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THE HIDDENNESS OF PSYCHOLOGICAL SYMPTOM AMPLIFICATION: SOME HISTORICAL OBSERVATIONS

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Nicholas Kontos' contribution to this volume is provocative, for a number of reasons that I will develop below. As I understand him, he has three main goals. The first goal is to articulate the theoretical possibility and clinical reality of what he calls "psychological symptom amplification" (PSA). The second goal is to ask why PSA is so hidden from clinicians and psychiatric researchers. The third goal is to indicate the negative consequences, for patients and clinicians, of failing to recognize PSA.

What is PSA? As he puts it, psychological symptom amplification takes place when patients present symptoms to clinicians that they do not actually have, or, perhaps more commonly, they exaggerate symptoms they do have. Crudely put, PSA refers to the situation in which a patient thinks "there's something wrong," but, in fact, there's "nothing wrong" (or, alternately, the case in which there *is* something wrong, but it's different from, or not as bad as, what the patient thinks is wrong). There is no implication of intentionality here. A man who likes to keep a tidy kitchen says that he has a touch of OCD. A woman who is down about a recent job loss says she's depressed. People who get nervous before making presentations believe themselves to be afflicted with anxiety disorders. Someone with occasional mood fluctuations wonders if he's bipolar. Too often, clinicians are only happy to validate the patients' erroneous interpretations of their problems. PSA is, as he puts it, the "psychological analogue of somatization."

In the following, I'm going to focus on the second problem that Kontos tackles: why is PSA so unrecognizable? Why is it so hidden? Kontos provides a number of reasons why PSA has evaded the kind of clinical and research scrutiny that it deserves. In my view, the "hiddenness" of PSA has deep historical and institutional roots. My argument, in a nutshell, is this: A major transition that took place in American psychiatry in the 1970s was the transition from seeing the symptoms of mental disorders as (typically unconscious) *strategies* deployed by patients for coping with unpleasant situations, to seeing those symptoms as the outcome of inner *dysfunctions*, nothing more. But in order for the clinician to recognize PSA, he or she must, as Kontos notes, look at the patient's reports as the outcome of a kind of unconscious "strategy" for obtaining the benefits of the "sick role." To recognize PSA, then, the clinician must adopt a way of seeing that has been effectively abolished in American psychiatry. So to begin to recognize PSA where it occurs, we have to unearth the complex play of historical and institutional factors that tend to obscure it. I'll begin with Kontos' observations and then develop my historical points.

Kontos notes that there are a number of obstacles that prevent a clinician from recognizing that the patient's presented symptoms are exaggerated or nonexistent. There are additional obstacles that prevent the clinician from telling the patient the same. First, medical students in psychiatry are trained to assume that, if a patient presents with some complaint or another, then the patient must have a mental disorder. The clinician's job is merely to figure out what it is. As Kontos puts it, "medical school primes the pump of pathologizing bias." Students are not trained, first and foremost, to pose the following question: *is* there, in fact, anything wrong? And is it possible that the symptoms are exaggerated or that the patient is misinterpreting them? Second, clinicians naturally want to help alleviate distress and suffering. If the clinician

realizes that prescribing an anti-depressant or anti-anxiety medication might alleviate the patient's distress, then that provides a strong incentive to do so, irrespectively of whether the symptoms do, in fact, satisfy the criteria for a specific mental disorder.

Third, and most generally, one reason that PSA is hard to see is because of the very general process of "medicalization." Very roughly, "medicalization" takes place when a certain kind of problem goes from being what Thomas Szasz famously called a "problem in living" to a "medical problem." The process of medicalization has been, in some ways, very positive for society as a whole. Patients who struggle with depression, anxiety disorders, or other major mental disorders feel less stigmatized about consulting a clinician and getting the help that they need, because they recognize that they have a bona fide medical issue. They don't have character defects or moral failings. "Medicalization" isn't a pejorative term. Yet for all the benefits that medicalization has brought, it also has its downside. It fosters PSA. People who don't actually have psychiatric problems turn up to clinicians in droves and believe themselves to be entitled to the same sorts of benefits that they see others enjoying. Being sick is not entirely without benefits! Kontos writes, "for [PSA] to have any staying power in an individual…there must be a perpetuating force available. What a person stands to gain from what otherwise appears to be bafflingly persistent suffering, must be examined in any consideration of symptom amplification."

This claim – that PSA is hard to see because of the process of "medicalization" – is roughly correct, though it suffers form a certain degree of vagueness. This is perhaps due to the overuse of the term. Since the 1970s, clinical psychologists have lamented the degree to which professional psychiatrists in the United States have "medicalized" everyday problems. Historians routinely describe the complex transitions that took place in American psychiatry in the 1970s in

terms of the imposition of the "medical model." We all recognize that the third edition of the DSM, the DSM-III of 1980, signaled a fundamental change in the way that psychiatry is practiced in the United States, and that the change had something to do with "medicalization." So what is this "medicalization," and what exactly took place in psychiatry in the 1970s that the term "medical model" is supposed to denote?

I'm going to suggest the following account of the transition that American psychiatry passed through in the 1970s. This is a transition that culminated with the publication of the DSM-III in 1980, and that makes PSA so hard to "see." I believe that what was most distinctive about this transition was that American psychiatrists went from seeing mental disorders as (generally unconscious) *strategies* to seeing disorders as *dysfunctions*. In other words, prior to the 1970s, many psychiatrists considered mental disorders to represent, at base, *various strategies that people deploy, unconsciously, to cope with unpleasant situations*. Mental disorders possessed a teleological dimension. They were "for" something. The characteristic symptoms of mental disorders represented the working out of various strategies to resolve, or deflect, or live with, unpleasant situations. There was no implication that these "strategies" were consciously selected. Nor was there an implication that these "strategies" were successful. In fact, they were typically unconscious, harmful, and counterproductive. As the American psychoanalyst Harry Stack Sullivan (1962, 8) put it, the clinician's job reduced to the following: "We must understand what the patient is trying to do."

A few examples will suffice to demonstrate the point. Freud's own psychoanalytic theories need no introduction. For Freud, dreams, slips of the tongue, and neurotic symptoms all represented distorted fulfillments of repressed desires. Consider Freud's account, in 1917, of a young woman's protracted and compulsive bedtime routine, which involved arranging her

pillows in a diamond-like shape (Freud 1966, 327-333). In Freud's view, her ritual was nothing more than a symbolic fulfillment of her wish to usurp her mother's place. The distortion, moreover, served the goal of preventing herself from becoming aware of the true nature of this desire. So, compulsions played various functions in her psychological economy. They represented the working out of a certain strategy. They were goal-driven and goal-directed.

The point here is not that Freud was right, or that we should bring back his form of psychoanalysis. The point is that Freud's work exemplified a type of reasoning that had a remarkable staying power throughout the first half of the twentieth century, namely, that symptoms of psychiatric problems represented a kind of strategy that the patient was adopting for dealing with something. A few more examples will suffice to illustrate that this concept of disorder-as-strategy was not merely a Freudian preoccupation.

The psychoanalysts who came after Freud also adopted this perspective, even those that differed significantly from Freud. Harry Stack Sullivan (who I noted above) was largely responsible, in the 1920s and 1930s, for the attempt to carry Freudian insights from the clinic to the asylum, and to use psychoanalysis to illuminate, and treat, schizophrenia. Sullivan was well known for emphasizing the social dynamics of schizophrenia, that is, the extent to which schizophrenia was an interpersonal disease. What is important for my purposes is that he viewed schizophrenia within a teleological framework. In his view, catatonic-type schizophrenia represented a regression to an earlier stage of psychological development. The function of this regression was to enable the patient to better incorporate distressing life experiences into his or her personal narrative (Sullivan 1962, 20). Again, the point here is not that Sullivan was right or that we should follow in his footsteps. The point is that he saw schizophrenia as a strategy, albeit

a dangerous one, that people used to deal with specific problems. The patient was actively, though unintentionally, "conspiring" with his or her illness to "get a job done."

In the 1930s and afterwards, figures such as Wilhelm Reich (1972) and Anna Freud (1946) developed psychoanalytic theory substantially (before Reich's expulsion from the International Psychoanalytic Society) through the study of human character traits. A crucial idea here was that personality types, mannerisms, or even bodily postures could represent mechanisms for defending the ego against id impulses as well as for "interfacing" with other people. Reich referred to these mechanisms as "character armor" and summarized his view concisely: "…the neurotic character traits as a whole prove to be a compact *defense mechanism* against our therapeutic efforts, and when we trace the origin of this character "armor" analytically, we see that it also has a definite economic function (48)." For Reich as well as Anna Freud, the elements of human character, even pathological ones, represented strategies for negotiating between the demands of the id, on the one hand, and the demands of the outside world, on the other. They were goal-directed and teleological.

In the 1950s, one of the most well-known theories of schizophrenia was the "double-bind" theory (Bateson et al. 1956). In this view, symptoms of schizophrenia such as delusions and disorganized thought represented mechanisms that people used for the purpose of resolving what the psychologist Gregory Bateson and his colleagues called a "double-bind" situation. In their view, as a child the patient was repeatedly confronted with a kind of "lose-lose" situation (typically imposed by the mother) in which any coherent response would be penalized, and which forced the patient to adopt more radical solutions, such as delusions and incoherent speech. Again, nobody wishes to return to the stigmatizing idea of the "schizophrenogenic" mother whose terrible nurturing practices drive her kids crazy. The point I am making is that,

throughout the first half of the century, many psychiatrists took it for granted that symptoms of various mental disorders represented strategic moves in a complex puzzle that the patient was trying to solve.

Finally, the American Psychiatric Association (APA), in the first edition of the DSM, canonized this view that mental disorders of different stripes could be understood as coping mechanisms. They were seen as goal-driven and goal-directed. In that manual, the APA recognized three major types of non-organic mental disorders: psychotic, psychoneurotic, and personality disorders. Crucially, it depicted *each type* as representing a different sort of strategy for resolving inner psychological conflicts. The psychotic reactions are those in which, "the personality, in its struggle for adjustment to internal and external stresses, utilizes severe affective disturbance, profound autism, and withdrawal from reality…" (APA 1952, 12). Psychoneurotic reactions are defined in terms of the various mechanisms that the patient uses to combat anxiety, such as depression, phobias, and compulsions (ibid.). The personality disorders take place when the patient "utilizes primarily a pattern of action or behavior in its adjustment struggle…" (Ibid., 13).

Not everyone viewed mental disorders as strategies. For example, Emil Kraepelin, that pillar of the "medical model," believed that many mental disorders could be understood as diseases of the brain or nervous system or as hereditary conditions. The idea that they represented strategies for coping with psychological conflicts was almost absent from his viewpoint. Almost, but not entirely! Kraepelin himself recognized that certain symptoms might represent the working out of a strategy deployed by the patient. For example, in his discussion of acquired neurasthenia, he tells us that chronic invalidity can, in some cases, represent a strategy for perpetuating the sick role and acquiring its associated benefits. In the most extreme cases, he

tells us, "the patients tend to become chronic invalids of a most distressing type…They betake themselves to the seclusion of a charitable institution with its freedom from annoyances…The increasing demand for sympathy leads to prevarications and to various assumed contortions, in order to assure the physicians or friends that they are in critical condition" (1912, 152-153).

All this changed in the 1970s, with the process that led to the publication of the DSM-III. The story has been told elsewhere; I will summarize it very briefly here (see Garson 2015, Chapter 8, and references therein). The APA was in the midst of several conflicts. Within the ranks of the APA itself, biologically- and behaviorally-oriented psychiatrists were in conflict with psychodynamically-oriented psychiatrists (as well as with clinical psychologists associated with the American *Psychological* Association). The APA was also engaged in an ideological battle with the so-called "antipsychiatry" movement, which saw mental disorders as mere "problems in living," or as social deviance. As a strategy for responding to their critics, powerful individuals within the APA, notably Robert Spitzer and Donald Klein, worked tirelessly to promote a certain framework for thinking about mental disorders, namely, the perspective of disorder-as-dysfunction. This perspective was canonized in the DSM-III as part of a working definition of "mental disorder" itself (APA 1980, 6).

One of the consequences of the ready adoption of this viewpoint was that what I'm referring to as this teleological framework for thinking about psychiatric problems was effectively abolished. Psychiatric symptoms were simply the result of various sorts of "behavioral, psychological, or biological dysfunction[s]" (ibid). Just as there's no sense in which cancer or diabetes represent the "working out of a strategy" on the part of the patient for accomplishing some unconscious goal, neither do mental disorders (which are, after all, merely physical disorders that manifest in a special way in the mind). This framework, for better or

worse, persists to the present day. For example, recently, some psychiatric researchers have been advocating for a transition from the DSM system of classification to a new system of classification, the Research Domain Criteria (RDoC), promulgated by the National Institutes of Mental Health (NIMH). Advocates of RDoC, however, still insist, as loudly as ever, that mental disorders boil down to inner dysfunctions (Insel et al. 2010, 748).

What does this transition – from disorder-as-strategy to disorder-as-dysfunction – have to do with PSA? As Kontos points out, the ability to recognize the existence of psychological symptom amplification requires the ability to detect when the patient is enacting a certain strategy. Namely, it requires seeing the symptoms, or reported symptoms, as movements within a certain strategy for accomplishing a specific end. In a line that's reminiscent of Sullivan, Kontos tells us that, "what a person stands to gain from what otherwise appears to be bafflingly persistent suffering, must be examined in any consideration of symptom amplification." This is the point that Harry Stack Sullivan made: we must understand what the patient is trying to do. But this is precisely a way of seeing that has become a piece of heresy in professional American psychiatry, as represented by the APA and the NIMH. It requires seeing the patient as an active, goal-directed, goal-seeking, agent, and potentially as an unwitting conspirator to the illness. And that's something that we rarely do anymore, for two reasons. The first reason is that we've learned to see symptoms as the expressions of inner dysfunctions, and nothing more. The second is that we're concerned, rightfully so, with the threat of stigma.

We've made extraordinary progress in de-stigmatizing mental disorder. Part of the process of de-stigmatizing mental disorder has involved changing the public perception of what it means to have a disorder. Specifically, as Kontos emphasizes, people who struggle with psychiatric problems are not malingerers. They're not making some kind of illegitimate bid for

the benefits of the "sick role." They're not social parasites. This change in perception has led to huge benefits for society and for people with mental disorders, unquestionably. To suggest that a person reporting symptoms is engaging in a certain strategy for obtaining certain benefits raises the specter of stigma. It's a delicate matter. But there are other ways of avoiding or minimizing the threat of stigma than to simply ignore the possibility of PSA.

In light of the threat of stigma, I should emphasize here that nothing in the view of psychiatry that I've laid out, where mental disorders are seen as having a strategic or teleological dimension, should be an excuse for stigma. First, not all mental disorders have this feature. Some mental disorders probably should be described simply and solely as the result of some sort of inner dysfunction. Second, when we talk about strategies, there is no implication of conscious intentionality. The idea is not that these are consciously pursued. Third, people who exhibit PSA very often do have genuine psychiatric problems – just not the ones they believe themselves to have. Finally, people who exhibit PSA are often themselves victims of misinformation. Seeing PSA where it occurs requires promoting public education about the nature of psychiatric problems. It's not that people are trying to dupe the system by pretending to something they don't have.

In short, I think Kontos should be applauded for facing up to a phenomenon that, owing to deep-rooted institutional and historical facts, often goes unnoticed. My goal here has merely been to complement his analysis by drawing out some very general historical observations about recent transitions in American psychiatry that contribute to making PSA so hard to see.

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