Concluding discussion

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by

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The concluding discussion of the symposium The Environmental Syndrome — Psychosomatic Experience Induced by Environmental Factors was held as a tribute to Professor Georg Klein, a distinguished scientist, cancer researcher, philosopher, and writer. The intention was to make possible a discussion where the experts in the field of psychosomatic disorders could approach the aspects presented by a scientist of molecular biology and cancer research—fields of medicine which are as far as possible from psychiatry. On the basis of his own life experiences, Professor Klein can be regarded as a person who has overcome experiences, which, for most people would lay a foundation for profound psychosomatic symptomatology. His cultural background and his way of coping, however, illustrate how such experiences can be converted into strengthening of the mind, into intellectual advantages and into heightened creativity. The discussion commenced with an interview, in which Professor Edward Shorter, a leading medical historian with special interest in psychosomatics, through his questions to Professor Klein, helped recreate a vivid picture of the background of one of the great personalities in today's medical science. From this the participants were able to see how positive and negative stressors act in the formation of personality.

Shorter. We have spent an intensive day and a half discussing some very important questions. One of the questions is: "What is psychosomatic illness", and I think there probably is a general consensus that it represents a breakdown in the mind–body relationship. There have been various efforts to compartmentalize it into distinctive diagnostic categories, sort of like drawing lines in water; they all blur together again, and it becomes a phenomenon in which it is very difficult to create subdivisions that last. As we hear of the various diagnoses that have brought us together, such as multiple chemical sensitivity, we realize that most of these diagnoses have the same symptoms. When we think about psychosomatic illness, I am sure most of us would agree that we have to distinguish between the symptoms themselves and the illness attributions that individuals bring to their own explanations of what they have. Of course the illness attributions may be very different from the symptoms themselves. The symptoms are socially determined to some extent, the illness attributions tend to be mediatized or given to us by the media. The environmental syndrome, which has brought us here, is probably a good example.

How about the causes of psychosomatic illness? Here it pains me to report that there is disagreement: Some of us would stress social factors such as unemployment in Finland and Sweden. Others might stress some kind of underlying genetic predisposition or constitutional factor. In a certain sense one is born into risk. The French have a wonderful expression for this; they call it "personalité fragile"—fragile personality—an exquisitely constitutional condition.

Finally, what is there to be done about psychosomatic illness. For an audience consisting overwhelmingly of physicians, this is an important point. There will be a general consensus that some kind of therapeutic use of the doctor–patient relationship itself is indicated. Professor Simon Wessely spoke very eloquently about this: how he, as a psychiatrist, tries to use the doctor–patient relationship itself to manage these very difficult multiple chemical sensitivity patients. Dr Lynn Getz gave us an overview of the kinds of approaches that might be indicated. So, clinically I think there probably is something of a consensus on what is to be done, that is, to let the physician permit his or her humanity to shine through in a systematic manipulation of the doctor–patient relationship.

In social terms, what is society to do? This is a large agenda indeed, as we talked about the role of social and cultural modeling of psychosomatic illness, particularly modeling on the part of the media. The media mold people into certain kinds of illness behavior. And this kind of molding is something that the diagnosis of chronic fatigue syndrome or multiple chemical sensitivity does in a formidable way. Professor Klein, these are some of the issues that we have talked about, and I am delighted you can be with us this afternoon to tell us what you think.

Klein. Thank you for the invitation, and thank you for this challenge. First of all, I have to disclaim any knowledge of your field. I am totally ignorant of the topics you have discussed, and all I can respond with is to ventilate my own subjectivities. Perhaps you can regard me as your guinea

pig in a way. Maybe I should start by speaking about the work of a Hungarian-American psychologist, Professor at the University of Chicago, Mihály Csikszentmihályi. He has developed the concept of "flow", and I was very strongly influenced by his concept. Not that I have modeled anything after this concept, but rather I have discovered in myself what he describes.

The concept of flow was developed by him when he did his doctoral thesis some 25 years ago on art students. He then noticed that there was a minority of students who, while they were painting or sculpting, totally forgot their environment. They lost sense of time. They concentrated on the work as if nothing else existed in the world and they looked very happy. As soon as they finished their work they threw it away. They were not interested in whether they could sell it or whether they could advance in their studies. They just wanted to go on to the next work.

He then noticed a similar unity of these three attributes, namely, timelessness, concentration and euphoria, in a variety of fields. The mountain climber standing on a cliff in a dangerous situation, which he, however, masters both physically and psychologically; or the ballerina in the air during her 15-second perfect pirouette; or the vascular surgeon who works under the microscope for 9 hours, not noticing that it is 9 hours. They are in flow.

He describes this condition as oscillating between states of anxiety and states of boredom. When we meet a challenge that is above our ability, we feel anxious, when it is below our ability, we are bored. Flow arises when there is a meaningful challenge, when we feel we "can do it". He found the oldest description of flow in a 4000-year-old Chinese document, where a butcher describes his incredible enjoyment of his own professional skill as he is cutting up an ox.

Children seek flow. Their play is a continuous seeking for flow—and then we teach them to sit down to be serious and forget about it.

Professional people, who often have to do routine jobs which are not very interesting, find ways of combining several such things, or increasing the challenge somehow so that it will nevertheless give them flow—a professional jazz player who is to play with amateurs may blindfold himself.

Csikszentmihályi did a study on a group of university students of the English language. He made them write an essay on the same topic. He then measured their subjective state of mind to see whether they were enjoying what they were doing, in other words, whether they were writing in flow or not. He then gave their papers to a literature critic for evaluation, without him knowing about the psychologist's study. He found that the quality of the writing, according to the evaluation, was directly proportional to the degree of flow in those who wrote. So if you write in flow you write better.

I want to mention two more things. One is a study that he has recently done on 100 persons chosen from various walks of life, half of them men, half of them women. The test persons had a buzzer in their pocket that rang eight times a day unpredictably. They then had to answer some simple questions on a tape. Of course they did not know what the psychologist wanted to find out. The essential questions were to find out whether they were engaged in meaningful activity and whether they were using some of their skills or not.

Another set of questions was designed to find out how they felt. Were they happy, optimistic, was life worth living, or were they bored, tired and life not worth living. He found that people who were at their workplace, and actually engaged in work, at the time when they answered the questions, reported flow in 56% of the cases. But people who were relaxing, either at their workplace or any other place, reported flow in only 18% of the cases.

He concluded that flow meant a higher level of challenge and a special skill use that was higher than the average of the same person for the whole week. The difference between the reporting of flow at work and during leisure applies to all worker categories, even those with very boring jobs. For instance, 40% of factory workers reported flow when working, and 20% when not working. Whenever they reported flow they reported a positive state of mind, life was exciting, and they were happy, but they were not in flow when they were bored and tired.

Now comes the paradox. When they were asked whether they wished to have more work or more leisure time in life, 100% of them answered that they wanted less work and more leisure time, although they reported a much happier mood when they were at work. In other words, they do not listen to their own subjective signals, but rather follow the cultural stereotype.

The cultural stereotype forces us to passivity. The commercial world utilizes the cultural stereotype by offering you more and more things that you neither need nor originally wanted, and more relaxation and less work. Everybody will tell you: "Don't stress, relax". I am thoroughly convinced after reading Csikszentmihályi, and from my own subjective experience, that this is a basic and profound fallacy. I wonder again, without knowing anything about your subject, just setting that as a question about the cultural modeling which Professor Ford mentioned, and the influence of the media in fostering psychosomatic illness. They weigh down the mind–body relationship in just fostering that passivity. TV is considered by Csikszentmihályi as the major culprit. Instead of engaging in sports themselves, people just watch sports. Instead of playing music they usually listen to rather bad music, and so on.

Can everybody attain flow or not? Csikszentmihályi says that there are essentially three kinds of people who have difficulties in attaining flow, which he otherwise regards as an absolutely general human property, just like laughing and crying. The three kinds of people that have difficulties in achieving flow are the self-conscious, those who are so concerned about the impression they make on others that they continuously watch their own behavior, the self-centered, those who can only evaluate experience in relation to whether it will serve their own interest, and those who have concentration difficulties and keep watching everything that happens in their immediate environment.

Shorter. Well, why don't we move on to your own subjective case history. Tell us about your childhood and about the attitudes towards illness that prevailed in your household.

Klein. I was born in Budapest in a middle-class Jewish family, and, when I think back to my early childhood, I somehow knew that it was very important for a boy to be very hard working and to achieve something in one or other of the intellectual fields. Now, only later, I understand that this was a very special conditioning that prevailed in this social group, largely as the result of the history during the last two centuries in this particular environment. In the mid-1800s there was a strong liberalization among the Jews in Hungary. Suddenly the Jews, who had recently moved out of the ghetto, and to whom most occupations had been closed until then, could advance in certain fields but not in others. The fields of culture, universities, arts, the worlds of finance and journalism were open to them, but not the traditionally important occupations of the country: not the army, not the civil administration, and not the feudal land owners' category, and certainly not the aristocratic class. This led in the beginning of this century to an extraordinarily skewed distribution of occupations. At this time, there were only 0.1% Jews in the army, and 0.01% in the civil administration, but 40% of the doctors, 50% of the lawyers and 60% of the musicians were Jews. And the world of finance and journalism was similar. So by the time I was born, the mothers had transmitted to their boys this notion which has driven many, many of us.

As for illness, it is clear that you had to be very healthy and strong to go through all this. Those who were weak, submerged or disappeared or met terrible fates. We got the notion from our mothers that there are only two choices for us in life, either to be 10 times better than anybody non-Jewish, because in a comparable situation we would otherwise not get the job, or to go down the drain. There was just nothing in between. So I regard this drive as a demon that I have inherited or acquired. It has been beneficial for those who could put it to some positive use, but it has been totally destructive for those who could not.

Shorter. In many middle-class Jewish households in Eastern Europe there was a climate of anxious hypochondriasis. Many physicians of the time comment on this. In systematic social surveys of the Jewish families, it is suggested that the concern about health is part of the expression of caring and of love within the family circle. I wonder whether you can comment on that?

Klein. I think that my attitude to the continuous exposure to hypochondria, which I have seen all around myself, has been a reaction of fear of hypochondria not of disease, a feeling that I know that there is this danger and I must therefore protect myself all the time. Let me tell you an anecdote on Jewish culture, which wonderfully represents both worlds. The great Russian-Israeli writer, Shlomsky was a hypochondriac. All his life he was afraid of illness and I think he could have been one of your patients. When he died, the greatest Hebrew writer, Shai Agnon, the Nobel laureate, was walking at the funeral with his young colleague Amos Oz, and Agnon turns to Oz and says, "Mr. Oz, he made it! It cannot be that difficult!"

Shorter. You were able to overcome hypochondria. Could you tell us a little bit about some of the subjective sensations of hypochondria you experienced, some of the feelings that you have had in relationship to your body, and the kind of psychological devices you used to overcome those feelings.

Klein. Well, I think these devices came not so much from within myself as from the outside help that I received as a very young teenager. I lived in two different worlds. One was my own intellectual peer group at school. The tradition of interest in literature, poetry and the arts comes not from our teachers, but from our peers. At the age between twelve and fifteen we were deeply immersed in discussions about whatever we read, literature or philosophy, and so on. This was a morbid culture because it was full of decadence and fantasy. We loved Baudelaire and Verlaine, also because they were forbidden. There were three reasons why a boy could be thrown out of school: for having been found in possession of communist literature, in the possession of a condom, and in the possession of Baudelaire or Verlaine. Anyway, that was one world.

Then I became a scout at the age of 12. The scouts were nonintellectual boys and their company was extremely boring, but there was a tremendous emphasis on physical coping. It was very much like what the Finns call "sisu". You had to go on long hikes, had to stand being hungry and thirsty. Our scout leaders, who were in their 20s and 30s, had been able to convey to us this enormous admiration of overcoming and coping. I think that is where I got the influence. Since my father died of heart disease I found myself wondering whether I was going to develop heart disease. But every time, this was counteracted by the scout's spirit. I should say that my ability to escape, and to cope during the Holocaust, and my survival, I can attribute to the scout experience. I can see an at least twice as high survival among the boys of my peer group who were scouts, compared to those who were not.

Shorter. So, if there is a lesson here for physicians who have to face psychosomatic illness, it is the importance of role modeling, because these men gave you very fine role models. Tell us what happened next. How did you get out of Hungary and come to Sweden and did you have some interesting somatic experiences along the way?

Klein. Well, somatic experiences I do not think I really had—except in the opposite direction, but let us come to that.

In 1944, the Germans occupied Hungary. That was the time of the Holocaust; everything changed overnight. I had the great fortune of being among the first people to read the so-called Auschwitz report that two Slovak Jews—Rudolph Vrba and Frank Wetzler—wrote after having escaped Auschwitz alive. At the age of 19 I was the junior

secretary of one of the members of the Jewish council. I was given this report to read in secrecy a few weeks after it had been written in April 1944.

I still remember the emotions I felt. I have them reconstructed because about 4 years ago a film was made about this period and about this report in the same room where I read the report. It is still the same room with the same furniture. The feeling was a combination of nausea and intellectual satisfaction. Nausea because the report, the first eye witness report, is written with scientific precision, in a sort of dry and cold way almost, very characteristic of Vrba's personality and scientific mind with its details, dates of arrival... And at the same time, intellectual satisfaction, because I immediately realized that this must be the truth. Everything else that had been fed until this point, propaganda, resettlement and work camps, could not possibly be true.

Now, I was given permission by my boss to tell about this report in secret to my relatives and friends. The interesting experience was that I found that nobody would believe me, with a few exceptions. Nobody who was in the parental age group would believe me. For them it would have meant leaving their homes, getting false papers, becoming criminal and going underground, and they were not ready to do that. Some people in my own generation believed me, and of course this is what made me escape.

First I was taken to a forced labor camp. There I was in continuous, almost breathless anxiety. Then I managed to escape—I lived in illegality with false papers for 3 months. Every morning I woke up with the knowledge that I may not be alive by night. But I was happy. I was in an incredible euphoria. It was one the happiest times of my life in spite of all the killing going on around me, because I felt that, even though I was risking my life every moment, it was my decision and I had freedom—for a moment.

Then the Russians came. That became a period of frantic work for me. I studied in Hungary at the University until the spring of 1947 and then went to Sweden purely by chance.

Shorter. Tell us, as you arrived in Sweden, already a young man with the print of Central European culture on you, did you find that the attitude of the Swedish population towards health or towards their bodies or towards illness differ from your own?

Klein. Very much, yes! And this was my experience as a medical student. It took some time until I realized that language is not what the dictionary says it is. The words did not have the meanings as I knew them from my language. For instance, if you said in Hungary: "I am dying", it could mean that you had a slight headache. If you said in Sweden "I am not quite well" it could mean that you were dying.

On the whole, tolerance to pain was entirely different. In Hungary one would continuously complain about pain and use the most extreme expressions even with slight discomfort. In Sweden I would find enormously tolerant people. *The Scandinavian Textbook of Surgery*, which I had to read in Sweden, which is written by people from all four Nordic countries, particularly notes that, in the Finnish Winter War, a big difference was noted in the pain tolerance between the volunteers who were born south of the Baltic and those born north of the Baltic. Maybe there is a difference in pain tolerance, but there is certainly a difference in the expression of pain.

There were differences in the doctor–patient relationship as well. I think it was much more distant in Sweden than in Hungary. At the same time it was objective and more correct, I would say. Patients often suffered from this great distance from the doctors.

Shorter. Can you tell us what your subjective reactions were, as a young physician, to your Swedish patients?

Klein. Let me give you an example. When the doctor came and asked the patients on the rounds "How are you", the answers were "Well" or "Not quite so well" or "Not well".

The doctor's usual answer was "I see", and then he went on to the next patient. This was in 1949—1950. I think things have now changed considerably.

Perhaps my most shocking memory goes back to when I was doing pediatrics. A little boy of 5 came with his mother. He had some slight bleeding on his hand, he had been tired and pale. We, the students, made the first blood smears. It was acute leukemia. So we reported to the doctor on duty, and he said "Go and tell the mother that there is nothing to be done. The boy will die"—again, it was 1950. I said "I cannot do that". So he would do it. I went with him and he said "Well Mrs So and So, I am afraid that this is a serious disease". She said "A serious disease? But it is not dangerous, is it?" The doctor says "I am sorry, it is a dangerous disease". Now I learned that in understatement language dangerous means deadly.

There was no emotional reaction; in Hungary there would have been an explosion. A little pause, and then the mother said: "But surely something can be done". The doctor said: "I am very sorry, but there is nothing we can do". Silence, no crying, then the mother said: "But can something be done that he does not have to suffer?" That was the end of the conversation.

When she comes home, she breaks down like any other mother, but she does not show it. This was the most important lesson: that you control your emotions and you do not show them in front of strangers.

Shorter. Did you observe your Swedish colleagues enough to get a sense of how they managed functional illness?

Klein. As far as I know, the somatic doctors essentially disregard it as much as they can, or used to do so, when I was a student. I don't know if that is still true.

The most striking observation was related not so much to somatic illness but to incurable illness. I found that terminal cancer patients were usually forgotten when the doctor went on rounds. Somehow the doctor forgot to see them, or they were treated very cursorily, sort of swept under the carpet. I think that has changed, however. I understand there has been a strong emphasis on the educa-

tion of both doctors and nurses in this regard at the cancer hospitals. The most important task of the psychiatrist is to make the doctor or the nurse face his own death anxiety. Not until he has done so can he face the dying patient.

Stenman. Professor Klein, you referred to the phenomenon of flow, which obviously contributes very positively to creativity and the ability to produce something. We have spoken in this symposium about patients in whom we cannot find anything wrong, but who complain of pain, of discomfort, and who feel themselves very ill. My first reaction when you spoke to us about flow is that the patients suffering from the environmental syndrome seem to suffer from a kind of "negative" flow, preventing them from experiencing their bodily sensations appropriately.

Klein. Yes, or rather from the lack of realization of what potential they have in using the flow mechanism. I asked Csikszentmihályi whether flow is used in psychiatric therapy. He knew of people who were trying it, and he told me an anecdote about a person trying to make contact with patients who had been for decades at mental hospitals. These people are miserable and they do not experience flow at all, and most of them are not in contact with the rest of humanity. But some of them can be reached. Of course the crucial questions are not whether they are well, or engaged in meaningful activity, but rather whether they at any particular point are less unhappy than at other times. There was one lady, who was always a little less unhappy after she had cut her fingernails. And they tried to see whether they could interest her in cutting other people's finger nails. It turned out that she was interested and very skillful. She then was given training as a manicurist. And after having been more than a decade at a mental institution, she could be rehabilitated and got a job as a manicurist. This is just an anecdote, I presume. But there are at least attempts to use the flow mechanism.

Levi. Well, I see two relationships between the concepts usually used in psychosomatic medicine and the story you have told us. One is the component of control. If you are in control, you experience the high load you are exposed to as a challenge rather than as a burden. If you can influence what you are exposed to, if you can change the way you cope with things, it makes a difference to those who cannot.

The second is Kopbasas's formulation of the three Cs: challenge, commitment and control. Does that not come pretty close to flow?

Klein. Yes, I think so. It is probably the same thing expressed in different words. Csikszentmihályi specifies flow as concentration, timelessness and euphoria, the three elements. I think euphoria would be part of it as a secondary consequence.

Boström. We have experiences, Professor Klein and I, from the same time period. I do not defend the doctors of Sweden, but things have changed since we did our basic clinical studies. I do not know whether the Swedish character has changed very much, but, in the training of the present students, these problems are better taken care of.

As far as incurable diseases are concerned, something very important has happened: in most cases we try something. You cannot start with cytostatics to a leukemia patient, or six weeks of radiation to a cancer patient without telling the truth. When we started our careers, I think many of our older colleagues just lied to the patients, and I have a feeling that we were more or less taught not to tell the truth. So there is a big difference and, hopefully, thanks to modern improvements in teaching, I think we are a little bit better than our teachers were.

Klein. I have the same feeling. What is interesting in this discussion is how important the attitudes towards truth or lying are. On that point I am very fascinated by the contrast between the Chinese and the Japanese. I once heard a lecture by the psychiatrist of Sloan-Kettering Memorial in New York, who said that there are essentially two kinds of cancer patients with regard to the attitudes to dying and death: the Chinese and the non-Chinese. All the Chinese, no matter where they are borne, are death-adapted in a way that the rest of the world is not. The Chinese never lie about cancer. Most cancer patients die at home. He attributed this to the tradition of the Confucian order and the large Chinese family, where everybody has his or her given rights and duties, depending on the order in which one is born and on age and on nothing else.

The Japanese are exactly the opposite, although their culture comes from China. They will lie. I have visited cancer doctors dying of cancer, denying that they had cancer, really believing the lies that they were told. Also there is this "never-give-up" attitude. That is why Japan has more cancer quacks and more quack drugs than any other country in the world. Why is this so? The Japanese have kept their warrior spirit, including the suicidal, the kamizake spirit, which the Chinese do not have at all. It is this "never-give-up" attitude that forces a doctor to lie, because, if he does not lie, the patient may commit suicide.

Lamberg. The situation in Finland was very similar to that in Sweden, in fact, after the war when I started my medical studies. But it depended on the doctor, on the teacher. At that time, the situation in the different clinics varied a great deal. So it depended very much on who was the leading person.

I would like to pose a few very simple and trivial questions to Professor Shorter. In the first place, do you make a distinction between psychosomatic disease and psychosomatic illness?

Shorter. No. The term psychosomatic disease does not exist, because by definition psychosomatic illness is without an organic basis. Disease, grosso modo, should be reserved for conditions that do have an organic basis. But you can distinguish objectively between psychosomatic symptoms — or psychosomatic experience, which may be

a lifelong experience — and the patient's representation in his or her mind of that experience. It is the latter that tends to be more hypochondriacal when we talk about things like chronic fatigue or chronic pain and other symptoms when they are in fact functional in origin. Those are then psychosomatic symptoms.

Lamberg. That is clear. Now the thing is that psychosomatic symptoms are a reality to the patient. Years ago, doctors used to say that it is just the patient's imagination. That is of course the wrong thing to say.

Shorter. Firstly, that is the wrong thing to say, and secondly intellectually that is wrong, because for the patients these symptoms are very, very real. There is no question of play acting or anything like that. Whether the symptoms are functional or organic in nature, for the patient they feel exactly the same. This is why psychosomatic illness is particularly challenging for the clinician. If one is trying to be an empathic physician, the temptation is overwhelming to think that there must be an organic basis here, and then to prescribe investigations that are inappropriate or medications that may well be addictive.

So the physician's best humane instincts may lead him or her into clinical error. This is a subjective side of psychosomatic illness that can enmesh both the doctor and the patient. I saw earlier Professor Levi shaking his head. Would you comment on your own views?

Levi. Yes, I would, thank you. The distinction of yours between organic and nonorganic presents some difficulties, because psychophysiologically every symptom has some organic basis. You cannot think without engaging a couple of nerves, can you? So, if you feel uneasy, if you are anxious, if you are angry, it means that something is really happening in your body. What exactly do you mean by "organic" then?

Shorter. The question is whether there is a peripheral lesion of a biochemical or a physiological or an anatomical nature in the periphery of the body.

Levi. Let us look at that as a process. Something scares you. Your heart is beating faster. That is clearly functional, nothing structured has happened to the heart. This goes on for quite a while. The sympathicotonia that has been produced increases the lipolytic activity. More fat is released into the blood and that fat, due to the lack of exercise and to bad dietary habits, eventually clogs your arteries. Well, at what stage do you take the step from functional to organic?

Shorter. That step is taken in the mind. This accelerated heartbeat, etcetera, passes from being a psychosomatic symptom to a psychosomatic illness only at the point when the patient says in his or her mind: "I am sick, I must seek medical help." At that point you have a psychosomatic illness to deal with.

Levi. Then imagine that you have cardiac disease that is very real. You don't know of it and you don't report any symptoms whatsoever. Your doctor, however, tells you that you have heart disease, and suddenly you interpret every signal that your heart sends in terms of health and disease. Is that psychosomatic or is it not?

Shorter. Every bodily signal, every bodily symptom, has some kind of psychological interpretation. It is interpreted in the patient's mind somehow, and that is true in cancer as it is in hysteria. But if we talk about the patient's subjective overlay in cancer, we wouldn't talk about psychosomatic affections, because, by definition, a very real organic lesion is present.

Stenman. There has to be also an opposite situation: when the patient has objectively very severe damage, but either does not experience any pain or suffers greatly. Could somebody comment on that? Professor Klein, if you are in flow, do you have pain experience like other persons then?

Klein. I do not think I can answer that. But I would like to ask from our Finnish colleagues about something that may be related. There is the Finnish term "sisu", which I already mentioned, which is somehow the opposite of what psychosomatic illness is. Also, I have one very intense recollection from my medical studies of a Swedish patient who had asthma, eczema, colitis, and gastric ulcer. He had been sick all his life. I asked whether there was any period when he had been better. He said, yes, there was a period when all his symptoms disappeared and that was when he was a volunteer in the Finnish Winter War, and it was the happiest time of his life. So I would like to ask, first of all, what is the Finnish comment to that, and is there a difference in psychosomatic illness or in the frequency of it that can be related to the "sisu" tradition or motivation in any particular group or is it another thing?

Lamberg. Well, I don't know whether it relates to "sisu", but I think that "sisu" could be defined as a kind of stubborn attitude. Would you agree with that?

Stenman. Yes, I have the same opinion that it is a kind of stubborn optimism that helps you achieve what you are up to; even if you lose, you have won the second prize.

Wessely. Professor Shorter—it is fascinating to hear you talk on psychology, but can I take you back to history? You said two things—first, that you have learned that the essential way of dealing with these problems clinically is to take them seriously, emphasize their genuine nature and so on. That is clinical skill and clinical judgment.

But you also said that the way in which these syndromes finally go is when the word gets out that they are really "all in the mind" and not to be taken seriously. There is a clear irony and contradiction between what is good

clinical practice for the individual, and what you propose would ultimately alter the disease attributions. How are we to resolve this irony?

Shorter. I do not see a contradiction here at all. The physician has a whole bag of psychological tricks for dealing with chronic psychosomatic illness, chronic somatization. It is very important not to legitimate these toxic diagnoses, and there is no doubt that multiple chemical sensitivity and chronic fatigue syndrome are toxic diagnoses, because they cause the patients to become fixated upon their symptoms and to dig in even further so that they acquire a sense of hopelessness.

Now, you do not have to endorse the patient's illness representations in order to treat the patient in a humane and serious way in the patient–doctor relationship. You do not have to contradict the patient. You can diplomatically slide over the illness attributions in silence, at the same time taking the patient's symptoms seriously in other ways.

Wessely. Suppose a transcript of the proceedings here was circulated among a group of patients who believe they have toxic dental amalgam or suffer from multiple chemical sensitivity, it would be clear that the clinicians in this audience would no longer get any patients. Once it was known that they had presumably endorsed the views they had heard at this symposium, that would be the end of their clinical practice. They would no longer be able to do the good things that you have said. So there is a fundamental tension between the public good, and the clinical necessity of treating patients, and it's one that is hard to resolve.

Shorter. The tension is between the need to be effective health care educators and the need to have patients. This is clearly a moral choice, and I am sure everybody in this room would opt for the side of the good guys saying, "Our role as physicians is to educate the vast public, which consists of millions and millions of people, that we are dealing with hocum here, rather than to cling to these few extra patients. We have plenty of patients after all who have plenty of other problems".

Lamberg. I would like to go back to the case that Professor Klein mentioned of the Swedish volunteer soldier who was without any somatic symptoms during the war. This has nothing to do with "sisu", I would say. Could it be just a substitution that he found in the war. He had something else to do, instead of think of himself.

Shorter. This soldier clearly experienced very positive flow as he went about his military tasks. It would be interesting to know on an empirical level, whether the presence of flow militates against becoming psychosomatic. Professor Klein, what are your views on this?

Klein. I do not think it relates to flow, which has to do with meeting specific challenges with abilities. I think it is more of what Lennart Levi was speaking about, when he spoke about coherence. A study of concentration camp survivors showed that there were three categories of survivors who survived significantly better than anybody else: orthodox Jews, orthodox communists and Jehovah's witnesses. The interpretation was that these three categories could put their terrible experiences into context. The orthodox Jew takes persecution for granted, he has his routine of prayers and he focuses on what his religion prescribes him to do, even in the most extreme conditions, and also there is a coherence of the group. Orthodox communists, likewise, took persecution for granted, and were prepared to spend time in prison or concentration camp. And, Jehovah's witnesses were looking forward to the ultimate apocalypse, and this was just one of the holocausts on the way.

Malt. I would like to go back to the flow concept from another perspective. These past days we have discussed some of the psychiatric disorders that have been associated with environmental syndromes. Consistently, at least 50% have some kind of depressive disorder. The research on creativity has for a long time recognized that there is a close association between creativity and manic depressive illness, that is, bipolar disorder. Actually creativity has been described as a kind of state where the person is hypomanic, where there is a kind of free-floating association, where we have the ability to associate different aspects of life that we usually do not connect. At the same time we have periods when we feel a little bit more blue, when we contemplate, ruminate over life and difficulties. These kinds of experiences are used during the hypomanic periods. There is also much evidence from the literature that, what you call flow, has been described as being periodic hypomania. For example, Robert Schumann wrote some of his most beautiful music during such periods.

My question is "Is there some kind of neurobiological relationship between this bipolar type of disorder, having depressive periods, and the environmental syndrome, and the ability to remain in a flow position, so to say, for a time period?"

Klein. That is a very interesting question, one that has fascinated me for a long time. Again you will have to forgive me that I will answer with an anecdote. I once sat next to a great poet at a Nobel banquet. When he saw I was not drinking he wanted to drink all my alcohol, and my wife's alcohol as well. He was an alcoholic but a very great poet. Then my wife asked him, why he drank? He said he has to start in the morning with a few brandies, otherwise he feels anxious. He always has anxiety in the morning. An artist, to whom we told this story, commented "who does not have anxiety in the morning?" I think it is a question of what you do about it. I think that some people learn to use creativity, others use alcohol, still others use both.

Earlier you asked me about my own subjective experience, and you probably thought about my heart operation. About two and a half years ago I suddenly had to undergo a bypass operation. The whole period between diagnosis and operation was five days, so it was very sudden. I asked my colleague, the surgeon who was to operate on me, how

long I would be away from work. He said at least six weeks, probably eight. That is impossible, I said, I have all kinds of things to do, and I asked why do I have to be away that long. He said: "Well you will have tremendous pain, you will feel every morning as if a truck had driven over you. You will be emotionally labile, you will have difficulties concentrating, you may have fits of depression." I did not believe that, because every morning, as long as I can remember, I felt as if I had been run over by a train. I have developed, from early childhood, my own mechanisms. Why? What was the train that had driven over me? It must have been depression, perhaps, because I was always hearing that I lost my father as a very young child. Everybody felt extremely sorry for me. Probably I felt sorry for myself. I do not know, this is just one of many explanations.

But then there was the mother influence saying that unless you become very, very outstanding, you will totally go down the drain. Therefore, whenever that depressive feeling came, usually in the morning, there was also the very strong reaction: "This is terrible danger!" I had to pull myself up by the hair. So in this particular situation with the operation the surgeon turned out to be wrong and I turned out to be right, because, again, feeling the danger, I had my work sent to me the very first morning after the operation. I used the telephone and the dictaphone and I really started functioning on the first day. I had very little pain; five days after the operation I was released and six days later I was back at work. Before I left the hospital I asked the surgeon how is it possible that I do not have more pain. He said: "You have more pain than you think, but you are suppressing it". Now, if I am suppressing it, do I then have pain? I think this brings us back to your question.

Shorter. This is a wonderful story because it illustrates perfectly the cultural molding of the somatic experience. You were being molded by the entire culture in the form of this particular cardiac surgeon into the belief that you would experience pain. A lesser man, perhaps, would have given in to that kind of molding and, in fact, responded appropriately in the way the culture anticipates. I think it is a wonderful comment you did not respond appropriately. You resisted this kind of cultural molding, but many don't. This is one of the things we have talked about at this symposium.

Ford. I would like to be a bit provocative, particularly to Professor Shorter on his opinion here that perhaps these patients with multiple chemical sensitivity should be converted or changed in some way. These patients are miserable, they are unhappy, they experience many discomforting symptoms. Suddenly, they have an explanation for their distress. They have a diagnosis. They concentrate upon this diagnosis, they feel much better, they no longer experience the distress they had before, and they organize their lives around this particular kind of concept of the world. They feel better. Now, for us, we look at this as misattribution, but the patients are coping, they have a creative style of dealing with their life problems. Is it our job to tell them, "Hey, listen, you don't have this disorder, you have got something else". Or perhaps we can, in a much more quiet and subtle way, help them learn new ways to cope.

Shorter. If these people really did feel better, that would be wonderful. I am very uneasy though about the proposition that they feel better. What happens, instead, after they get the diagnosis, is that they join the patients' support group. There they learn that they feel awful indeed; in the case of the chronic fatigue syndrome they learn that exercise is harmful to their condition and they must stop exercising, that it is pointless to see uncaring doctors who don't know what they are talking about, and they become further embedded in this subculture of hypochondriasis. The newsletters that come out of these patients' subculture confirm that this is exactly what happens. In fact they become further disabled.

Lamberg. Well, it has been a very great experience to have both of you, Professor Klein and Professor Shorter here for this remarkable discussion. It has been really wonderful to try to put together the pieces of mankind in order to get a whole human being again.

Shorter. On behalf of all of the participants in the Symposium, I would like to thank very heartily Doctor Stenman and Doctor Wallgren, and the Gyllenberg Foundation for having made possible this wonderful Symposium, in which for a day and a half now we have been able to enrich ourselves with an unconstrained and free flowing discussion of these very important concepts. Without the support of these individuals and this Foundation none of this would have happened. Thank you all very much.

Participants in the discussion

Bror-Axel Lamberg, Professor of Endocrinology, University of Helsinki. Chairman for the discussion.
Edward Shorter, Professor of History of Medicine, University of Toronto.
Georg Klein, Professor of Tumor Biology, Karolinska Institute, Stockholm.
Simon Wessely, Professor in Psychological Medicine, King's College School of Medicine and Dentistry, London.
Charles W Ford, Professor in Psychiatry, University of Alabama at Birmingham.
Lennart Levi, Professor of Psychosocial Environmental Medicine, National institute of Psychosocial Environmental Medicine, Stockholm.
Harry Boström, Professor of Medicine, University of Uppsala.
Ulrik Malt, Professor in Psychosomatic Medicine, Rikshospitalet, Oslo.
Svante Stenman, Reader in Medicine, University of Helsinki.