modern Perspectives on an Ancient Malady* 2

Psychiatrist and cultural studies scholar Bradley Lewis describes a twentieth-century "scientific revolution" in the field of psychiatry that can be traced to the radical changes made when the second edition of the *Diagnostic and Statistical Manual* (1968) was revised as 1980's *DSM-III*. The new approach, described explicitly as the "New Psychiatry," was hailed as science's final defeat of psychoanalysis, that last medical bastion of discursive contingency. The new nosology was meant to be purely—objectively—descriptive, rejecting all theorizing as empirically unverifiable speculation. Lewis points out that this move was somewhat naïve: science is of course itself ever at theoretical. He also notes that psychiatry's move away from discourse and theory mirrors the opposite move taking place around the same time in the humanities and social sciences (and, Lewis points out, the "intellectual community at large")—away from the pseudo-scientism of, for instance, literature's New Criticism toward a transdisciplinary "theory" often equated with poststructuralism, postmodernism, or postdisciplinary critique. To this extent, hypochondria offers an X-ray of psychiatry, too: returning repressed doubts about somatic evidence of feared conditions in which the fear, rather than the somatic condition, constitutes the relevant pathology. It was as if, just as other disciplines concerning the human subject were becoming postmodern, psychiatry decided to become rigidly modern. This paradox has significant implications for the recognition and treatment of hypochondria (and hypochondriasis) in both general medicine and in psychiatry. Medicine continued to psychologize any somatic illness it could not explain biologically—to understand it as the somatic masking of purely mental disturbance. But, as Freud found, in hypochondria the body keeps interpersonalizing itself in what would otherwise become, in the absence of organic evidence, a purely mental problem.
The actuality of the patient’s body, materially embodying both inaccessible diseases and inexpressible anxieties, forces its doubt inescapably on the clinician. Susan Baur's reading of hypochondria reflects her background in psychology rather than psychiatry. She psychologizes its bodily content, her account of the condition far closer to a description of somatization than what I have been calling hypochondria so far. Baur advocates honesty and authenticity as ways to overcome hypochondria, which she sees as a sort of bodily lie. One must, that is, uncover the “real”—emotional, psychological—trouble that is masquerading as somatic. According to Baur, the hypochondria’s “sickness is used to say I’m unhappy,” and so the patient is “engaging in a form of indirect communication, and although the underlying message may be fairly clear, deception is involved.” Reading hypochondria as synonymous with somatizing, Baur psychologizes the condition, attempting to exclude from it the underlying somatic reality of its content.

But now psychiatry was working in the opposite direction, striving to somatize the mind, anchoring mental disturbances in the biology and chemistry (and hence the pharmacology) of the brain. The hypochondriac patient could all too easily be discarded, along with theory, in these mutual denials of whatever cannot be empirically accounted for.

Following this trajectory along an expansion of the “scientific basis of psychiatric classification and diagnosis”—the forthcoming fifth edition of the manual (DSM-5), due to be published in 2013, is set to eradicate the word “hypochondriasis” altogether. Current proposals are to have it subsumed into a new classification: “Complex Somatic Symptom Disorder” (CSSD), which could then be subdivided by “optional specifiers.” What is presently classified as hypochondriasis would be specified as “High health anxiety.” This keeps the focus on the fearful preoccupation that characterizes hypochondria but removes the assumption that such anxiety is focused on symptoms that have been misinterpreted, or that may have unstable or contestable meanings.

The reclassifications for DSM-5 have unsurprisingly led to controversies. Perhaps most relevant here is a broad challenge to the very idea of revising the classificatory system (and thereby revealing its constructedness and contingency). In a 2009 article in Psychiatric Times, Allen Frances, editorial director of the fourth edition of the DSM, excoriates the editors of DSM-5 for what he considers the folly of revising the classification of psychiatric disease before it is possible to know more about biological (rather than experiential or social or cultural) etiology—cause, that is, in the form of observable organic changes. Until then, Frances argues, changing diagnostic classification and criteria is “absurdly premature,” an expensive and risky waste of resources: “Simply stated,” he argues, “descriptive psychiatric diagnosis does not now need and cannot support a paradigm shift. There can be no dramatic improvements in psychiatric diagnosis until we make a fundamental leap in our understanding of what causes mental disorders.” This anticipated leap, he continues, will arise from “incredible recent advances in neuroscience, molecular biology, and brain imaging that have taught us so much about normal brain functioning,” but these are not yet ready to be applied to “the clinical practicalities of everyday psychiatric diagnosis.”

For Frances, then, psychiatric nosology is on the verge of being able to identify organic causes of psychopathology, such that a magnetic resonance image or a blood test, rather than subjective interpretation of a patient’s discourse and behavior, will be the basis for diagnosis. In a recapitulation of Bichat’s morbid anatomy of somatic disease, Frances believes that psychiatry will soon be able to extricate itself from relying on subjective accounts of experience and look directly at bodily lesions and their measurable chemical equivalents instead. Should this ever be achieved, mental illness will have become brain disease, diagnostics as independent of the patient’s subjective account as somatic diagnostics became in the second half of the twentieth century. The catch is that, as hypochondria itself exemplifies, somatic diagnosis still depends a great deal on the patient’s account of subjective experience—on the mind’s experience, and communication, of how the body feels.

A further shift promised by the DSM revisions shows how hypochondria, whatever it comes to be called, will be situated in a potentially infinite matrix of disorders. In DSM-5, psychiatric diagnostics is expected to move to a spectrum model, with all disorders assessed along continua rather than subjected to exclusory yes/no diagnoses.

I believe that many patients might benefit from clinical recognition and attention to problems that are currently subclinical, unrecognized and untreated. But it also means that, under the DSM-5, rather than being positioned either on or off a particular disease spectrum, should we choose to be tested against it, we will all be embedded in a matrix of disorders; we are all present on all the continua, minutely mappable (but always dynamically), on all possible axes of mental organization and experience. What follows is the assumption that we will all be more or less pathological, all more or less in need of psychopharmacological management. DSM-5 thus promises to be the biocultural matrix par excellence. Describing the way it situates us will require a poststructuralist language for the relationships between medicine and the mind.

If we look back about a hundred years, we can see this matrix of pathologizing emerge out of efforts at social improvement, medical efficacy, and cultural change based in particular on increases in popular access to information. In the twentieth century, as a public preoccupation with health in Western society not only matched that of the Romantic period but was now founded on medical technology’s hugely expanded capacity to identify and treat somatic disease, and to dictate public and patient responses to the threat or presence of disease, hypochondria can be seen to emerge as a shared cultural condition of doubt, rooted both in high expectations of medicine and insistent insecurity about the individual clinician’s ability to fulfill that promise. In the 1960s, this skepticism would merge with the era’s wider social anti-authoritarianism, and patients would
Three Kinds of Twentieth-Century Hypochondria

In a 1934 taxonomy of "Hypochondriasis: Individual, Vicarious, and Communal" in the British Medical Journal, the physician Robert Hutchison defines the condition as "any morbid interest in or over-anxiety about health." While definable only at the level it is morbid or excessive, Hutchison's version of hypochondria is securely distinct from somatic etiology and fairly independent of psychological etiology: while it may lead to fully delusional mental illness, Hutchison evidently sees hypochondria as primarily a culturally determined amplification of normal attention to health and risk.

Focusing on sociocultural vectors stimulating anxiety about disease and, importantly, promoting any kind of excessive interest in health, Hutchison anticipates the view of contemporary hypochondria that I find most persuasive, that it is not a mental (or physical) illness but a "position" (John Diamond, recall, considered it a "rational position"), a troublesome and distracting but not delusory or idiosyncratic attitude to the problem of uncertain and vulnerable bodily being. Hutchison's account of hypochondria in 1930s Britain gives us a view of twenty-first century cultural hypochondria in embryonic form.

He distinguishes three broad categories based on the question of who fears for whose health: "individual hypochondriasis," when a person worries about disease in his own body; "vicarious hypochondriasis," concerning fear for the health of a loved one; and "communal hypochondriasis," where the anxious subject is collective, constituted by an entire community's shared fears for the health of its constituent members. Were the second of these, vicarious hypochondria, considered an illness today, we might call it "hypochondria by proxy" (on the model of Munchausen syndrome's parental iteration). But this now tends to be considered diligent and often appropriate vigilance, even when overzealous parents may become tiresome to the pediatrician on call. "Communal hypochondria," as Hutchison presents it, is almost identical to contemporary Western mainstream attitudes to health. So common and so encouraged by new sociocultural norms, such fears are no longer considered pathological, no matter how much anguish they might still cause. Only "individual hypochondriasis" remains an illness category today.

Hutchison identifies four types of individual hypochondria sufferer: the "general hypochondriac," the "nosophobe," the "crank," and the "physical prig." Only the first seems to have developed his condition relatively independently of medical culture, and then only partly. The others can be hypochondriacal only to the extent that medicine and medicalizing culture have made them so.

The "general hypochondriac" is a familiar stereotype, "the man who is always fussing about his health and fears that he is getting, or has already, some disease." Hutchison has a very clear image of this type of patient: "usually a man in advanced middle life, generally retired from business, who makes his health his hobby, and who collects symptoms as others collect stamps." The general hypochondriac is, for Hutchison, bored rather than sick. Without adequate external diversions, he focuses on himself. Hutchison finds such concern "harmless enough"—though he warns that it can devolve into "delusional insanity" and so must not be encouraged.

Hutchison blames popular and media accounts of disease for another of the forms of individual hypochondria, which he calls nosophobia, the fear of a particular disease. He gives the example of a patient who is afraid he has syphilis after seeing "a propagandist film" that had convinced him he has become infected and reduced, in the terms of the film, to "damaged goods." Hutchison calls such a patient a "good example of the fact that nosophobia is apt to result from health propaganda acting upon a nervous temperament—a fact which enthusiastic health propagandists would do well to note." Hutchison is skeptical, then, about the positive value of public health's cautionary tales and the guilty vigilance they were meant to promote.

Where, by Grinell's account, Romantic hypochondria was a rebellion against the panopticon of public health, Hutchison finds the twentieth-century hypochondria a biddable, even paranoid, consumer of health scares and admonitions. This did not diminish such a patient's skepticism about particular information from the individual physician, though, especially if that information were intended to reassure.

Hutchison partially blames medicine for encouraging a third type of individual hypochondria, whom he calls the "crank," or "health faddist." This is "the man who believes that health is only to be attained by following some special rule in life." Hutchison observes that medicine provides the fadist with authority, and he especially blames those in the medical profession who "undertake to enlighten the public on health matters in the daily Press." The diligent health obsession Hutchison warns against is no longer, on its own, considered a medical pathology; it is both widespread and encouraged. Hutchison concludes that argument (rational and evidence based) is "of no use" in tempering the fadist's obsession, but that "ridicule is sometimes effective" (he does add that the mass rather than the individual should be the object of such mockery). The "crank," he concludes, should not be treated, for he can provide the physician with light relief: "after all he often contributes to a grey world an element of comedy for which we should be thankful."

The fourth kind of individual hypochondria is closely related to the fadist, but with an aesthetic form of narcissism attached. This is the "physical prig," represented by "young men with an exaggerated standard of health and well-being, who wish... to be 'utterly fit'" and eventually become addicted to exercise.34 Like
the "crank," such a patient is today no longer considered ill. Hutchison urges doctors to encourage "more scientifically directed physical education" and reminds them that middle-aged men may be endangered by belated enthusiasm if he tries "to do 'physical jerks' ... it is time that we put in a word of warning in the interest of his heart and arteries."

Both faddish and priggish hypochondrias, like the more miserable nosophobia, are therefore products of a culture that imposes an individual responsibility not to be sick. For this reason, Hutchison's most meaningful type does not involve diagnosis of the individual at all. He calls it "communal hypochondria." This condition, he observes, was not yet common in England as he wrote in the 1930s but, he says, "seems to be rampant in America." Hutchison considered it to be a sociocultural ill caused by efforts to persuade populations to be responsible for their own health. He blames the rise in public health of cultural agencies working to produce "what is termed 'health conscience,'" but what is better termed 'disease consciousness.'" The vicarious and the communal have become so naturalized and encouraged ("rampant" one might indeed say) as no longer to count as pathologies at all. American society is far more critical of neglect than of hypervigilance.

For Hutchison, the physician's primary duty to the hypochondriac was still premised on the profitability of the perpetual patient. Medicine, he argues, has a duty to keep the hypochondriac "out of the hands of quacks, of whom he is the predestined prey," but a sentence later, Hutchison shows that the identity of such predators is not exactly separate from the physicians themselves. In parentheses he gives, with a nudge, a reason for not attempting too hard to cure hypochondrias: "I say nothing of the unwise of killing the goose that lays the golden eggs." 293

Doctors today do not need the added value of the hypochondriac, a source of predictable repeat income and the sale of inexpensive bromides. To this extent, Hutchison's account points to one aspect of hypochondria where in 1930 little had changed since Molière's Argan, swarmed by enthusiastic doctors who want to foster his ailments so they can charge him for their elaborate but inevitably ineffective treatments. Argan's observant maid-servant points out that his doctors "amuse themselves finery with your body. They have a rare milk-cow in you, I must say; and I should like them to tell me what disease it is you have for them to physic you so." 294 A milk (milk) cow is an ongoing renewable source of income (unlike the terminal cow who is butchered for meat). For any patient to be this kind of cash cow (or golden-egg layer) requires a health care system fundamentally different from the present one, where repeat visits are more likely to penalize clinicians than to be profitable.

Yet in a predictor of the changes to come, Hutchison also notes that legislative and economic developments in health care delivery and compensation might have been contributing to the prevalence of a certain type of hypochondria, by providing the patient rather than the doctor with economic incentives, such as when the employed could be certified as too sick to work but able to claim benefits. As Hutchison asks, "How many hypochondriacs have the Workmen's Compensation Act and the National Insurance Act ... produced? The morbidity statistics of insured persons provide the answer." 295

But it is in his clinical recommendations for treating individual hypochondria that the difference between Hutchison's medicine and that of our time becomes clear. He advises the physician to do two things: to protect the hypochondriac from those who would exploit his willingness to be a patient, and to reassure him, not by telling him that nothing is wrong, but by providing a treatment the patient believes will make him better—"Listen to him patiently, examine him thoroughly, reassure him confidently, give some explanation of his symptoms, prescribe a placebo, and send him away happy—until next time." 296

This kind of reassurance is very different from the candid disclosures that doctors are now expected to provide. While Hutchison is explicit that "one should never tell the patient that there is nothing wrong with him, for that is the sure way to lose his confidence forever," he has no restrictions about the veracity of explanations offered instead. Yet in the era of informed consent and patient rights, doctors would no longer be able to use placebos or confidently invent normalizing explanations for symptoms.

From the 1960s on, "communal hypochondria" would become most fully the reverse image of medicine, its skepticism and suffering directly proportional to medicine's increasing yet always-insufficient mastery of both individual and population-wide physical and mental well-being.

In Hutchison's account of hypochondria we can see the sociocultural construction of health and disease determining patients' doubts regarding knowledge and bodies. Not limitable to physical pathology or to mental illness, hypochondria could now begin to be fully understood only as an epistemological condition concerning the representation of illness, as a struggle between patient and doctor for authority to know the patient's body. It is here that the division of explanation into the bodily and the mental could be—or rather could have been—resolved in recognizing hypochondria as a condition of medicine, and as indissolubly biocultural.

Contemporary Hypochondria and the Price of Autonomy

A signal article appeared in *Time* magazine early in 1969: "Medicine: The Plight of the U.S. Patient." It begins, "American medicine is the best in the world. Most Americans take this statement as an article of faith—so long as they are in good health," and it continues by observing that "growing numbers of patients, the consumers of American medicine, are asking questions that range from mildly nagging to openly angry." These questions are about authority and control and trust: medicine, the article claims, "is the only big business in which the ultimate
consumer has no control over what he buys. The doctor prescribes the drug, for which the patient must pay," and framing this new consumer role is the patient's growing need to evaluate the product: "The patient has no way of knowing whether he is getting good counsel from his family doctor, good drugs from his friendly pharmacist, good technical performance from his surgeon." Society had already developed a communal fear of ill health. It was now also developing a newly articulated, and shared, distrust of its primary source of preventing or remediating ill health.

In the rebellious late 1960s and the 1970s, patients increasingly questioned the hierarchical power structures of the clinic, especially the authority of physicians. This escalation of tensions had particular implications for hypochondria. As patients began to assert their right to participate in medical decision making, clinical interactions became based in patient access to medical information—and the anxious new responsibility that was its price. Bad outcomes could no longer be blamed on luck or the power of disease, or even on the inadequacy of a particular clinician. Instead the patient's vigilance and knowledge and assent were being built into medical transactions. The rise of medical ethics, with the principle of respect for patient autonomy codified in informed consent, meant that the default role for all patients was nearer than ever before to the querulous, skeptical persona of the hypochondriac. This constituted a radical change for what we might call the decorum of medicine, another word, in effect, for its poetics: the rules of form governing its practice. The manner of medicine changed when the patient was granted decision-making power and access to information, and this in turn changed medicine's authority over its ways of knowing.

Writing in 1988 about how worrying over our health was coming to characterize the American mindset, psychiatrist Arthur Barsky convincingly describes the epidemic of communal hypochondria predicted by Hutchison as an extensive medicalisation of all aspects of life alongside the paradoxical sense of health's fragility that follows from medicine's increased efficacy in treating disease: "Our sense of medicine's rapid progress leads us to distrust the knowledge of the present, suspecting that future medicine will prove our fears founded."

This means, Barsky observes, that even "undiagnosable aches and pains" must be watched, since they "might now be recognizable as signs of some new disease that has just been discovered." We know too much to trust that health is real or possible—it has become harder to be complacent than it used to be—"predisposing risk factors are so widely appreciated, and diagnostic technology so powerful and so discerning, that a state of apparent good health seems no more than a screen for troubles hidden and troubles to come."98

This side effect of medicine's successes must have been a shock to its practitioners: not only were there more hypochondriacs and less financial compensation for their doctors, but patients were becoming empowered to reject reassurance, to be suspicious of naively accepting the word of a doctor just because he is an "expert." Edward Shorter, historian of psychosomatic illnesses, nostalgically recalls the way things used to be: "In past times, physicians were able to contain the eruption of symptoms they knew to be without an organic basis through the therapeutic use of the doctor-patient relationship"—by which Shorter means a paternalistic one based on the assumption of the doctor's authority and the patient's unquestioning trust.46 This is the basis of Hutchison's confident recommendation of placebo for hypochondria. Yet even Robert Burton in the seventeenth century could recognize the educational effect of serious hypochondria, a determined effort to learn about medicine in order to be one's own patient, that made the man who believed he had frogs living inside him become a doctor because none of his own doctors believed him. Or Molière's Argan whose attentive doctors have given him what passes for a medical education. This amateur expertise, rejected by defensive professionals as both presumptuous and erroneous, may be another transhistorical characteristic of hypochondria.

Shorter attributes the increasing power of "subcultures of hypochondriasis" promoting skepticism about mainstream medicine to "the tremendous loss of prestige the medical profession has endured in the last 30 years, which has entailed the loss of one of the most precious therapeutic components of the doctor-patient relationship: the ability to reassure."47 Given patients' current "adversarial stance," he asks, "what sufferer could possibly find solace in the physician's cautiously optimistic prognosis?" Perhaps contemporary communal hypochondria is, then, the culture-wide expansion (or epidemic, depending on one's perspective) of the hypochondriac's inherent curiosity about medicine, a curiosity resistant to the mystifying reassurances of paternalistic expertise.

Arthur Barsky described, in 1988, what was happening as this curiosity became the norm and "new self-diagnostic kits, the imperative to educate oneself about the body, and the self-care movement" were all intended to turn patients into "autonomous medical experts who will never require a doctor's skill or assistance" (223). Barsky observed the effect of this "trend toward patient autonomy" on clinical relationships: "in the decline of the physician's authority and our increasing mistrust of him" (223). "Dependence upon doctors," Barsky observes, was coming to be seen as "distrustful and dangerous" and this led to defensiveness: "when people do become sick and have to defer to a doctor, they enter the hospital accompanied by patient advocates who stand at the ready, asserting their protection under the Patient's Bill of Rights" (223).

Barsky notes that this inability to submit to medicine's authority comes at a high cost to the patient, and that such relative autonomy is now a fact of Western patienthood: "being a patient is far more demanding and more exciting than it was. You acquire more factual information about your illness, learn to manage it, and observe and regard yourself in a clinical fashion. To the burdens and fears of being ill have been added the responsibilities and duties of being your own physician." Molière's early modern parody of the ill-qualified hypochondriac-physician comes full circle in this new postmodern reality.
Hypochondria's radiographic ghost-image history of medicine reveals not a consistent progress but a turbulent series of negotiations over authority and knowledge, as well as over hopes and fears, regarding our living (and eventually dying) bodies. The anatomical site of hypochondria has moved from the spleen to the brain, its matter from black bile to serotonin, but we can see now that the real constant is in the way doctor and hypochondriac struggle over the patient's body and what can be told—known and narrated—about it. This struggle and the body at its center are given their vocabulary and form by the biocultural contexts that determine meaning for physicians and patients alike.23

Hypochondria's doubt has perhaps always been an emulsion of the two minds at work on the patient: the doctor for whom the body must be object of a knowledgeable gaze, and the patient for whom it must be locus of self-defining experience. Hypochondria therefore transgresses the boundary between authoritative doctor and compliant patient. The redrawing of that boundary came with all the other rebellions of the 1960s and 1970s and has been secured by the information revolution of the past few decades. As a result, hypochondria proliferates as a cultural and epistemological position that is, as David Morris almost concluded, "the distinctive postmodern illness."44 As such, and this is probably the biggest difference between hypochondria now and then, it has become as much the doctor's disorder as the patient's. No longer the Romantic hypochondriac's resistance to a new panopticon of the clinic and public health, it has become modern medicine's own internalized resistance to the vertiginous threats and promises of postmodern illness.

3

Swimming in the Dark

The Hypochondriac in the Body

The body is a curious monster, no place to live in, how could anyone feel at home there?
—Katherine Anne Porter, Pale Horse, Pale Rider

The body is a part of the mind.
—Kathryn Montgomery Hunter, Doctors' Stories

John Diamond, a hypochondriac whose anxious efforts to give up smoking almost certainly led to the cancer that would kill him, describes a direct encounter with his tumor. After most of his tongue has been surgically removed, Diamond asks the pathologist to show him the specimens. He looks first at slides from the early cyst biopsy, mostly normal but peppered with a few "black spots," the scattered cancer cells that have migrated from a primary tumor somewhere else. Then, he sees a biopsy section from the lump on his tongue: "it was all cancer." He finds this almost reassuring, because the simple fact of these cells' visibility means that they will not be the ones to kill him: "It was out of me now: by that definition alone these weren't the killer cells even if there were some killer cells still around." Finally, he confronts the excised primary tumor itself: "a grayish lump of rubbery matter" (181–182). It, too, is now harmless. But the cancer that is still killing him remains hidden within his body.

The full title of Diamond's cancer memoir is Because Cowards Get Cancer Too: A Hypochondriac Confronts His Nemesis. The subtitle describes both its author's lengthy reckoning with disease and also, I think, his particular and physical confrontation with the cancer itself. This direct meeting between the patient's mind and the pathology of his body, made possible by medicine but certainly no typical clinical event (the pathologist says Diamond is the first patient ever to ask him for this access), is an extraordinary realization of the crux of hypochondria, its material substrate, the content of its fears and doubts: the body itself.

After learning that a benign cyst on his neck contained cancer cells, Diamond underwent extensive radiation in the hope of destroying the source of those cells, the primary tumor, which no one had been able to find. When he develops a slight cough, a nasendoscopy is done, but the doctor reports that the camera