

IS THERE HEALTH IN WELLNESS?

Susan Levenstein, MD

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When I was in medical school, the reigning approach to the patient combined the paternal, the veterinary, and the priestly: interrogate, palpate, pontificate. Bleak diagnoses were veiled in fibs, and treatment was assigned by fiat. Even bringing up the question of compliance was a dangerous move in the direction of fostering patient autonomy. An exception that proved the rule was made for diabetics, who, our instructors told us with some distaste, had to be “made partners in their own care.” The major health risk behavior we were aware of was shooting heroin, and we knew better than to waste our time trying to “modify” it; our closest approach to admitting the relevance of psychological factors was in sniffing out crocks. Diseases were caused by germs, bad genes, or the ravages of an imprudently long life span. It being the early 1970’s, we students disputed this reduction of the patient to an anonymous carcass, but our achievements were often in practice limited to dawdling a little longer over the social history.

Twenty years later, everything has changed. Diagnoses and prognoses are disbursed in painstaking not to say merciless detail, cancer patients choose their own chemotherapy regimens, and diseases are mostly caused by stress — even the common cold, it says so in the *New England Journal of Medicine* (1) — or by lapses from correct living. The alternative medical therapies used by 1/3 of Americans (2) have their own Office at the NIH; half the territory of the State of California is occupied by holistic health spas. The fields of medicine are occupied by the armies of the biopsychosocial model. We have won.

Or have we? Can we rest on our laurels? Certainly the very existence of that loose agglomerate of thinkers and practitioners that the late Aaron Antonovsky referred to as the “well-being movement”¹ represents a welcome blossoming of valuable concepts that two decades ago were avant-garde. But, alas, some things are wrong with this picture.

1) Impact on theory

As much as traditional medicine ignores the individual’s potential for prevention and self-healing, so many purveyors of the “mind-body” approach exaggerate it, downplaying physiologic causes. Their resulting crude psychological reductionism hampers its proponents’ capacity for subtle etiologic understanding — just at the moment, ironically, when the monomaniacal kind of reasoning that attributed ulcers to frustrated oral needs (and Down’s syndrome, alas, to mothering defects) is being definitively abandoned by psychoanalysts. In actual fact we know as yet very little about why most diseases originate, fluctuate, or remit. Patients with lactose intolerance have to thank their lucky stars that a few inquisitive physicians refused to knuckle under to the hegemony of psychology over

¹Professor Aaron Antonovsky’s work in furthering a paradigm shift from pathogenesis toward salutogenesis (3) gave him fair claim to be one of the fathers of the “well-being movement,” but he took his disciples to task for looking toward the inner environment as the ultimate source of all disease and the privileged locus for health-promoting interventions (4). My own critique takes off from his.

“irritable bowel”-type symptoms.

Reductionism and a sense of cozily shared assumptions risk being reflected in methodologic sloppiness in the exquisitely vulnerable field of psychosomatic research. The difficulties specific to this sphere — e.g. the tendency of sick people to try and explain their disease, which contaminates all cross-sectional studies — should push us to be more rather than less rigorous. For example, physicians and patients alike are convinced that stress leads to flare-ups of ulcerative colitis (5-7), bolstered by a vast retrospective and anecdotal literature, but the few prospective studies with any scientific validity have been surprisingly negative (8-10).

It's easier to take the lazy way out with a monocausal explanation for all ill-health. Convictions about the truth of the biopsychosocial model and enthusiasm for healthy living and self-healing must not blind us to the complexities of etiologic pathways.

2) Impact on medical practice

We have reached a point where patients and physicians alike dream up psychological or behavioral components in every pathology from hepatitis to hangnails. This would be merely a touch of Aquarian local color if it weren't for a dead-serious corollary: blaming the victim. The patient cursed with pancreatic cancer must have enjoyed too many coffee breaks, the one with colon cancer didn't eat his vegetables, and if that woman with Crohn's disease had only stood up to her mother she wouldn't have lost half her bowel. In reality not more than a few percent of the variance in disease prevalence has ever been explained by such factors. People with serious illnesses have enough trouble as it is. Here I think old-fashioned psychological reductionism is being cross-fertilized by the puritan American version of the Protestant Ethic.

3) Impact on lifestyle

I hope not to pass for an apologist for couch potatohood, the use of insecticides as table seasoning, or cigarette smoking. But I begin to fear that the no-holds-barred probing of the health effects of any activity before engaging in it has begun to be carried to the point of self-parody. Some Americans seem driven by the goal of achieving a fussy, narcissistic state of healthier-than-thouness, while others are paralyzed by a fear of living which can reach near-phobic proportions — *sans* sex, *sans* sun, *sans* salt, *sans* everything — avoiding risk-taking literally like the plague. I met a young couple who had chosen their hometown according to the relative merits of its water supply. Surely this glorifying of life in a bubble involves a generalized washout of the richness as well as the filth of our lives, and the late-breaking reaction to it is no surprise: the newspapers confirm my clinical observation that college kids are taking up smoking again, and homosexuals are returning to unprotected anal sex.

4) Impact on health policy

The well-being movement has a tendency to ignore social causes of disease in favor of individual ones, honing in exclusively on so-called health risk behaviors. For example, the plummeting incidence of coronary artery disease often gets attributed solely to changes in dietary and smoking habits, while the important role of hypertension detection and treatment is downplayed. This is partly, I think, because the treatment of hypertension is more doctor-dependent than self-directed; also, possibly, because it is too painful to probe the roots of the ludicrously high and racially skewed prevalence of hypertension in our society.

The emphasis on lifestyle changes can contribute to disregarding a need for social remedies, making it easier to justify shortchanging the societal level of prevention (e.g. decreasing noise and pollution) or treatment (e.g. improving access to medical care by removing

financial barriers and guaranteeing the availability of services).

5) Impact of filthy lucre

This leads into another danger: the contamination of both theory and practice by economic motives. Drug treatment of hypertension is not only less “self-healing” than quitting smoking, it also costs more. Medicine is expensive, meditation is cheap; how much of the interest in stress management clinics is generated by the hope that a sprinkling of their holy water will keep “high-utilization” patients with irritable bowel syndrome from draining the insurance companies’ coffers? And the subtle applications of this principle can be still more insidious: after using as an opening wedge the laudable aim of not keeping women unnecessarily cloistered in hospital after childbirth, insurance companies have by now limited their payment policies to the point where an exhausted new mother may be kicked out willy-nilly after 24 hours.

6) Polarization of the medical community

In the face of the upsurge in holistic medicine, the chasm between the mind-body school and the dominant medical model may, paradoxically, have widened. There is a danger that humane, holistically-minded individuals, finding a home in the well-being movement, will give up on affecting the medical mainstream — a dichotomization between touchy-feely practitioners and traditional ones who become harder- and harder-boiled. Three-quarters of the people who used alternative treatments in the *New England Journal of Medicine* article (2) hadn’t told their allopathic physician, and you can bet that includes many of your patients with inflammatory bowel disease. This phenomenon risks widening the gap between the human and the technological sides of medicine rather than improving integration of the two.

It is my impression, for example, that to the plethora of psychologists, counselors, spiritual guides, and other offers of talk therapy has corresponded a progressive narrowing of the focus of psychiatrist-patient interactions to symptom recitation and drug prescription. Similarly, the response of gastroenterologists to the discovery of *Helicobacter pylori* has been to immediately discard with relief any residual notions they may have had of a role for stress in peptic ulcer — although the failure of ulcers to develop in the vast majority of *H. pylori*-infected individuals practically screams for the existence of other co-factors. One may dare to hope that this philistinism is a temporary digging-in-of-heels phenomenon, belonging to an old guard destined in the end to fade away, rather than an enduring entrenchment of the hard-nosed home team versus the soft-bellied invaders.

Living outside the United States, in a Mediterranean country where a peasant legacy of fitness and healthy eating has never died out, I’m tempted to attribute some of the shortcomings as well as the strengths of the “well-being” movement to the lack of an anchoring tradition in the United States to keep the pendulum from swinging too far, too fast. I call it the 180° rule: if a car is not a gas guzzler it’s an electric two-seater, and if breakfast isn’t bacon and eggs it’s carrot juice.

The forward march of mind-body medicine, and the growth of the well-being movement, represent a step forward for the conceptualization of the health-illness continuum, for the understanding of disease etiology, and for the discovery of new tools for health maintenance and disease treatment. Yet its emphasis on internal causes and therapies should not be allowed to detract mental and economic resources from the equally difficult causes and therapies outside the realm of lifestyle. To put it another way: Gandhi was a man of God, but when he wanted to get the British out of India he didn’t rely on prayer alone.

Abstract

In the last twenty years patient autonomy has vastly increased and a “well-being” movement has flourished, with great benefits but with definite drawbacks as well. Exaggeration of the individual’s potential for prevention and self-healing can foster a crude psychological reductionism which hampers potential for subtle etiologic understanding and may weaken research, as well as creating a tendency to blame the victim. Probing of the health effects of any activity before engaging in it can lead to healthier-than-thouness and a fear of living. The well-being movement tends to ignore social causes of disease in favor of individual ones and therefore to disregard a need for social remedies. Both theory and practice can be contaminated by economic motives: medicine is expensive, meditation is cheap. The chasm between the “mind-body” school and the dominant medical model may have widened as some holistically-minded individuals, finding a haven in the well-being movement, give up on affecting the medical mainstream. Thus the advance of mind-body medicine, and the growth of the well-being movement, have aided in conceptualizing the health-illness continuum, in understanding pathogenesis, and in discovering new preventive and therapeutic tools, but their emphasis on internal causes and therapies should not be allowed to detract resources from the equally important ones lying outside the realm of lifestyle.

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