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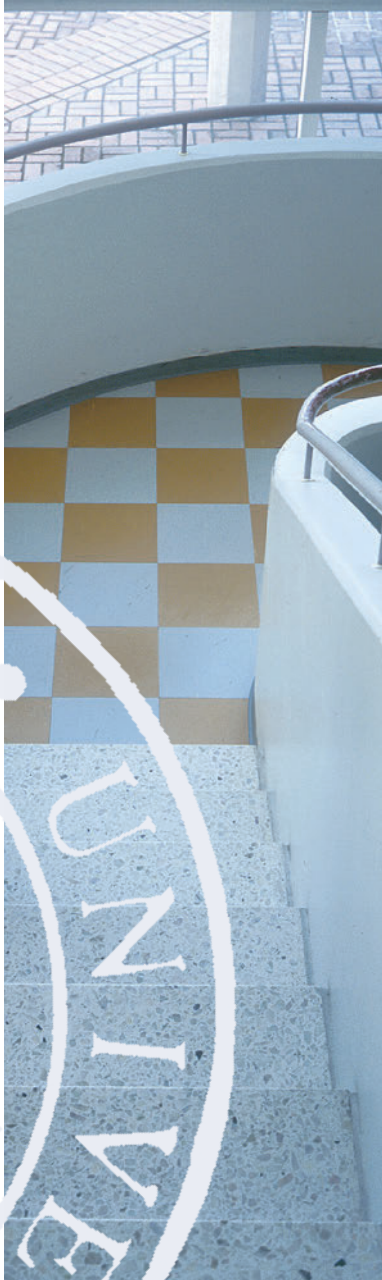

Eve-Riina Hyrkäs

PSYCHOSOMATIC CONNECTIONS

MIND-BODY HISTORIES IN FINNISH MEDICINE, CA. 1945–2000

UNIVERSITY OF OULU GRADUATE SCHOOL;
UNIVERSITY OF OULU,
FACULTY OF HUMANITIES

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EVE-RIINA HYRKÄS

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Mind-Body Histories in Finnish Medicine, ca. 1945–2000

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Abstract

This dissertation explores how the psychosomatic concept brought together medical experts, patients and policymakers in twentieth-century Finland (ca. 1945–2000). The meanings of psychosomatics are multiple, but, in essence, the concept addresses the alleged psychosocial causes of illness and their therapeutic implications. Based on printed and archival sources, the original articles study how the psychosomatic concept figured in the Christian views on health, diagnostics of thyroid disease, socio-medical debates on children's health and maternal employment, and in discussions on musculoskeletal pain. The dissertation builds on histories of medicine, concepts and knowledge as well as science and technology studies to argue that the psychosomatic concept should be explored as a vehicle for communication and a catalyst of new associations. I stress that boundary-crossings (or attempts at such crossings) are central to understanding how the concept has functioned on scientific, social and cultural levels. Further, the concept has been defined by its divergence from biomedicine, and this departure has taken many forms. This dissertation argues that the concept of psychosomatics has given rise to a contact zone where different medical (sub-)disciplines and alternative and unorthodox approaches have been able to meet and exchange ideas. The shape and location of the zone has varied a lot following the movement of the concept across time and space. All in all, the dissertation foregrounds negotiations about the standards of medical knowledge and their relationship to the world-readings of historical actors. By doing so, it extends the study of problems of scientific communication to the multiple margins of medicine.

Keywords: contact zone, Finland, history of knowledge, history of medicine, mind-body connection, psychosomatics

Hyrkäs, Eve-Riina, Psykosomaattiset yhteydet. Mielen ja kehon vuorovaikutuksen historiat suomalaisessa lääketieteessä, n. 1945–2000

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Tiivistelmä

Väitöskirjassa tutkitaan, kuinka käsite "psykosomaattinen" toi yhteen eri alojen lääkäreitä, potilaita ja päätöksentekijöitä toisen maailmansodan jälkeisessä Suomessa (1945–2000). Käsitteen merkitykset ovat moninaisia, mutta ne voidaan tiivistää ajatukseen psykososiaalisten tekijöiden vaikutuksesta sairastamisessa ja tämän havainnon hoidollisista seurauksista. Alkuperäisartikkelit, jotka perustuvat julkaistuun lääketieteelliseen keskusteluun ja arkistolähteisiin, käsittelevät psykosomatiikan yhteyttä kristinuskoon, kilpirauhassairauksien diagnostiikkaan, sosiaalis-lääketieteellisiin keskusteluihin työssäkäyvien äitien lasten terveydestä sekä käsityksiin kivusta tuki- ja liikuntaelimissä sekä sidekudoksessa. Tutkimus rakentaa (lääke)tieteenhistorian, käsitehistorian ja tiedon historian sekä tieteen ja teknologian tutkimuksen pohjalle argumentoidakseen, että psykosomatiikan käsitettä on hyödyllistä tarkastella kommunikaation välineenä ja uusien mielleyhtymien edesauttajana. Painotan, että rajanylitykset tai ylitysyritykset ovat keskeisiä sen ymmärtämiseksi, kuinka käsitettä on käytetty tieteellisillä, sosiaalisilla ja kulttuurisilla tasoilla. Psykosomatiikan käsitteen käyttö on auttanut peilaamaan biolääketieteen näkemyksiä kriittisessä valossa. Kritiikin sisältö on vaihdellut paljon ajan kuluessa ja eri ryhmien välillä. Tältä pohjalta väitän, että psykosomatiikan käsitteen avulla on muodostunut kohtaamispaikka (*contact zone*), jossa eri lääketieteen alojen edustajat ja vaihtoehtoisten sekä epäortodoksisten näkemysten kannattajat ovat päässeet keskustelemaan ja vaihtamaan ajatuksia. Käsitteen liike ajassa ja eri ryhmien välillä on jatkuvasti muovannut kohtaamispaikan toimintaa, ulottuvuuksia ja sijaintia. Väitöskirja nostaa etualalle neuvottelut siitä, mitä tieto on ja miten se kytkeytyy keskustelijoiden tapoihin lukea maailmaa (*world-readings*). Näin tehdessään tutkimus laajentaa tähänastista tieteellisten vuorovaikutusongelmien tutkimusta valtavirtalääketieteen kirjaviin marginaaleihin.

Asiasanat: kohtaamispaikka, lääketieteen historia, mieli-keho-vuorovaikutus, psykosomatiikka, Suomi, tiedon historia

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I would like to thank the Academy of Finland and the University of Oulu for the sustained financial support of my work as a part of the PROFI3 “Fibrosis Diseasome” research project. The project has combined expertise from the Faculties of Biochemistry and Molecular Medicine, Medicine and the Humanities. Fibrosis, a scarring process in which healthy tissue becomes replaced with extracellular matrix, is a common feature of many pathologies that burden contemporary societies, including pulmonary, cardiovascular and musculoskeletal diseases, diabetes, various skin afflictions and even degenerative neurological disorders. The role of historical research in the project has been to identify the long-term socio-historical trends that have factored in health and disease. The initial challenge was to define the object of study so that it would correspond with the breadth of fibrotic pathologies but could also shed light on the psychosocial determinants of disease. This objective led me to consider psychosomatic theories of disease, which have this kind of approach built-in. The original publications show how high blood pressure was connected to pressures of working life, cardiovascular diseases to secularisation, asthma and ulcerative colitis to poor mother-child-bond, stroma tumours to urban culture and so forth. In their way, these hypotheses made the journey from cell to society.

I am grateful to the Finnish Cultural Foundation for the grant that allowed me to bring the thesis work into completion. In addition, the University of Oulu Graduate School has supported dissemination of research results by covering travel costs and participation fees. Special thanks also go to the people at the Signe and Ane Gyllenberg Foundation who were kind enough to let me visit their archive and to point me to the esoteric interfaces of psychosomatic medicine.

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May 2, 2022 Eve-Riina Hyrkäs

Original publications

This dissertation is based on the following publications, which are referred to throughout the text by their Roman numerals:

I Hyrkäs, E-R. (2021). Sin Embodied: Priest-Psychiatrist Asser Stenbäck and the Psychosomatic Approach to Human Problems. *History of the Human Sciences*, forthcoming.

II Hyrkäs, E-R. (2021). "A Transverse Scar on the Neck" – Psychosomatic Approach in the Differential Diagnosis and Surgical Treatment of Hyperthyroidism in Post-War Finland. *Medical History, 65*(2), 140–156. https://doi.org/10.1017/mdh.2021.4

III Myllykangas, M. & Hyrkäs, E-R. (2020). Adaptation to the New Normal – Maternal Employment in the Framework of Psychosomatic and Stress Discourse in Finland from the 1950s to the early 1970s. *Social History of Medicine, 34*(3), 984–1004. https://doi.org/10.1093/shm/hkaa052

IV Hyrkäs, E-R. (2021). Psychosomatic Pain? The Meanings of Musculoskeletal Affliction in Finnish Medicine, c. 1950–2000. *European Journal for the History of Medicine and Health, 78*(1), 128–154. https://doi.org/10.1163/26667711-bja10004

Contents

1 Introduction

Let us begin with the origin myth of psychosomatic medicine. In the 17th century, the French philosopher René Descartes perpetrated a cool-blooded murder of medical holism. By postulating that the mind was separate from the body, he lay the groundwork for a bias that the twentieth-century psychoanalysts saw themselves to undo. According to the historian Theodore M. Brown, this "historical fiction" was purported to voice psychoanalysts' critique of biomedicine in a less antagonistic manner (Brown, 1985, pp. 53–57). The objective to overcome dualism, real or imagined, has driven the psychosomatic enterprise. That the Cartesian myth worked as a rhetorical device to cross-specialty criticism illustrates the central theme of this dissertation: psychosomatics in/as communication.

Studying mind-soul-body relations opens many historiographical possibilities. They are pertinent objects for historical research, since, following the late historian Roy Porter, the body has been recurrently subsumed to Western systems of theology, ethics, politics and jurisprudence (Porter, 1991, pp. 212–213, 224). Psychosomatics sits neatly alongside these other systems that ascribe meaning to bodily phenomena and symptoms of disease. A complementary possibility is to view psychosomatic medicine as part of the history of the mind and mind sciences, which appreciates its intellectual roots in phenomena such as Mesmerism, moral therapies and Freudian psychoanalysis (Hayward, 2011). By way of summarising the above approaches, the historian Anne Harrington has characterised the history of mind-body medicine as a storied endeavour. Its raison d'être has been to make sense of experiences of illness (Harrington, 2009 [2007], pp. 15–30, 243–255).

Meaning-making has also been integral to Finnish medical discussions that make reference to the psychosomatic concept. This dissertation explores their themes and characteristics from the Second World War to the millennium (ca. 1945–2000). The title *Psychosomatic Connections* is a play on words with a two-fold connotation. For one, it refers to the first meeting of the Finnish medical society *Duodecim* in which psychosomatic questions were addressed. A presentation titled "Psychosomatic connection", given by the internist Bertel von Bonsdorff, the paediatrist Carl-Eric Räihä and the psychiatrist Aito Ahto in 1950, sparked "lively" discussion among internists, paediatrists and psychiatrists alike (Hallman, 1951, p. 164; also, Puustinen, 2011, pp. 130–131). The cross-disciplinary scope of the participants already suggests that the concept of psychosomatics resided at the interfaces of different specialties. As will be shown in this dissertation, it also brought together other specialist and advocacy groups, ideologies and

policies and, last but not least, doctors and patients. The original articles, which address the intellectual biography of the priest-physician Asser Stenbäck (1913–2006), the differential diagnostics of toxic goitres and neuroses, the socio-medical discussion on maternal employment and meanings given to musculoskeletal pain, exemplify the multiple points of contact. I examine the many interpretations of the concept to argue that crossing boundaries (or attempts at doing so) underpin psychosomatic readings of illness. Therefore, the history of psychosomatics is apt for studying the relational nature and communicative aspects of medical knowledge.

In an influential Finnish psychiatric textbook (1971), the section on psychosomatic illnesses underlined the usefulness of the word "psychosomatic" that had not suffered from its equivocality:

> Despite the ambiguity around the concept of psychosomatics, it has been useful for the development of medicine. With the technological advances in medical science, there has been an impending threat that the person becomes secondary in the physician's mind. In addition to interesting findings and details related to illness, the physician should pay attention to the person as a whole; to how they experience illness and to their personalities and life situations. All this is of great importance in diagnostics and treatment but particularly in rehabilitation. (This and subsequent translations by Eve-Riina Hyrkäs) (Achté, Alanen & Tienari, 1971, p. 311)

The above quote does two things: it restates the grand promise of psychosomatic medicine to attend to the sick person in the technical age, but simultaneously disputes the success of this proposition by making a reference to persistent ambiguities around the word and the concept. This compilation part tackles the questions of what these ambiguities were, where they came from, and what held the psychosomatic enterprise in place so long despite the issues never being fully overcome.

1.1 Concept definition

Understanding the construction of medical knowledge, particularly concepts and theories, is one of the core objectives of medical history (Hakosalo, 2012a, pp. 28–29). Starting from here, I treat the psychosomatic concept as a form of medical knowledge (see also Puustinen, 2011). While the manifold meanings of the concept will be explored in the following chapters, for now, we need an initial formulation. The task is challenging since the definition of the word "psychosomatic" varies

considerably in historical research. Edward Shorter, whose *From Paralysis to Fatigue* (1992) is perhaps the best-known treatise on the topic, makes the uncomplicated proposition that psychosomatic pathologies equal lesionless symptoms. This definition has been copiously criticised for anachronism (Greco, 1998, pp. 27–29; Hodgkiss, 2000, pp. 9–10; Puustinen, 2011, pp. 190–192), as it projects the present-day connotation of psychosomatic illness as something "medically unexplained" to past medical texts (cf. Jones & Wessely, 2005a).

More recent works apply a broader definition that correlates psychosomatics with mind-body interaction, though it does not delineate the concept unequivocally. For instance, historians Alexa Geisthövel and Bettina Hitzer discuss the grounds on which anthroposophical medicine was excluded from a recent volume on the history of German psychosomatics (Geisthövel & Hitzer, 2019, pp. 11–12). As for psychosomatic medicine as a psychiatric subdiscipline, Brown has noted that it is "something like a Rorschach, which stimulates people to project their own associations onto it" (Brown, 2000, November, p. 1). There is a similar tendency in commentaries on "stress", as the concept potentially connects psychological and physiological narratives to "any number of experiences and events" (Hayward, 2014a, p. 320). Being open about the ambiguity of the psychosomatic concept serves historical explanations, since historical actors have engaged in similar processes of interpretation. The boundary-work around the concept is important also in that too vague or misleadingly simple a concept definition risks the historical conclusions becoming negligible or uninteresting (cf. Kuukkanen, 2008).

It is easier to define the psychosomatic concept by the absence rather than presence of distinguishing features. Christopher Lawrence and George Weisz's conceptualisation of the equally inconclusive concept of holism can be used to illustrate what this means in practice. For historical purposes, they state that holism is "essentially relational" since "it constitutes a rhetorical claim made in opposition to other approaches that are characterised as excessively narrow or reductionist in focus" (Lawrence & Weisz, 1998, p. 2). Holism comes into being so far as it opposes reductionism, and as implied in the opening paragraph of this dissertation, the similar is true of the psychosomatic concept. It is characterised by its denial of dualism, which creates cohesion between those heterogenous agendas that the concept has been used to further. The sociologist Monica Greco has put it so that the word "psychosomatic" delineates a specific type of "problematic". She argues that staying with the troublesome word that "has animated a host of partial, never definitive … quests for solutions" is useful as it "points straight to the heart" of the dualistic problem in medicine (Greco, 2019, p. 104).

Well into the nineteenth century, the Galenic "passions", the sixth of the six unnatural causes of disease, associated emotions with disease causation. Galen's view has since been identified as a kind of proto-psychosomatic approach to illness (Ackerknecht, 1982, p. 18; Porter, 1997, p. 74); but the word "psychosomatic" is modern at heart. Following Charles Rosenberg, until the mid-nineteenth century, medicine was "necessarily and ubiquitously 'psychosomatic'", to the extent that there was no need for a special word to describe such a common-sense observation (Rosenberg, 1989, p. 187). The same proposition has been put forward by Brown, who writes that the replacement of humoural and post-humoural physiology by "anatomical localism, cellular pathology, and microbiological aetiology" culminated by the turn of the twentieth century (Brown, 1985, p. 52). It was only then that emotions and illness dispositions of patients had to find a new place in medicine.

In her reading of the "age of nervousness" in Finland, the historian Minna Uimonen has importantly raised the question of whether the more exacting methods and careful attention to the body really narrowed the space given to the mind. Diverging explicitly from Brown's perception, Uimonen notes that she has not encountered any such categorical shift in Finnish medicine (Uimonen, 1999, p. 181). Although it is correct to criticise perceptions of abrupt and revolutionary change (they rarely are accurate), it should be noted that Brown also recognises that holistic ponderings were carried on to the 1910s. Much like medical discussions in fin-de-siècle Finland, Anglo-American debates entailed confused or mixed interpretations of mind-body interactions, derived from evolutionary biology, physiology, different philosophical traditions and experimental psychology (Brown, 1985, p. 55; in Finland, see Aho, 1993).

The twentieth-century psychosomatic medicine, a manifestation of European and American holistic movements, transpired in Germany and in the US during the interwar years. Robert Powell has criticised traditional representations of the American psychosomatic movement for making a sharp distinction between "specificity" theorists (usually psychoanalysts) and "non-specificity" theorists (usually physiologists), and for simultaneously ignoring the holistic roots of the movement in Adolf Meyer's "psychobiology". The current robust research on mind-body histories has remedied the situation so that no one continues to overlook holistic currents, but it may still be worthwhile to repeat Powell's contention that psychosomatic endeavours consisted of three conceptual threads: the holistic approach to the problems of medicine existed alongside a narrow field of psychoanalysis and a psychophysiological laboratory method (Powell, 1977, pp.

135–136). Although the elements, accents and actors of these ideational currents differed for Finland, Powell's view applies in the Finnish case as well. Given that Finnish psychosomatics was strongly shaped by international influences, the relevance is perhaps not so surprising.

Although the psychosomatic concept has been broadly connected to holistic and dualistic interpretations of illness, it can also be described more precisely. As defined by Anne Harrington, the key narrative of psychosomatic medicine is that of the "speaking body", according to which symptoms are coded messages that need to be deciphered to reach health. Harrington employs mind-body medicine as an umbrella term which links the overlapping narratives of suggestion, speaking bodies, positive thinking, modern strain, healing social ties and more exotic and romantic Eastward journeys in the way to medical and moral redemption (Harrington, 2009[2007], pp. 26–27, 95, 245). Inspired by Harrington's insights on elastic appropriations of the mind-body framework on different levels of culture, I too explore the psychosomatic concept within this broad semantic field but focus more on the relational work of the concept. To this end, I study the uses and connotations of the word "psychosomatic", which constitute the meaning of the psychosomatic concept (on conceptual history, see also 3.3). This dissertation presupposes that the concept has, for one, sought to leave the door open for non-somatic (often psychogenic) explanations to somatic diseases and symptoms and, secondly, held that these components have therapeutic implications. Here, the term "psychosomatics" is used more broadly than "psychosomatic medicine", to designate the discursive space that the psychosomatic concept has created, in other words, the area of the concept's application. This choice is related to my argument for psychosomatics as a contact zone, elaborated in following chapters.

The Google Books Ngram Viewer indicates that the 1950s and the 1980s were decisive decades for psychosomatic hypotheses. In the 1950s, the word "psychosomatic(s)" and *Psychosomatik* proliferated in the medical literature. During the 1980s, references to such terms were frequent or peaked only to drop during the 1990s. A look at the most prestigious Finnish medical journal *Duodecim* suggests that references to psychosomatics (in its abridged Finnish form *psykosoma**) have accumulated from the late 1940s to the millennium, but that the 1950s and the 1980s similarly mark episodes in the uses of the word. In what follows, I turn to the historical context behind these numerical changes.

1.2 A history of psychosomatics in Finland

This section outlines a rough chronology of Finnish psychosomatics. Unlike Germany (Roelcke, 2004) or the United States (Brown, 2000, November), a separate field with stable institutional status did not emerge in Finland. Instead, resembling the French situation, Finnish psychosomatics progressed through personal or collective initiatives (cf. Keller & Leydenbach, 2019). Likewise, the psychosomatic movement did not figure strongly in Britain, but the ideas behind it were mediated by prominent individuals like James L. Halliday and Michael Balint. The most enthusiastic advocates of psychosomatic medicine were often attracted by the promise of a new clinical specialism and defended personalised primary care (Hayward, 2014b, pp. 75–77, 112, 114). Though there are currently no works that discuss the history of Finnish psychosomatics in depth (see, however, Pietilä, 2005), there is no shortage of helpful literature. Finnish researchers have mapped the interfaces of psychosomatic thinking, including the histories of psychoanalysis, traumatic stress, psychopathy, psychodynamism and nervousness (Ihanus, 2000; Kivimäki, 2013; Kivimäki, 2022; Parhi, 2018; Peltoniemi, 1996; Uimonen, 1999).

While even a short description of German psychosomatic medicine evokes mention of the great ideational currents of Enlightenment and Romanticism and inescapable thinkers such as Kant and Kierkegaard, the Finnish story is far less grandiose (cf. Kutter, 1998). In 1957, the psychoanalyst Allan Johansson described the situation to the Finland-Swedish banker and philanthropist Ane Gyllenberg (1891–1977) as follows:

> It is clear that … the contradictions in, for instance, psychosomatic questions are here [Basel, Switzerland] more deeply rooted than in Finland and in other peripheral countries. To put it concisely, I believe it is because the traditions of material and natural scientific thinking first emerged within the German cultural sphere, and the more deeply rooted some idea is, the more inertia the opposite reaction has to overcome … This opposition is not only a bad thing but also an advantage as it forces one to pick a side and to delve deep into things. In Finland, there is no equal tradition of one-sided materialistic thinking, an antithesis has not emerged, which results in certain shallowness and indifference. (The Gyllenberg Foundation Archive [GA], A. J. to A.G., April 4, 1957)

Johansson gave a counterintuitive reading of the situation of psychosomatics in Finland by arguing that facing strong opposition makes one's own arguments better

and more profound. Even though it is unclear whether a more stable establishment of psychosomatic medicine in Finland really would have required a bigoted biomedical opponent, Johansson's note does underline the relationality of the psychosomatic concept. Furthermore, the remark about the shallowness of Finnish ideational currents relates to another theme: in a country where national research traditions were often young and "shallow", international influences had that much greater an effect. That the Finns were not so strongly bound by certain research networks or schools of thought let them to piece things together in an unorthodox manner. As a result, Finnish psychosomatics took an eclectic form.

Small medical circles and the exceptionally uniform medical training, which fostered a consensus-seeking atmosphere, make Finland a peculiar site for studying the movement of medical knowledge in general and the creation of psychosomatic knowledge in particular. Until the mid-twentieth century, the University of Helsinki (prior to 1917, Imperial Alexander University) was the only medical school in the country, and as a rule all its graduates were licensed by the National Board of Health [NBH]. In 1943, Turku medical faculty was established, and faculties in Oulu, Kuopio and Tampere followed during the 1960s and the 1970s. The clustering of medical teaching led to a homogenous scope of skills but also to uniform social and professional attitudes. In her study on how gender could affect a fundamental departure from the ideal medical persona, Heini Hakosalo has identified a set of virtues expected from a good Finnish doctor: he should be knowledgeable about the human body, courageous and always capable to action even when faced with death, disease and unpleasant sensory experiences as well as "fiercely" collegial (Hakosalo, 2021, p. 169). The appreciation of collegiality pertained to medical discussion more broadly and, for long, open criticism remained uncharacteristic of Finnish medicine. This traditional value was slowly undermined, first after the Second World War through increasing specialisation and then by the vastly divergent political views that emerged within the medical community in the 1960s and the 1970s (Aalto, 2010, pp. 108–118). Despite these later differentiating tendencies, the similarities in doctors' basic education and social orientation may have caused psychosomatic ideas to diffuse across specialties.

1.2.1 Early years

In the first half of the twentieth century, Finland was a materially backward agrarian country. Common health problems – including the high prevalence of parasitic and bacterial infections and the goitre problem discussed in publication II – testified to

poor external conditions. As the ethos of public health emerged, collective good was furthered through initiatives to improve the health of individuals: combatting infectious diseases, improving mental healthcare and disseminating health knowledge linked the medical establishment to social organisation (Helén & Jauho, 2003, p. 26). As in other Western countries, fears of degeneration led to invasive hygienic interventions, especially in the area of reproductive health (Mattila, 1999). From the nineteenth century to the 1940s, German medicine was the exemplar to follow. This orientation influenced the development of Finnish psychiatry, which started admittedly late, but was rather goal-oriented and quick to progress in the twentieth century (Hirvonen, 2014, pp. 271–272).

During the nineteenth century, two medical societies and their respective journals (*Finska Läkaresällskapets handlingar* and *Duodecim*) were established. This division reflected a language strife that prevailed between Swedish- and Finnish-speaking physicians from the 1800s to the 1930s, and extended beyond language to cultural, political and scientific questions (see, e.g., Hakosalo, 2012b). *Suomen Lääkäriliiton aikakauslehti* (later *Suomen Lääkärilehti*), the journal of the Finnish Medical Association [FMA] which did not differentiate its members by language, joined the ranks of prominent journals in 1922. That the FMA was a trade union made its journal less prestigious than those of the scientific medical societies. However, with the founding of these periodicals, print became an increasingly relevant discussion channel for Finnish doctors.

Remarks about nervousness, anxiety and strain mushroomed in the medical discussions of the late nineteenth century (e.g., Jackson, 2013; Pietikäinen, 2007; Uimonen, 1999). Fin-de-siècle worries about the frantic pace of modern life, combined with perceived inherited weaknesses, painted a threatening picture of modernity. Such worries were accompanied with optimistic attempts to intercept the downward slope of civilised peoples. While the foundation of nervous ills was believed to be embedded in inherited diatheses, it was not unheard of for unhealthy choices and immoral habits to leave a psycho-physiological imprint. Drawing from contemporary theories of (moral) evolution, the clinical diagnoses of neurasthenia, hysteria and hypochondria also acted as social metaphors. Neurasthenia, which entered Finnish medical discourse and clinical use in the 1880s, was perceived to be precipitated by frights, overwork and a delicate nervous structure. That nervous ills often manifested in the body or were accompanied by organic disease shows perhaps most clearly in that nervous patients were commonly admitted to wards of internal medicine. The socially telling diagnoses persisted in the so-called nerve

discourse up until the 1950s (neuroses and psychoneuroses were included in the lexicon during the teens) (Uimonen, 1999, pp. 113–125, 177, 187).

The above considerations were connected to contemporary ponderings of whether mind (or soul) could be located with scientific means. These inquiries had multiple nexuses. For instance, during the nineteenth century, psychology was transformed from an abstract subdiscipline of philosophy into an experimental science of mental phenomena. When experimental psychology arrived in Finland in the 1880s, it started to reconfigure the relation between stimulus and perception, and, in the process, the understanding of mind-body connection (see Aho, 1993). The mind-body problem became an increasingly medical one with growing interest in pathological anatomy in Finnish psychiatry that followed the European model (Hirvonen, 2014, pp. 59–64, 99–106). In particular, anatomical methods were employed in brain research to investigate where mental defects could be localised in the central nervous system (see, e.g., Hakosalo, 2006; Harrington, 1987; Star, 1989). The study of emotions, on which both anatomical and physiological techniques of brain research eventually bore, was yet another area in which mind-body boundary-work occurred (see Aho, 1993, pp. 123–130; Dror, 2001). As stated by the historian Otniel Dror, early twentieth-century physiologists were riddled by the "noise" that emotions created at the clinic and in the laboratory (Dror, 1998; 1999).

The history of psychosomatics has a close relationship to the soul-body-dyad. The connection dates back to Johann Christian August Heinroth (1773–1843), the first chair of "psychic therapy" at the University of Leipzig, who has been credited for coining the word "psychosomatic" in 1818 (Margetts, 1950). Not uniquely for his time, Heinroth sought the seat of health problems in sin (Steinberg, 2004). Though some of Heinroth's books were translated from German to Swedish by a Finnish priest and published in Stockholm during the 1830s, according to the historian Jouko Aho, they remained negligible for Finnish psychological discussions (Aho, 1993, p. 23). However, Christian views of the soul became otherwise significant. In her thesis on the emergence of psychodynamism in Finland, Anu Peltoniemi has identified Lutheran soul-body discussion as a predecessor of psychosomatic medicine. In the form these discussions took in the 1930s and the 1940s, existing medical practices were perceived to discount both the psychology of the individual and the care of the soul (Peltoniemi, 1996, pp. 169–175). Interestingly, the Finnish word *sielullinen* could be used to refer both to soul in the transcendental sense and to psyche in secular psychotherapy. This vagueness of connotation, as pointed out in article I, was welcome to Christian

doctors who could thus more easily conflate religious doctrines with medical statements.

By the 1900s, the therapeutic attention of the mind sciences had shifted from "optimistic psychosomaticism" to therapeutic dualism. "New psychotherapies", among which Freudian psychoanalysis eventually emerged victorious, gave their exclusive attention to the mind (Hakosalo, 2014a, pp. 33–34). The move towards psychotherapy was paralleled by the emergence of irregular forms of suggestion that also attracted attention in twentieth-century Finland. In the 1920s, a self-suggestion method, originating from the French Nancy School and developed by Emile Coué (1857–1926), inspired some Finnish healers to prescribe health-restoring mantras to a host of diseases from insomnia to goitres and heart disease (Kananoja, 2021, pp. 144–165; see also Rytty, 2021, pp. 188–190). Psychotherapeutic institutes of the Couéan model were curiosities and not particularly long-lived, but they do bring attention to the tension between unorthodox healers and licensed doctors, for the latter of which Couéism was a form of quackery. At the time, the breakthrough of biomedicine was yet to take place in Finland, and as authorised doctors were few and far apart, various cures – for instance, folk healing, natural therapies and homeopathy – were feasible options to both ordinary and well-to-do Finns. Therefore, the history of the suggestion movement outlines the allegations of quackery that the psychosomatic concept would also have to overcome. It is illustrative that although the first Finnish psychoanalyst, physician Yrjö Kulovesi (1887–1943), did not condemn suggestion as a healing technique, he did warn against reckless charlatanry – thus drawing a line between psychoanalysis and psychological crazes (Ihanus, 1994, pp. 86–95).

Kulovesi is also otherwise significant to our story as he appears to have been responsible for introducing the word "psychosomatic" into Finnish medical discussion. Kulovesi, who remarkably was not a psychiatrist, met Freud personally in the 1920s and underwent personal training analysis with Paul Federn. In 1933, Kulovesi published the first Finnish introduction to psychoanalysis, in which he discussed Freud's theory of conversion at length and also mentioned the early works of Franz Alexander and Felix Deutsch (Kulovesi, 1933). I have personally traced the first appearance of the word "psychosomatic" to Kulovesi's 1935 summary of Alexander's article "The Influence of Psychologic Factors in Gastrointestinal Disturbances", originally published in *Psychoanalytic Quarterly*. Kulovesi became acquainted with Alexander's research programme through direct correspondence (Kulovesi, 1935, p. 806) but was also otherwise very well aware of international trends in psychoanalysis.

Kulovesi's advocacy made psychoanalytic concepts better known, though other contemporary doctors had but superficial impressions of the new form of therapy. According to Juhani Ihanus, psychoanalysis was usually reprimanded for oversexualising neuroses, but, perhaps more importantly, the approach seemed to neglect the role that individual endowment – heredity or "constitution" – played in the disease process. If this perception were accurate, appropriating psychoanalytic premises would undermine eugenic efforts that were also under way in Finland (Ihanus, 1994, pp. 111–118; on sterilisation, see Mattila 1999; 2018). Though Kulovesi's interests were shared by a few early proponents, the broader adoption of psychoanalysis took place only after the Second World War.

Finland – save for a small number of volunteers – did not participate in the First World War, which is why theories of war trauma were discussed here later than elsewhere in Europe. However, there was a short and bloody Civil War in 1918 soon after the country became independent from Russia. The historian Ville Kivimäki has noted that this class war between the militia of socialist Reds and bourgeois Whites "consisted of short skirmishes between light infantry", which left the majority of the Finnish population untouched by the horrors of modern warfare. In the interwar years, Finns referenced some German works on "war neurosis", but did so only in passing (Kivimäki, 2022, pp. 94–95). The Second World War, in which Finland fought two wars against Russia (1939–1940, 1941–1944) and a smaller one against Germany (1944–1945), was a different story. As Kivimäki has shown, doctors then noticed that the symptoms of war trauma had a strongly physical character, defying mind-body dichotomies (Kivimäki, 2013, p. 407, 412). Therefore, the psychophysiological consequences of combat contributed to the adoption of psychosomatic ideas in Finland (publication II). Proto-psychosomatic ideas already appeared in the scarce wartime body of sources, although the Second World War delayed the publication of much medical research. Soon after the end of the war, more works exploring the somatic picture of mental strain were published.

1.2.2 Post-war decades

The Second World War fractured Finnish society in many ways: rebuilding the country, resettling thousands of refugees and paying off war debts taxed the adaptive capacity of the nation. The processes of industrialisation and urbanisation upheld social instability. Within a few decades, mostly agrarian Finland turned first to an industry- and then to a service-driven economy. The consequent changes in

working life – for example, different pace of work, new educational demands and increased female participation – reflected on values and morale, and even led to a sense of anomy. In the words of the psychiatrist Kalle Achté (1928–2019), the dissolution of agrarian normative structures and families, together with hectic city life, put a new strain on mental health (Achté, 1963, pp. 12–14). These changes began to replace communal and intimate forms of care with a more centralised responsibility that also worked to raise social consciousness. As the country recovered, the economic success that ensued created the means for improving healthcare, education and living standards (Ojala et al., 2019).

The winds of change were also blowing in medicine and scientific research at large. Finns aspired to cut ties with the now infamous German science, which also led doctors to seeking a new intellectual home. The academic life in European peripheries had always relied on "transfer, translation and mélange of ideas" from international centres, but now many scholars were drawn across the Atlantic (Jalava & Rainio-Niemi, 2018, pp. 166–168). That war debts to the US were partly paid in ASLA-Fulbright stipends fostered connections to American science (see, e.g., Honkamäkilä, 2015). In line with these developments, the main foreign language of research changed from German to English. The shift was apparent in biomedicine, where Professor of Forensic Medicine Unto Uotila, physiologist Martti J. Karvonen and Professor of Anatomy Olavi Eränkö were harbingers of the new age of measuring and numbers (Niemi, 1995). By the same token, stress became the biomedical touchstone of psychosomatic phenomena. Uotila's American connections, which dated back to the interwar years, supported a line of Finnish stress research (publication II). In 1954, the first dissertation on stress was published from Uotila's forensic institute (Gylling, 1954). The fashionable concept of stress research also inspired Eränkö to study the fluorescence of adrenal cells (the adrenals occupied a central place in Hans Selye's adaptation syndrome, see Jackson, 2013), leading to methodological advances in histology (Eränkö, 1973, pp. 869–871).

Post-war American psychoanalysis was a product of multifarious influences due to the intellectual exodus from Central Europe. Finnish visitors to the US were most fascinated by reformed Freudianism that put anxiety before sex and real experiences before fantasies in its attempts to explain mental disorders (see Harrington, 2019). The Anglo-American psychodynamic amalgam was the backdrop for many young Finnish psychiatrists, who became acquainted with the works of Franz Alexander, Helen Flanders Dunbar, Stewart Wolf, Harold G. Wolff, Edward Weiss and O. Spurgeon English (publication II). Initially, these works were

linked to existing conceptions of individual diatheses. That psychosomatic ideas could rework the prevailing theories of mental disorders was a great part of their appeal, providing an alternative to disreputable biological interventions. In his dissertation on the mother-child-bond in schizophrenia, the psychiatrist Yrjö O. Alanen (1927–) stated that a "psychosomatic type of investigation" could solve the problem of the illness's aetiology (Alanen, 1958, p. 30; see also Peltoniemi, 1996 and publication III). The mind-body problem, situated on the mind-brain axis, hence bore upon aetiological discussion on schizophrenic psychosis (see also Hyrkäs, 2018). Reminiscent of brain research of the preceding century, disorders of speech were still found to be a useful reference point for the psychosomatic approach. One of the Finnish pioneers in this area, the psychiatrist and psychoanalyst Martti Siirala (1922–2008), claimed that a narrow understanding of speech disturbances epitomised the defectiveness of the contemporary medical view (M. Siirala, 1966, p. 6).

Like many psychoanalytic schools, post-war Finnish psychoanalysis was also divided by conflicting perceptions (see also 4.1). By 1958, it had split into mainstream psychodynamism that would come to be supported in Finnish universities (see below) and a separate Therapeia Foundation that Siirala and his theologian brother Aarne established to offer a distinct kind of psychoanalytical education. Like those of his medical colleagues, Siirala's interest in psychoanalysis was sparked during the post-war boom, but his sources of influence quickly started to deviate from the Finnish mainstream. Siirala's scattered readings included the works of Freud himself, and, by the suggestion of a famous Finnish physiologist Yrjö Reenpää, Kant and Heidegger. Eventually, Siirala found his answers in the German psychosomaticist Viktor von Weizsäcker (1886–1957). In Siirala's words, Weizsäcker's work was "like a missing link in my ponderings", as it emphasised that illness, importantly also organic disease, always came with biographical details. However, already in the early 1950s, Siirala criticised Weizsäcker for being too focused on the individual and began to use the metaphor of a social body to underline the relational nature of disease (cited in Ihanus. 2000, p. 18 and note 18). In 1952, Siirala contacted Weizsäcker directly about the possibility of visiting the Heidelberg psychosomatic clinic and was welcomed by Alexander Mitscherlich. However, like many Therapeians after him, Siirala instead chose to visit Zürich. Bringing together existential, phenomenological and theological perspectives, Siirala created an eclectic understanding of illness that was reflected in the Therapeian agenda to be an organisation unbound by any single school of thought (Ihanus, 2000, pp. 27–57). Relating to Siirala's frustration to restrictive ways of

thinking, he always felt closest to the anthropological medicine of Weizsäcker and his disciples, which to his mind promoted a nondogmatic and responsive approach to each individual patient (Ihanus, 2000, pp. 36–37).

The 1950s ideational shift in psychiatry is crystallised in the ambivalent attitudes that Martti Kaila (1900–1978), professor of psychiatry in Helsinki from 1948 to 1967, held towards the psychological take on (mental) illness. When he first included a short and cautious chapter on psychosomatic illnesses in the fifth and fully revised edition of his psychiatric textbook in 1956, Kaila characterised the talk of such illnesses as a "fad" but remained favourable towards a "psychosomatic approach" in medicine (Kaila, 1956, pp. 109–110). In fact, Kaila used the fact that doctors had begun to attend to psychological issues also in non-psychiatric illnesses when he argued for reorganising psychiatric teaching to the Helsinki medical faculty in 1952. Two courses on psychology were subsequently integrated in the standard curriculum of medical schools in Helsinki and Turku in the early 1950s (Aalto, 2016, pp. 163–164 and footnote 182). Thus, it appears that psychological understanding emerged as a new virtue for a qualified doctor, although admittedly to a modest extent.

In the late 1960s, the psychodynamic view triumphed in Finnish psychiatry with the advocacy of long-time Professors Kalle Achté (Helsinki, 1968–1991), Yrjö Alanen (Turku, 1968–1990) and Pekka Tienari (Oulu, 1965–1992). All of these professors had a professional point of contact to the psychosomatic approach: Alanen used it to reimagine mental illness, Achté was interested in studying the psychosomatic aspects of placebo and chronic diseases, and Tienari, like Alanen primarily occupied by schizophrenia research, authored the chapter on psychosomatic illnesses in *Psykiatria*. Yet, none of the professors took psychosomatic medicine as their principal concern. The psychiatrists most invested in these issues, Ranan Rimón (1938–) and Asser Stenbäck (1913–2006), were highly regarded professors and clinicians, but their research was based on personal initiatives rather than sustained institutional support (see publications IV and I respectively). Nevertheless, the adoption of the psychosomatic concept nudged psychiatric research towards organic diseases such as rheumatoid arthritis, asthma, allergic skin conditions, pulmonary tuberculosis and cancer. During the 1960s and 1970s, the dissemination of psychosomatic research followed the establishment of academic psychiatry outside of Helsinki, with the new department in Kuopio, Eastern Finland, eventually becoming the most invested in the study of mind-body interactions and in developing consultation psychiatry (see Lehtonen, Viinamäki & Väänänen, 1995; Tähkä, 1983).

The unstable academic and institutional status of psychosomatic medicine has accentuated the role of private philanthropies, which traditionally have an important role in Finnish research funding (cf. Brown, 1987; Pressman, 1998). In Finland, the Signe and Ane Gyllenberg Foundation was a significant supporter of psychosomatic research. The foundation was established in 1949 by the banker and philanthropist Ane Gyllenberg and his wife Signe to further research on the interconnections of the spiritual and the medical. For instance, in 1958, the foundation announced in *Suomen Lääkärilehti* that it would contribute 12,000,000 Finnish marks (374,503.84 euros in 2020) for research on how psychic factors influenced blood and circulation, other organs and physical diseases (Board of the Gyllenberg Foundation, 1958). As a rule, grants were relatively small, usually covering the salary of one or two persons or the acquisition of research equipment. Their total sum varied from year to year depending on investment returns. Furthermore, the fragmented nature of the funding hindered the establishment of long-lasting research agendas. However, the goal of the foundation's goal was extraordinarily focused, and it came to support a broad scope of research initiatives and organise interdisciplinary seminars. Rudolf Steiner's anthroposophy was the key framework behind the Gyllenberg's agenda and special interests – this explains, for instance, its emphasis on blood, which in anthroposophical occult physiology is not a mere bodily fluid but a spiritual substance. The history of anthroposophy in Finland will be discussed in more detail in subchapter 4.1.

1.2.3 Late twentieth century

During the 1960s and the 1970s, holistic theories gathered to make a claim on the subject matter of psychosomatic medicine. In particular, the biopsychosocial model introduced by George Engel sought to extend psychosomatic thinking to social and cultural matters (Engel, 1977). According to the historian Minna Harjula, the World Health Organisation's (WHO) holistic perception of health as a state of complete physiological, psychological and social state of well-being, formulated in 1948, continued to encourage social scientific and behavioural research on the determinants of health in Finland (Harjula, 2015, p. 254). Furthermore, the concurrent rise of social medicine and its systemic disease models (see Purola, 1971) altered the interpretations of psychosomatic illnesses. They gained in importance when taken as indices of broader social problems. Research on mind-body connections also broadened from traditional approaches, that is, psychoanalytic case studies and laboratory testing, to epidemiology. The prevalence of

psychosomatic symptoms would be charted as a part of large health surveys (Väisänen, 1975; Lehtinen & Väisänen, 1984; Heistaro, Vartiainen & Puska, 1995, pp. 206–209).

By the 1980s, "psychosomatics", now used as a shorthand for all kinds of mind-body interactions, had an indistinct relationship with the complementary approaches. The first Finnish textbook on the topic, titled *Psykosomatiikka* [Psychosomatics] (1984), addressed almost everything from psychoneuroendocrinology and psychoneuroimmunology to rehabilitation, and from consultation psychiatry to learning therapies. In its all-inclusiveness, the psychosomatic concept became nearly shapeless.

The third 1980 revision of the Diagnostic and Statistical Manual of the American Psychiatric Association [APA] contributed significantly to the broadening of the psychosomatic concept. The revision was a grand effort to distance psychiatry from aetiological speculations and psychoanalysis, and, led by the psychiatrist Robert Spitzer, engaged in a dispute about what to do about pre-existing Freudian lexicon. On the psychosomatic side, this struggle handled the disposing of Freudian hypotheses of conversion hysteria and related psychogenic disturbances in motor and sensory functions (see Decker, 2013). Eventually, the DSM-III task force settled on the umbrella term "somatoform disorders" to designate lesionless bodily symptoms. In addition, the former class of psychophysiological disorders, defined separately for each organ system, was replaced with "Psychological Factors Affecting Physical Condition" that would be used together with a somatic diagnosis (APA, DSM-III).

Both new categories were included in the Finnish adaptation of WHO's disease classification (ICD-9, 1975), published in 1987 (NBH, 1987, p. 76, 80). Finnish psychiatrists approached the change favourably. For instance, Rimón, who recounted he had spoken with an American psychiatrist belonging to DSM-III task force, rejoiced that the category "Psychological Factors Affecting Physical Condition" appreciated the psychosomatic element in all diseases (Achté et al., 1981, pp. 230–232). However, perhaps the introduction of DSM-III also moved the psychosomatic concept further away from organic lesions and diseases. On one hand, the convoluted phrase "psychological factors affecting physical condition" was useful but also reduced the psychological element to complementing an organic diagnosis. On the other hand, that "somatisation disorder", the new quintessential "psychosomatic" diagnosis, was defined by the lack of any explanatory organic finding, arguably pushed the connotations of the

psychosomatic concept in the direction of "imaginary" illnesses and wastebasket diagnoses.

The importance of diagnostic classifications grew with the improvement of Finnish healthcare system and compensation practices. In this respect Finland, was a latecomer to Europe and the Nordics, as exemplified by the slow introduction of sickness insurance. It is striking that compulsory sickness insurance, although first discussed in the 1880s, was passed only in 1963 (Kettunen, 2001, pp. 235–238). Prior to that, help was provided for the poor and the ill, but practices were scattered and did not fully cover treatment costs, let alone other expenses. The Sickness Insurance Act concerned all Finns regardless of work status, lowered the threshold for doctor consultations, facilitated the collection of health-related information and included rehabilitation costs. The system was now better organised and more inclusive while costs were still jointly covered by public, private and employer sectors. When, in the 1950s, the expenditures of Finnish social welfare were clearly below the European standard, by the mid-1980s the average level had been reached (Urponen, 1994, pp. 231–232, 238–239).

That sickness insurance included rehabilitation speaks for the contemporary incentive to uphold and, whenever possible, restore people's work ability (Harjula, 2015, pp. 262–263). Nevertheless, although broadening programmes meant that Finland emerged among welfare nations, the development was also met by dissenting voices that warned about the sustainability of the system. As demonstrated in publication III, the psychosomatic concept had a two-fold grip on the determination of work ability. First, the process of disability determination (done chiefly by occupational physicians and insurance doctors) had become complex, which called for holistic evaluative models. Second, the pension law that still stipulated that pension may be granted if "illness, defect or injury lowers a person's work ability by at least two fifths" (Työntekijän eläkelaki 3: 35§) posed an issue with regard to "psychosomatic" symptoms: how to show that there was a chain of cause-and-effect between diagnosis and disability if the disease process itself is unclear?

Finnish healthcare system developers also began to prioritise outpatient care over institutional treatment, which would both improve the accessibility of services and reduce costs (see Harjula, 2007). In the process, psychiatry became better integrated with general health care, which raised discussion around the points of contact between psychiatric and somatic ill-health. Developing consultation and liaison psychiatry became an intermediary in Finland. Since 1955, the Finnish Psychiatric Association [FPA] had organised training seminars for proponents of

different specialties, including dermatologists, general practitioners and gynaecologists (Alanko & Sorri, 1983, p. 344). During the 1970s and the 1980s, the FPA continued to insist on the relevance of the psychiatric view to general practice (Tienari, 1983, p. 62). However, despite the recurrent claim that up to half of the patients in primary care actually suffered from a psychosomatic complaint, the development of consultation psychiatry was slow. The psychiatrists Antti Alanko and Pentti Sorri lamented in 1983 that none of the opportunities to consolidate consultation psychiatry into medical practice were pursued. The reason "had to" be the "scientific conception of a human being that severed the mind from the body" (Alanko & Sorri, 1983, p. 343). Although general hospital psychiatry is still not a medical subspecialty in Finland, it has been possible to acquire a "special competence" in this field through FMA's medical education system (an organ that supplements official specialisation) since 1999 (FMA, n.d.).

The increasing popularity of alternative healing practices, which took place in the late twentieth century, reflected the less compliant and more consumer-oriented stance of the postmodern patient (e.g., Harrington, 2006, p. 189). Taken as a sign of a crisis of biomedicine, the development was noticed and confronted also by Finnish experts. That the status of acupuncture as a medical treatment was discussed in the Finnish Parliament during the 1970s – when decisions concerning medical techniques were not usually made by politicians – indicates the cultural momentum behind unorthodox treatments (Record of plenary session [RPS] 146/1978, parliamentary session [ps]; RPS 147/1978, ps]). While the debate on acupuncture was in progress, the Finnish Medical Research Council was conducting a survey on alternative medicines. In 1981, a report was completed. It discussed natural products, folk healing, acupuncture, anthroposophical medicine, Spiritism and homeopathy under the heading "physiological treatments" and linked them to the handling of chronic pain and psychosomatic illnesses (Hänninen et al., 1981, pp. 4–6, 31). Alternative remedies also weaved effortlessly into the eclectic New Age spirituality that emerged in Finland. As in other Western countries, the New Age movement did not have a single agenda, but it tended to oppose mind-body dualism and reject dogmatic structures such as mainstream Christianity and reductionistic science (Ketola & Sohlberg, 2008, pp. 215–228).

The alternative conceptions of healing questioned prevailing hierarchies of health knowledge to an unprecedented extent. By doing so, they intensified the need for sensitising diagnoses to patient experience. For instance, talks given in the 1995 Gyllenberg symposium (including the ones by medical historians Edward Shorter and Simon Wessely) pointed to the social and cultural determinants of

multiple chemical sensitivity, chronic fatigue syndrome and amalgamism, often deemed "psychosomatic" in a dismissive tone (Wallgren, 1995). Today, the tension between explanations pertaining to the individual and the environment still persists and has been intensified by patient advocacies that reject psychosomatic illness attributions (see publication IV and 4.4). Contested illnesses reflect their social environments as their appropriation often varies by local diagnostic traditions. For instance, in Finland, fibromyalgia has a more established status than burn-out or chronic fatigue syndromes. With the COVID-19 pandemic and the "long Covid" syndrome, the interplay of psychological, social and immunological factors has resurfaced, where neurological symptoms (e.g., so-called brain fog), respiratory problems, diffuse pains and anxiety persist after the active infection (Liira, 2021). As I have suggested elsewhere, the discussion around the long Covid syndrome resembles debates around contested diagnoses (Hyrkäs, 2021). The author of the long Covid description in *Duodecim* Health Library is the head of the clinic for functional disorders as well as a fresh long Covid outpatient clinic at the Helsinki University Hospital (Liira, 2020). It therefore seems that the syndrome has been cast to the category of functional illnesses.

That the term "functional" occupies part of the space that could be called "psychosomatic" brings us to the status of the psychosomatic concept in the 21st century. In Finland, a close equivalent of psychosomatic medicine, general hospital psychiatry, seems to be doing well and on the way to becoming an official subspecialty. Psychiatric consultation is offered in all Finnish hospitals, and the first textbook of general hospital psychiatry, drawing heavily and explicitly on a history of psychosomatic medicine, was published in 2019 (Pesonen et al., 2019). In this sense, psychosomatics has embarked upon a path towards institutionalisation. However, the word and the concept "psychosomatic" seem to be lacking their former vigour, as they no longer represent dynamic vehicles for communication between specialties and different cultural levels, mostly because of conceptual replacement. Like the concept of hysteria, as analysed by Mark S. Micale, the psychosomatic concept seems to have "vanished into a hundred places" (cf. Micale, 1993, pp. 525–526). Parts of it have been appropriated by new categories like somatisation, biopsychosocial and diathesis–stress models and a host of psychiatric diagnoses, leaving the scope of the word "psychosomatic" more restricted. The word persists in the vernacular, but its connotations are perceived negative and pejorative (cf. Greco, 2019). It is still doubtful that the idea of psychosomatic illness will ever disappear from cultural (and perhaps also clinical)

imagination. That the psychosomatic concept has blended into a multitude of conversations renders the history mapped in this dissertation open-ended.

1.3 Research questions and original publications

The historical background illustrated above introduces multiple actors and agendas that found the psychosomatic concept useful. So far, I have only cursorily described the interfaces between these spheres. Exploring them in depth is the main objective of this dissertation, where the research questions are as follows:

1. Who participated in psychosomatic discussions, that is, debates in which the psychosomatic concept was used? Who was the argumentation directed to?
2. How did differences between groups, their world-readings, interests and values influence the meanings given to the psychosomatic concept? How did the meanings change over time? What sort of things did actors agree upon? What were the central points of contestation?
3. What explains the appeal of the psychosomatic concept? Why has it persisted in the face of challenges and controversies?

Together, answers to the above questions put the original publications in a broader conceptual perspective. I argue that the salience of the psychosomatic concept came from its potential to cross ideational, scientific and institutional boundaries and to create dialogue between groups. In this study of communication, controversies are given a centre stage: they tell historians about the fractures in the air of self-evidence that often surrounds scientific claims. The research questions are approached through a theoretical perspective of a "contact zone" that is developed in the course of the work to shed light on the tensions, meanings and contexts of psychosomatic discussions.

Publication I sets out to trail the intellectual biography of the theologian-turned-psychiatrist Asser Stenbäck (1913–2006), who pioneered psychosomatic research in Finland. The article weighs the relevance of Christian doctrines for Stenbäck's thinking and compares it to that of other spiritual or ideological groups. Furthermore, the article participates in the discussion about the role of religion in psychosomatic medicine by evaluating the differences between scientific and spiritual ways of knowing. Combining the psychosomatic concept with religious guidelines could be used to support a moral structure with physiological underpinnings. The legitimisation that Stenbäck sought from "mythical transcendence" also persuaded conservative political advocacy (cf. Mannheim,

1986). In service of both ethics and health, Stenbäck, after his medical career, called for social change that concurred with Christian ideals as a member of the Finnish Parliament (1979–1983).

Publication II discusses the continuum between psychological and organic illness by looking at medical discussions on hyperthyroidism in the middle decades of the twentieth century. In post-war years, the concepts of psychosomatics and stress were introduced to address diagnostic issues that seemed to lead to unnecessary thyroid surgeries on neurotics. Diagnosing functional complaints brought out the different orientations of surgeons, internists and psychiatrists. A core issue was the overlap between the categories of neuroses and hyperthyroidism, supported by new knowledge on the physiological effects of emotions. The article highlights that psychosomatic claims entered at a stage of medical uncertainty, which left room for both conflict and dialogue. What is more, the psychosomatic concept was introduced as a critique of somatic practitioners, underlining the relational function of the concept.

Publication III, co-written with Dr. Mikko Myllykangas, focuses on maternal employment and the role that the ideas of psychosomatics and stress played in the socio-medical discussion around the issue from the 1950s to the 1970s. These concepts (allying with other medical theories such as maternal deprivation) expressed contemporary anxieties about a changing way of life on medical, popular and political levels. The claims acquired a different tenor depending on the values of the interlocutor. “Psychosomatics” and “stress” could be used as tools for victim-blaming, but also to call for changes in social conditions. The article was contributed equally, but Myllykangas put more effort to the sections about stress.

Finally, publication IV explores how musculoskeletal pain was discussed in psychosomatic terms in three conditions, rheumatoid arthritis, chronic backache and fibromyalgia, during the latter half of the twentieth century. The distinction between objectively verified disease and subjectively “felt” illness became prominent and strained the doctor-patient-relationship. Patients chafed at the psychosomatic rationales put forward by doctors at least to the extent that can be judged from published reader comments. This article argues that psychogenic illness explanations rendered conspicuous values, moral norms and social expectations that often underlie biomedicine.

In this dissertation, there have been two guidelines in case selection. First, the articles discuss issues that seemed significant entry points and areas of contribution for the psychosomatic concept itself (an internal criterion). The second, more external criterion was to select cases that could be used to examine whether the

concept had any broad social significance or distinct Finnish idiosyncrasies. Publication II started from the first Finnish dissertation on psychoanalytical psychosomatics, *Mental Disorders in Thyroidectomised Patients: A Psychosomatic Study of 53 Cases* (1957). Why the first psychoanalytical work would focus on thyroid surgeries seemed non-obvious. Therefore, I began to trace its origin, which revealed pre-existing conceptual confusion and practical problems that were harnessed to support the psychiatric agenda in the late 1950s. Article I on Asser Stenbäck unveiled a whole different story behind the adoption of the psychosomatic concept. Stenbäck's intellectual life testified to the bearing of Christian revivalism, language disputes and conservative values, but, more importantly, showed that the tension between spiritual and biomedical statements was a nuanced, non-binary issue. In contrast, the other two publications began from a more circumstantial standpoint. Publication III was motivated by the plethora of comments on maternal employment in Finnish medical and popular journals, which illustrated that the psychosomatic concept rode the wave of a big social issue. Publication IV looked for links between psychosomatics and post-war welfare state development and so led me to consider the rationale behind evoking psychosomatic explanations. The concept was perceived to have explanatory power in a distinct situation, where ailments that were difficult to verify exacerbated concerns about the sustainability of the new social system.

Now, one could very well argue against the choice of individual case studies; there would indeed have been many other possible entry points. However, an argument against the themes they address would be much less tenable. In total, the original publications explore controversies related to the indistinct dichotomies of the internal and the external, the somatic and the psychological, the secular and the other-worldly, the objective and the subjective, the male and the female as well as the personal and the political that the psychosomatic concept opened for discussion (on dichotomies in the history of medicine, see Jordanova, 1989). This dissertation is not and does not try to be an exhaustive overview of all things "psychosomatic", but it is an effort to relate the uses of the psychosomatic concept to the twentieth-century trends in medicine and to the economic, cultural and social history in Finland.

Scholars studying the history of psychosomatics have thus far directed their attention mainly to the psychiatric side (see 2.1). This statement holds true for Finnish and Anglo-American, but also, rather surprisingly for the German accounts. As historians Alexa Geisthövel and Bettina Hitzer argue, the fact that the history of psychosomatics has been dominated by research on psyche and psychotherapy calls

for more attention to the body (Geisthövel & Hitzer, 2019, p. 19). The present study, prompted by the Finnish idiosyncrasies in the uses of the psychosomatic concept, moves in this direction. Publications II and IV use non-psychiatric sources to examine the concept in somatic specialties. Thus, one intention of this dissertation is to underline the complexity of "psychosomatic connections" that do not stop at the borders of the history of psychiatry.

2 Theoretical Background

2.1 Previous research

I turn now to what is already known about the history (or better, histories) of psychosomatics. Works that focus on psychosomatic illnesses, psychosomatic medicine and the stress concept are reviewed here to formulate a mandate for the present study. Themes touching upon psychosomatics have also been discussed widely in historical research on behavioural sciences, pain, religion, alternative medicines and so forth. Though these literatures are not detailed in this section, they are referred to for the relevant parts in the original publications and the Results chapter.

The earliest accounts on psychosomatic medicine were written by medical experts when the field was still young (Margetts, 1950; Stainbrook, 1952; Zilboorg, 1944), and informative reviews continued to be produced for decades to come (Gottschalk, 1975; Lipowski, 1984; Schwab, 1985; Weiner, 2008). Gradually, psychosomatic medicine began to attract the attention of professional historians. In 1982, the renowned medical historian Erwin Ackerknecht (1906–1988) traced the long history of psychogenesis from Galenic passions to the psychosomatic medicine of German emigrant psychoanalysts in the 1930s (Ackerknecht, 1982; for an earlier and shorter version, see Ackerknecht, 1968). The account is regrettably brief but it does present a useful conceptual outline.

The history of psychosomatic medicine has traditionally been classified under the "history of psychiatry" heading (see Berrios, 2018; Porter, 1993). Works on hysteria, hypochondria, chlorosis and neurasthenia have discussed both medical theories and social hypotheses around these diagnoses (see, e.g., Figlio, 1978; Fischer-Homberger, 1972; Micale, 1990; Porter, 1993; Sicherman, 1977). Shorter's *From Paralysis to Fatigue* (1992) apparently grew out of this tradition (see also Shorter, 1994). Despite its anachronisms, Shorter's book, especially his idea of a "symptom pool" from which patients unconsciously choose their ails, has catalysed broader discussion on how social and cultural change may affect trends of psychogenic illness. A similar argument regarding fluctuating hysterical epidemics has been made by Elaine Showalter in *Hystories* (1998).

The historiography of the 21st century emphasises the connections that psychosomatic illnesses have to a variety of scientific and social contexts (Geisthövel & Hitzer, 2019; Harrington, 2009[2007]; Hayward, 2014b). The same

is true for the history of stress research, which as a field has become fairly crowded during recent decades (see Viner, 1999; Jackson, 2013; Cantor & Ramsden, 2014; Jackson, 2016). Among other things, volumes on stress discuss military stress, urban planning and evolution, stress in the workplace and at home, popular perceptions of it and scientific theories around it. Following the two world wars, there is also a vast and expanding literature on shell shock and post-traumatic stress (Shephard, 2000; Jones & Wessely, 2005b; Kivimäki & Leese, 2022). To illustrate the prevailing variety, the anthology edited by Geisthövel and Hitzer contains biographies of central actors (e.g., Viktor von Weizsäcker and Alexander Mitscherlich), articles on relevant concepts and theories (e.g., psychoanalysis, cybernetics and alexithymia) and accounts of various therapies. The broad scope covered illustrates that it is difficult, perhaps impossible, to write an exhaustive history of the directions that research on mind-body interactions took during the twentieth century, even less so of its multiple sources of influence. Nevertheless, the variety of uses provides a useful shorthand for studying how changing contexts inform medical theorisation.

New analytical approaches, such as those highlighting gender and class, have enriched the study of mind-body histories (see Björk, 2011; Haggett, 2012; Jasen, 2003; Kirby, 2019; Riska, 2002). Since the "emotional turn" a few decades ago, there has been a strong call for integrating emotions to the history of science, which has also supported interest in psychosomatic phenomena (Alberti, 2006; Dror, 1999; Dror, Hitzer, Laukötter & León-Sanz, 2016; Hayward, 2009). As observed by Bettina Hitzer and Pilar León-Sanz, emotions do not necessarily figure in psychosomatic theories, which may solely consider psychic influences and personality factors. However, feelings did often link the psyche to those physiological and psychoanalytical models that emerged at the turn of the twentieth century (Hitzer & León-Sanz, 2016, p. 69). Even though the articles in this dissertation do not apply a framework for the history of emotions, the moral sentiments noted in article I, physiological measurements of fear and anxiety in publication II, pathogenic mother-child-bond in publication III and anger dynamism and alexithymia in publication IV all testify to the prominence of emotions talk in Finnish psychosomatic discussions.

Studies inspired by Foucault have copiously stated the interdependence of knowledge and power (see, e.g., Petersen & Bunton, 1997). This basic assumption has inspired sociological research on psychosomatics. In an influential study of historical sociology, Karl Figlio has argued that there is a dialectical relationship between social setting (e.g., labour relations and legal practices) and the

construction of psychosomatic knowledge (Figlio, 1982). Similarly, Greco's social constructionist approach views psychosomatic knowledge as "embedded in a field of power relations" (Greco, 1998, p. 10). It is important to note that these statements ascribe specifically to the social construction of knowledge, not that of reality itself. To follow Ian Hacking's reasoning, the ontological cost of the social construction of reality – that is, of everything from one's own feet to the aroma of coffee and polar bears – is significantly higher than that of ideas, knowledge or facts (Hacking, 1999, pp. 22–24). Assuming a degree of social construction in this less obligating sense has become commonplace in the historiography of medicine (Jordanova, 2006).

Much of the above research implies that psychosomatic theories provide an attractive entry-point to how ideas of mind and body, within contemporary social realities, have been negotiated. The psychosomatic concept holds a special place among medical knowledge as it has continuously tried to bridge between mental phenomena and physiological change. I suggest that it is fruitful to dig deeper into what it means to study the psychosomatic concept as a form of medical knowledge, and to pay attention to underlying epistemological questions. What was deemed worth knowing, counted as evidence, and constituted a legitimate argument? Why have psychosomatic claims to knowledge remained uncertain and contentious? In what follows, I explore what we might learn by elaborating on such questions.

2.2 History of knowledge

The concept of knowledge is of course a natural companion of histories of science and medicine. In the last decade, a new historiographical field, the history of knowledge, has emerged, claiming to rethink their objects of study and scope of research (see Östling et al., 2018). However, historians have held cautious opinions about the rationale of the new field, asking whether the history of knowledge is anything more than "new wine in slightly stretched old wine skins" and whether deeming ideas knowledge merely makes an "unnecessary epistemological commitment" (see respectively Marchand, 2019, p. 127; Strang, 2020, p. 245). On a more optimistic note, Lorraine Daston has suggested that the concept of knowledge broadens the scope of the history of science beyond modernist origin myths and questions of demarcation (Daston, 2017). All in all, the new field promises to bring together scholars, approaches and methods in "cultural history, global history, media history, intellectual history, history of science, [and the]

history of the book" to improve research through cross-fertilisation (Östling & Heidenblad, 2020, p. 1).

According to historians Fabio de Sio and Heiner Fangerau, history of medicine differs from history of science in that the distinction between scientific and non-scientific has been accidental, not foundational. They convincingly argue that "everything", no matter how vaguely connected to health and disease, can be studied under the rubric of medical history and that there is thus no need to refashion the field as history of knowledge (De Sio & Fangerau, 2019, p. 175). But this concession does not mean that the demarcations of knowledge would be negligible in medical history. The question of what constitutes proper knowledge has had the potential to tip the scales in medical discussions ever since medical "science" became an element in this horizon. According to Simone Lässig, "evidence" separates knowledge from other ways of apprehending the world, such as from beliefs and feelings. However, the boundary between knowledge and non-knowledge is negotiable, since what constitutes evidence varies with time and place (Lässig, 2016). The history of psychosomatics has involved active attempts to change these rules of "admission". Therefore, I argue that psychosomatics was integrally caught up in processes of demarcation. This perception is concurrent with the present definition of knowledge, which I regard, following Peter Burke, as something more "cooked" than information. When data is perceived and processed, the assumptions and prejudices of human minds become interwoven with knowledge claims (Burke, 2016, p. 10).

The concept of knowledge extends beyond the questions of scientific demarcation to the interplay between evidence and meaning, which is one of the main reasons why it has been selected as the overarching theme of this dissertation (instead of, for instance, scientific boundary-work; see Gieryn, 1983; 1999; in Finland, see P. Vuolanto, 2013). As noted by Philipp Sarasin, "[k]nowledge circulates between individuals and groups because signs, discursive forms and semantic contents have the power to glide across institutional, social, political or even geographical boundaries". This movement transforms knowledge as it reacts to impulses from other disciplines and social spheres (Sarasin, 2020, pp. 2–3). John V. Pickstone's book on "ways of knowing" (natural history, analysis and experimentalism) lays out a conception of knowledge that is well-suited for my purposes and acknowledges that different forms of scientific inquiry are connected to deeper meanings. Pickstone argues that ways of knowing within science, technology and medicine are framed by world-readings, that is, systems of meaning and values found by "decoding" the world (Pickstone, 2000, pp. 8, 15–17). Hence,

the very act of knowing becomes meaningful, starting from questions asked and methods adopted. Expectations and prejudices transfer to and transform in public understandings, since the consumers of knowledge actively evaluate facts against their previous assumptions (Pickstone, 2000, pp. 197–199). Finally, Pickstone asks for analytical accounts that "differentiate between kinds of knowledge and also between the different ends for which knowledges are created, circulated and used", and goes on to highlight history as a key discipline to achieve this task (Pickstone, 2000, pp. 218–220). I like to think that this dissertation offers a take on the history of psychosomatics that is sensitive to both standards of knowledge and broader structures of meaning.

Studying the psychosomatic concept as a form of knowledge then brings to the fore the epistemological issues that have defined its uneasy relation to biomedicine. For instance, Greco has pointed out that acknowledging the body's potential to succumb to "fiction" (processes of symbolic conversion or subjectively felt life stress included) risks the scientificity and hence the legitimacy of medicine. The tension accounts for the recurrent notions of "heresy" and "revolution" in psychosomatic discourses (Greco, 2004, p. 694). According to the sociologist Nissim Mizrachi, the epistemological "openness" of psychosomatic medicine has resulted in constant re-examination of its knowledge base. That the editorial board of *Psychosomatic Medicine*, the first journal devoted to the topic in 1939, constantly struggled not to publish "nonsense", in other words to set the standards for psychosomatic knowledge, underlines this point (Mizrachi, 2001, 2002). Similarly, German psychoanalysis (and by extension psychosomatic medicine) has been accused of being speculative and ideological rather than scientific (Roelcke, 2004, pp. 482–484). Like other holistic approaches, psychosomatic theories have importantly tried to reconcile extra-scientific, for instance, philosophical, experiential and religious ways of knowing with laboratory science (Lawrence & Weisz, 1998). Making peace between the ostensibly incompatible views and different levels of explanation has then been the Herculean, or, rather, Sisyphean objective of psychosomatic discussions.

2.3 Knowledge in/as communication

Scientific claims can transform into powerful conceptual, rhetorical and political tools. But for them to do so, they must find support among groups that the message is directed to (see, e.g., Latour, 1987). James A. Secord's influential article of 2004 continues this thematic. It calls for "understanding science as a form of

communication" and reminds us that the boundary-crossings of knowledge claims should not be taken for granted (Secord, 2004, p. 654). When the psychosomatic concept is analysed as knowledge, the question of its persuasiveness in different contexts becomes a weighty issue. In this section, I synthesise elements of works that relate knowledge to communication to argue that the relational function of the psychosomatic concept is well-captured through the idea of a "contact zone".

The need for persuasion calls attention to possible problems of communication, which often coincide with scientific controversies. This dissertation does not shy away from controversies but rather embraces them as something helpful for historical explanation. In their seminal work *Leviathan and the Air-Pump* (1985), Steven Shapin and Simon Schaffer mention two central benefits of controversy studies. First, building on the work of Harry Collins, they note that controversies display knowledge in its unsettled form. Second, controversies "offer the historian resources for playing stranger", since historical actors often take distance from their antagonists' dearly held beliefs and try to pick them apart. The points raised by contemporaries are of course not analogous to historical analysis, but they do raise points that were not self-evident (Shapin & Schaffer, 1985, p. 7). I similarly treat controversies as clues to stranger perspectives. The approach is warranted as the tendency to ask uncomfortable questions at the risk of appearing foolish or ignorant was accentuated in psychosomatic discussions. Furthermore, it is no coincidence that the areas of medical uncertainty discussed in Collins and Pinch's *Dr. Golem* often touch upon the history of psychosomatics (Collins & Pinch, 2005; see also Aronowitz, 1998; Grob & Horwitz, 2010).

Communication issues have been addressed most notably by Thomas Kuhn's concept of incommensurability, according to which scientists from different paradigms (and often also eras) cannot meaningfully communicate with each other (Kuhn, 1962). Given that there is no revolutionary shift drawing a wedge between historical actors, the Kuhnian paradigm changes cannot very well be applied to the analysis of the psychosomatic concept in twentieth-century Finland. Although the differences in the thinking of historical actors were real enough, they were far less consequential. Kuhn's incommensurability was inspired by Ludwik Fleck's theory of thought collectives, which refers to the professional and semi-professional groups in which knowledge is produced, as well as related thought styles, characterised by shared judgments, methods, background information and styles of communication. In particular, Fleck paid attention to challenges in inter-collective communication and highlighted words as special vehicles for this. In other words, the meanings of words conform to suit different thought styles (Fleck, 1979[1935],

pp. 98–99, 105–110). Fleck's remarks are more relevant to studying psychosomatic discussions, as they can be applied to less fundamental interpretative differences between contemporaneous actors, experts and non-experts alike.

Since the times of Fleck and Kuhn, historians and sociologists of science have approached communication issues in a way that does not presuppose a total lack of understanding between distinct theoretical frameworks. For instance, Peter Galison has suggested the concept of a "trading zone" to analyse how problems of communication are managed in scientific practices with a degree of incommensurability. Galison defines trading zone as a "partly symbolic and partly spatial" site in which beliefs and actions are coordinated (Galison, 1997, p. 784). In relation to interdisciplinary collaboration, Galison's view has been elaborated, among others, by Harry Collins, Robert Evans and Mike Gorman, who have distinguished between its collaborative or coerced and homogenous or heterogenous forms. Importantly, Collins and others have stressed that the existence of a trading zone presumes a problem of communication, and if issues are resolved, the zone disappears (Collins, Evans & Gorman, 2007, pp. 658, 662).

To bring attention to a discursive rather than a concrete space, it is useful to relate the concept of trading zone to the theory of social worlds developed in American sociology. While this theory has been applied to "boundary objects" and concrete practices in complex institutional settings, it also extends to more abstract sites of discussion. Boundary objects, which themselves may be abstract or concrete, "are both plastic enough to adapt to local needs … yet robust enough to maintain a common identity across sites". Boundary objects are generally weakly structured but become more defined when adapted to the needs of different social worlds (Star & Griesemer, 1989, p. 393). As defined by Adele Clarke and Susan Leigh Star, social worlds are connected by shared interests, may share an increasing number of commitments and finally merge; however, if conflicts accrue, the whole of social worlds can be studied as an "arena". "Arena" therefore fosters multiple social worlds and is organised around a mutual concern or commitment to actions (Clarke & Star, 2008, p. 113). Furthermore, "arena" has been approached as a "site for interactions between knowledge actors and their audiences" in the history of knowledge, though this definition seems to sustain a more concrete understanding of arenas as regulated places and platforms (Östling, Olsen & Larsson Heidenblad, 2020, p. 7).

Trading zones and social worlds share the idea that dissimilar views can be mediated when actors have a common goal. Developing tools or advancing a political agenda may override scientific controversies. Discussion is then built

around and held together by a shared purpose and often also concrete forms of organisation. However, as I perceive it, the psychosomatic concept was not a goal of but a vehicle for action, which has been used to express individual distress or political claims and to demarcate clinical authority. The qualities of the discursive space change when attention is shifted from the goal of action to the devices that are used to make the action happen. Focus on discursive devices gives precedence to connectivity.

The concept of stress has also been discussed through this lens: in the introduction to *Stress, Shock and Adaptation* (2014), Cantor and Ramsden describe stress as a "boundary object", which "provides an opportunity for the exchange of ideas and practices, for the development of new scientific networks and subdisciplines, and for public and disciplinary engagement and disagreement" (Cantor & Ramsden, 2014, p. 8). Yet, as Star has underlined, using the term "boundary object" to describe simply different interpretations of a word does not really exploit its potential for analysing cooperative arrangements (Star, 2010, p. 613). In line with this suggestion, I prefer to consider the "psychosomatic" as a relational concept rather than a boundary object (on a similar take on stress, see Kirk, 2014). Viewing the psychosomatic concept "relational" means paying attention to its capacity to mediate communication between groups and to its function as an ideational link. As a thing in the historical landscape, the psychosomatic concept was a vehicle for creating connections.

Now, inspired by the above perspectives, I argue that the uses of the psychosomatic concept have given rise to a "contact zone" where different medical and scientific disciplines and subcultures were able to meet and exchange ideas. The contact zone allowed for negotiating standards of knowledge and for giving a hearing to unorthodox and alternative views. The term "zone" itself connotes discussions on the margins and thus highlights tactics for dealing with relative outsiders (cf. Secord, 2004, p. 664). It can be considered a persistent borderland that for long managed to retain its heterogenous identity (cf. Collins, Evans & Gorman, 2007). The movement of the psychosomatic concept across time and place has caused shape and exact "location" of the zone to vary somewhat. Tracing the dimensions and limits of this heterogenous space can be summarised in a call to "follow the vehicle" – that is, to follow relational concepts or boundary objects that link entities together. The phrase is my adaptation from the actor network theory's slogan "to follow the actors themselves", which avoids "limit[ing] in advance the shape, size, heterogeneity and combination of associations" (cf. Latour, 2005, pp. 11–12). "Following the vehicle", or in this case, following the psychosomatic

concept, is apt to unearth expanding networks of meaning, but I believe its benefits go further. These other advantages are detailed in the next subchapter.

2.4 Following the vehicle

"Following the vehicle" has at least three interrelated benefits. First, taking a single concept as an entry-point makes a phenomenon that runs in all directions manageable. The approach is analogical to the description that Latour has provided of cycles of accumulation, through which distant things are brought to scientific centres for a process of abstraction. Selecting a limited number of things and bringing them to one location puts the world to a tangible scale, which in turn makes understanding possible (Latour, 1987, pp. 215–232). Studying relational concepts and the contact zones around them opens up possibilities to go down new avenues but importantly also creates cohesion between disparate objects. Without such guidelines, it would be incomprehensible to analyse, for instance, surgical techniques, anthroposophy, welfare reform and women's rights within a single narrative. Following the vehicle offers a way to think about protean mind-body histories that, so to speak, brings robust reality to one place.

Second, since research concepts invariably affect the impressions we form of historical reality, choosing entry-points wisely helps to identify general themes from a sea of detail. For instance, Michael Hau has noted that paying attention to distinct organisations and different practices (e.g., temperance movement or vegetarianism) can lead to a fragmented picture of a phenomenon that actually has a distinct common thread (regaining health through life reform) (Hau, 2003, pp. 2–3; also Rytty, 2021). Therefore, although relational concepts are historical, the historian has agency in choosing whether s/he highlights the unifying theme or the individual phenomena (on selection, see also 3.3). It is important to recognise that even similar concepts act as bridgeheads to different discussions. To offer a few examples, the idea of "constitution" was more sensitive to heredity and fears of degeneration; "stress" to physiological parameters and critiques of modernity; and "psychosomatics" to people's inner worlds and changing structures of meaning. A relational concept delineates a contact zone in a way that is specific to that concept alone.

Third, exploring different interpretations of concepts can significantly improve our understanding of why attempts at boundary-crossings work or do not work. Interestingly, the use of relational concepts or boundary objects can also function to undermine attempts at better mutual understanding. Taking an example from the

relationship between biomedicine and Christian Science, the sociologist Kellie Owens has contended that the Christian scientists' use of the "placebo effect" to argue for the health effects of prayer healing failed, since the placebo has negative and deceptive connotations in biomedicine. Therefore, the "boundary object" worked to underline the social distance between the two groups, leading Owens to conclude that contextual awareness is elementary in explaining the appropriation and function of concepts (Owens, 2015, pp. 23–24). Associations of words indeed play a significant part in their relational work and relate to deeper structures of meaning. To follow the philosopher Uffe Juul Jensen's reasoning, standards of evidence are entwined with different ontologies and political dimensions of medical practices that define struggles over authority (Jensen, 2007). I would add that by following the same vehicle, it is easier to distinguish what elements in contextual surroundings make or break the success of an idea. The comparison also helps to identify points of divergence within groups that from the outside may appear homogenous, such as the so-called medical fringe and the medical mainstream.

3 Material and Methods

3.1 Published sources

The primary sources for this dissertation comprise medical writings on psychosomatic medicine and related topics. The material includes textbooks, popular and scientific monographs, original research publications, committee reports, published minutes of meetings and transcripts of lectures held in Finnish medical societies, as well as editorials, reviews, letters to the editor and announcements. The sources display different communicative acts and medical knowledge in its approved of and tentative phases. This dissertation highlights debates that crossed the threshold of publicity, in other words, those psychosomatic claims that were deemed suitable for and worthy of disseminating. The use of published sources is therefore congruent with studying the psychosomatic concept in/as communication.

To begin the process of research, I started by viewing the digitised numbers of *Duodecim* systematically from 1885 to 2018. This, in turn, guided further source collection both by sketching a rough timeline and by suggesting themes that had been connected to the psychosomatic concept. In total, 35 periodicals published between 1945 and 2000 were perused to create grounds for comparisons between publications (see Appendix 1 for the full list of journals and exact timeframes). While some journals were obvious choices because of their longevity and wide circulation (*Suomen Lääkärilehti* [Finnish medical journal], *Terveydenhoitolehti* [Health care magazine] and *Finska Läkaresällskapets handlingar*), others, for instance, religious journals, women's magazines or journals of advocacy groups, formed interesting points of comparison due to their specific audiences and aspirations. For publication III, *Huoltaja*/*Sosiaaliturva* [Carer/Social security], *Epione*/*Sairaanhoitajalehti* [Journal for nurses], *Kätilölehti* [Journal for midwives], *Kotiliesi* [roughly Home and Heart] and *Eeva* were inspected together with Dr. Myllykangas. The source material has been continuously supplemented with titles relating to each original publication. Further, scattered articles and books, traced through bibliographies, reference lists and database searches, have been used.

In addition to the Finnish journals, I have searched articles in *Psychosomatic Medicine* (1939–2020), leafed through the *Journal of Psychosomatic Research* (1956–1996) and investigated the indices and made use of selected writings from

Nordisk medicin and *Nordisk psykiatrisk tidsskrift*. These materials have been used to compare Finnish discussions to international trends in medicine.

I decided to include less prominent titles that cannot match major journals in dissemination and scope to gain a more comprehensive view of the medical discussion. To offer an international point of comparison, Sally Frampton and Jennifer Wallis have commented on the disproportionate attention that *The Lancet* has received in current histories of medical media. Both Frampton and Wallis regret that other periodicals with a more limited time span and less obvious contemporary resonance have not been as attractive to digitalisation ventures and are thus absent from many accounts of the nineteenth-century medical press (Frampton & Wallis, 2019). This statement has perhaps even more bearing in the twentieth-century context, when the number of journals just continued growing. Including only major titles entails a real risk of skewing the results particularly when it comes to marginal topics.

The increase in the number of journals was paralleled by the extent of their dissemination. The historian Jonathan Topham has pointed out that the transformation of audience relations, generated by the appearance of the mass medium of print, has increased the cultural authority of science since the nineteenth century (Topham, 2000, p. 561). This trend has been reinforced by the popularisation of science (see, e.g., Cooter & Pumfrey, 1994, p. 239). In Finland, the first popular medical journal *Terveydenhoitolehti* was established in 1889 and became at once a significant medium of direct and indirect circulation of health knowledge (see Halmesvirta, 1998). Again, the development set in motion in the nineteenth century bears present-day relevance, as the increasingly interactive platforms have fostered doctor-patient dialogue in print.

Historians studying medical journals have tended to be more interested in the "words on the page" than "the page itself" (Bynum, Lock & Porter, 1992). Although I too focus more on content than form, I recognise that the medium of dissemination changes the way in which knowledge is presented. Following Sarasin, knowledge always has material constraints: it exists on the conditions of "storage, transport and presentation media" and becomes formatted to fit the logic of these channels (Sarasin, 2020, p. 3). The sources of this dissertation are appropriate for an analysis of how the publication channel has modified (re)presentation. Recognising that periodicals are purposeful appreciates the fact that psychosomatic claims in medical, philosophical or religious arenas differ decidedly from those, for instance, in the annals of experimental biology. To underline the mediality of the psychosomatic concept, each of the original publications emphasises a particular

set of published sources: publication I compares medical statements to articles in Christian journals, publication II focuses on medical research and technical discussion, publication III explores popular and political media, and publication IV highlights reader comments and documents in which treatment strategies were formulated.

Most Finnish newspapers are text-searchable at the National Library Digital Collections only until the 1930s, prior to which searches have not resulted in any occurrences of the word "psychosomatic". Although the word *sielullis-ruumiillinen*, "relating to soul and body", was used, this was mostly in religious and educational contexts. The limited material that is readily available gives some direction to what sort of topics initially reached a newspaper audience. What appears to be the first substantive Finnish-language newspaper report on psychosomatics was published in the tabloid *Ilta-Sanomat* in 1939 and dealt with the American psychoanalyst Joseph C. Rheingold's thyroid hypothesis of schizophrenia (*Ilta-Sanomat*, October 28, 1939). That this anonymous text was based on an article published in the all-time third issue of *Psychosomatic Medicine* (July, 1939) and published already in the same year illustrates how fast news could travel already in the pre-digital age. The apparently first Swedish-language report was based on a *Lancet* article and was published in *Vasabladet* in 1943. It stated that the Scottish doctor James L. Halliday was able to predict future diseases by the personality of the prospective patient alone – a promise that the reporter found "sensational" (*uppseendeväckande*) (*Vasabladet*, December 17, 1943). In the early 1950s, when psychosomatic medicine was at the height of its novelty, the newspaper *Uusi Suomi* wrote frequently on psychosomatic theories of, for instance, childhood diseases, headaches and allergies (*Uusi Suomi*, 1951; 1952). Although the above references are instructive, their themes and yellow press tone do not deviate much from popular articles that were published in magazines produced for lay audiences.

It is difficult to estimate the exact amount of works that made use of the psychosomatic concept in the present body of sources. That some accounts were dedicated to psychosomatic problems and others mentioned them only in passing creates further differentiation. Both kinds of references are noteworthy as they indicate how, why and to what extent the concept infiltrated the medical discussion. To achieve a rough estimate, a simple search for the word "psychosomatic" (*psykosoma** in the abridged Finnish form) in *Duodecim* returned 345 items appearing between 1935 and 2021 (the latest search conducted on April 21, 2021). The corresponding number for biopsychosocial (*biopsykosos**) was 51 and for stress (*stress**) 2,473. "Psychosomatics" lands in between these numbers also in

the database of Finnish University Libraries, where *psykosomatiikka* returned 1,026 items in the face of 23 titles including *biopsykososiaalinen* and 6,798 including *stressi*. In *Duodecim*, psychosomatics and especially stress were fairly common compared to widely used medical terms "heart" and "infection" that received around 8,000 hits (respectively *sydän** and *infekti**), but were nowhere near the approx. 25,000 instances of derivatives from essential words such as "patient" and "medicine/medication" (respectively *potila** and *lääke**). It seems safe to conclude that the total number of works collected for this study, from which the material for close reading was selected, is in the thousands and thus representative of the uses of the word and the concept "psychosomatic".

3.2 Archival and parliamentary sources

Using published material alone may conceal from sight more controversial motives and thoughts that historical actors have not been willing to parade in public. Though the printed minutes of meetings offer glimpses of events behind closed doors, they too are often altered by the politics and conventions of what was written down. To supplement the view gained from published works, I obtained material from the Archive of the Signe and Ane Gyllenberg Foundation, which contains correspondence, articles, newspaper clippings and official documents relating to psychosomatic and anthroposophical research in Finland. The archive is situated at the foundation's office in Helsinki, where reports and lists of financed projects are also stored.

The documents from the Gyllenberg Foundation have influenced the research in both direct and indirect ways. Tax reports and lists of funded projects have helped me to locate medical research on psychosomatic topics. The correspondence between Ane Gyllenberg and Finnish doctors has been invaluable in specifying conflicts and goals in psychosomatic research. Publication I, which traces the intellectual biography of Asser Stenbäck, the first Gyllenberg grant recipient, makes use of the archival material to explore the tensions between the representatives of scientific and spiritual holism within the foundation. These convoluted relations will be discussed further in section 4.1.

Article I and the discussion in the Results chapter have been supplemented by material from the archive of the Finnish Christian Medical Society (FCMS). In addition I extracted Stenbäck's veteran MP interview from the Oral History Archive of the Finnish Parliament. These interviews are not public to preserve the authenticity and confidentiality of the material, but their structure and the criteria

for the selection of interviewees can be found on the Parliament website (Finnish Parliament, n.d.). The digitised parliamentary documents (transcripts of plenary sessions, speeches and written questions) that have been used in publications III and IV and this compilation part are available in open access from 1907 to 2000.

3.3 Concepts, contexts and contact zone: Implications for method

Critical use of sources, contextualisation and reasoning through writing are the basic methods of historical research (Danielsbacka et al., 2018, pp. 11–12). In addition to them, this dissertation builds on tenets of conceptual history. The two dominant approaches in the field, the Anglo-American Cambridge School known for the works of Quentin Skinner and J. G. A. Pocock, and *Begriffsgeschichte* developed in Heidelberg most notably by Reinhart Koselleck, are in many ways distinct, but both study concepts in their social and political contexts. I have found the Anglo-American approach more useful, as it relates concepts to language, rhetoric and discussion – in other words, it analyses words in a way akin to Wittgensteinian language games. The distinction between "term" and "concept", articulated in *Begriffsgeschichte,* has also informed the present analysis. In practice, this has meant scrutinising words that belong to the semantic field of the studied concept (cf. Hampsher-Monk, Tilmans & van Vree, 1998; Kuukkanen, 2008).

In "Meaning and Understanding in the History of Ideas" (1969), Quentin Skinner posits that proper history-writing requires analysis of statements, their contexts and underlying intentions. To elaborate, historians should study words in the full variety of instances in which they have been used; the social context should be identified but not taken to be all-explaining; and finally, the true intentions of the author should be interrogated by comparing statements with the general textual context of the time (Skinner, 1969). Skinner was inspired by J. L. Austin's "speech acts" that place emphasis on the function of utterances and view successful statements as contingent upon the idiosyncratic beliefs and attitudes of interlocutors. Whether one wishes to call it "de-rhetorisation", source criticism or close reading, deconstructing the text is the starting point for historical analysis. This is then followed by an interpretative synthesis that is argued in narrative form (V. Vuolanto, 2007).

Contextualisation begins with source collection. Books and journal articles are material things, and already their physical form implies the former uses of texts and features of the contemporary context. For instance, Finnish journals were significantly thinner during and immediately after the Second World War, which

conveys difficulties of obtaining paper for print. If an article did not fill pages evenly, its remains were scattered across the journal to make good use of every column inch. The increase in economic affluence was reflected not only in the proliferation of titles but also in the amount and quality of the paper pages produced. Advertisements, often excluded from digitalisation efforts, can prove to be instructive. Such was the case for drug commercials in *Suomen Lääkärilehti*, which in the 1960s and 1970s often touted the "psychosomatic" benefits of different tranquilisers. The physical condition of print material can also betray how much the material has been used. Sometimes the folded pages were not even cut open and other times the binds on the back of the book or journal fell apart from repeated browsing. Hand-written inscriptions can reveal surprising connections between actors (see 4.2, p. 63) and notes in the margins may disclose insights of an anonymous reader. All of this exemplifies that the materiality of print is more than empty play on words, as it conveys traces of the text's past.

Furthermore, following Lara Putnam, reading printed material "forces" upon the researcher information about themes that other people have found important; the topic is automatically set to perspective by other contemporary concerns (Putnam, 2016, p. 393). Going through various journals and edited volumes reminds the reader that this immediate context is not one but many, allowing comparison between publication arenas. Articles reprinted in more than one journal or collection are particularly interesting as they reveal connections between individuals and groups. Although most of my sources are in print format, I want to acknowledge the bearing that the availability of text-searchable materials and OCR technologies has had for my focus on the connections and communication in the history of psychosomatics. That such central titles as *Duodecim* and *Psychosomatic Medicine* are fully or partly available in digital form has laid bare unexpected connections. As Putnam has noted, the possibilities of borderless term-searching and side-glancing generate hypotheses of entanglement that could not have been created in the pre-digital age. However, Putnam also warns that the cost of accessibility might be superficial historical understanding (Putnam, 2016). Therefore, searches are best paired with traditional forms of immersive reading and contextual browsing.

Initial decontextualisation allows the researcher to entertain many possibilities as to how to frame the object of study, since the context put forward by the sources is not necessarily the most productive one for analysis (cf. Hyrkkänen, 2002, pp. 200–203). When one is interested in the contact zone around a relational concept, the choice of contexts is even more crucial. The zone is historical in the sense that

one cannot go beyond applications of a particular concept; the actual movement of knowledge limits associations. However, explanatory contexts chosen by the researcher influence how the zone appears to them and what elements are foregrounded. This process might be described as relational mapping, in which the researcher imposes order between things and contexts (cf. Bowker & Star, 2000[1999], pp. 303–304). Map is a convenient metaphor for how first identifying and then delimiting a contact zone works by way of research methodology. Producing a "map" helps us to reconceive the subject, puts it in context and guides us in explanation. Mapping brings to sharper focus the structures of meaning that concepts are attached to, since world-readings in the sense meant by Pickstone are part of both scientific constructs and human histories (Pickstone, 2000, pp. 33–59). As with real maps where 3D space is fitted to a two-dimensional plane, the process distorts reality. To quote the geographer Mark Monmonier, all maps "lie", but they must do so or otherwise the user drowns in information (Monmonier, 1996[1991]; see also Burton 2020, February 4). This is true for historical representations as well, so we must be mindful about what story we are telling.

Differing from a traditional historical monograph, this dissertation assumes a case-within-a-case structure (Gondo, Amis & Vardaman, 2010). Subcases were chosen from the vast variety of topics to which the psychosomatic concept had been applied. To offer a comprehensive picture of the studied phenomenon, I have selected dissimilar cases. Still, by necessity, some actors and institutions are emphasised at the expense of others. The study began with in-case analyses, presented in original publications. The compilation part looks across cases to identify points of convergence and divergence. The cross-case comparisons provide a robust view of historical reality and create grounds for making broader theoretical statements. However, the relationship between case studies and generalising conclusions is not straightforward. For one thing, grand narratives may appear misleadingly coherent (Shapin, 2005, p. 242), while, on the other hand, the worth of case studies may be questioned if they remain mere descriptions of isolated instances (Sarasin, 2020). As this dissertation scrutinises only four cases in a small geographical setting, the potential for extrapolations is limited. Still, there is no reason why big questions cannot be asked in small places. The small setting leading to uniform medical education, collegiality and plenty of opportunities to engage with doctors who were not like-minded has in fact given rise to the consideration that distinct traditions and projects may intersect in less than obvious ways.

4 Results

This section presents the results of the cross-case analysis. The uses of the psychosomatic concept are first explored within the medical profession, after which the analysis moves away from the core of medical knowledge debates to the external realm. The subchapters discuss transcendental knowledge systems and specialty demarcation, social and political uses of psychosomatic claims as well as the differences between expert and lay ways of knowing. Following Shapin and Schaffer, conflicts are highlighted to penetrate the impression of self-evidence. In line with this approach, it is noted that becoming controversial was not the end, but rather a beginning for the psychosomatic concept. To quote Latour: "[t]here is something still worse… than being either criticised or dismantled by careless readers: it is being *ignored*" (Latour, 1987, p. 40). The conclusion of the chapter reflects on the functions of the contact zone and suggests that there is added value in the heterogeneity of the psychosomatic concept, as each perspective, with its individual agenda, tried to alter and take apart existing hierarchies of knowledge.

4.1 Transcendental knowledge systems and medical science

Demarcations between orthodox and unorthodox medicine are changing and socially constructed (Bynum & Porter, 1987). One aspect of the demarcation problem is the dichotomy between science and non-science, which easily creates a false impression that the "non-scientific" group would be coherent internally. Christian doctors, anthroposophists and existential analysts discussed in article I held vastly different theoretical presuppositions, which created tension between the actors unified by their contestation of the biomedical perspective. As Julia von Boguslawski has argued regarding Finnish anthroposophy, defining "otherness" was part of its identity work (von Boguslawski, 2017). This subsection discusses the differences and similarities between outsider ideas, often spiritual in nature, and comments on their relations to the medical mainstream.

As explained in the introduction, Christian soul-body considerations paved way for the psychosomatic concept. The Lutheran Christian background of Finnish physicians was a relatively easy fit to scientific medicine and idealised doctor-patient relationship as an equal partnership of trust (Dhondt & Kontturi, 2021, September). However, more fundamentalist Christian beliefs, often arising from revivalist roots, were not always compatible with the medical mainstream. For instance, the psychiatrist and founder of the Finnish Christian Medical Society

Helmi Heikinheimo (1879–1968), who came from a revival Christian family, discussed faith healing under the rubric of suggestion and saw also other parallels between psychiatry and religion (Hakosalo, 2014b, p. 94). In 1933, a presentation held in the FCMS went as far as to imply that Christian healing was superior to medical techniques (The Archive of Finnish Christian Medical Society, Annual report 1932–1933). When psychosomatic medicine came to Finland following the Second World War, many Christian doctors regarded it as another way to combine faith with medicine. They seemed drawn to psychosomatic medicine as it could legitimise some of their spiritual beliefs and allowed them to comment on the moral aspects of health and disease (publication I).

However, somaticists did not share the connection that was constructed between the psychosomatic concept and religion. A 1950 article on prayer healing, interviewing three high-standing doctors, illustrates the diverging viewpoints. In the interview, the professor and internist Pauli Soisalo "did not want to comment on prayer healing" at all but spoke instead favourably of psychosomatic medicine; the surgeon Pauli I. Tuovinen was cautious about "psychic" influences in tissue pathologies but recognised their role in the recovery of surgical patients; and Johan K. Runeberg stated that psychosomatic symptoms could be alleviated through prayer, but anyone who claimed to have exorcised tuberculosis, cancer or organic blindness or deafness was either "mistaken or possibly lying" ("*Sielulliset tekijät ja sairaudet*", 1950). These physicians denied the interchangeability of the psychological and the spiritual, while it was precisely their overlap that the religiously inclined found useful and even reassuring (publication I).

The relationship between Christianity and emergent psychoanalysis was similarly ambivalent. Some priests viewed the Freudian method positively as a vehicle for pastoral care, while others were put off by its sexual connotations (publication I). Whether and how to connect theological ideas to psychotherapy was a source of discord among psychoanalysts. The existential strand, developed by Martti Siirala and heavily influenced by his theologian brother Aarne, regarded faith and health as inseparable as they were both elements of unified human existence (A. Siirala & M. Siirala, 1960). Both Asser Stenbäck, the protagonist of article I, and the psychiatrist and future professor Yrjö Alanen disliked Siirala's tendency to conflate psychoanalysis with theological and philosophical convictions to the extent that they did not want Siirala to be given a lectureship at the University of Helsinki (Alanen, 2012, pp. 35–37). Similarly, Professor Martti Kaila accused Siirala of leading Finnish psychiatry astray through "daydreaming, fantasising and speculation" (cited in Ihanus, 2000, p. 134). However, in the decades that followed,

Siirala's thinking became further removed from theology, which relieved some of the tension.

Even Christian psychosomaticists could hold dissimilar ideas of medical science which influenced their relationship to the medical community at large. Stenbäck was active in the FCMS and a devoted Christian revivalist but still ascribed to empiricism in medical research, which he regarded as distinct from faith, a religious way of knowing (publication I). Siirala's goals were bolder. He wanted to renew the basis of medical knowledge by combining it not only with theology but also with philosophy. In the preface to Therapeia's handbook *Medicine in Metamorphosis* (1969 [1966]), Siirala quoted the neurologist Kurt Goldstein: "the function of the organism could be understood only if we include[d] that point of view usually called philosophic". Siirala regretted that the philosophical approach was normally depreciated as non-medical, non-empirical and non-physiological, although the clinical reality (particularly problems of speech, which the handbook focused on) did not seem to follow the demarcation between empirical research and philosophical reasoning (M. Siirala, 1969[1966], p. 10). Siirala insisted that the distinction between theological, philosophical and medical ways of knowing was an artefact of the "delusion of an unlimited, primarily autonomous observer-position" (M. Siirala, 1969[1966], p. 4). In other words, Siirala chided doctors for mistakenly thinking that they were in a position to differentiate between dimensions of existence, and hence able to heal without paying attention to the existential message of illness.

Although the Therapeian form of psychoanalysis formed a separate islet in Finnish psychotherapy, it was seldom openly criticised. Then, in 1976, Stenbäck's public critique of Therapeian treatment in a prestigious Finnish medical journal revealed the depth of differences of opinion between Siirala and Stenbäck. Stenbäck scolded analytical psychotherapy for being "too speculative" and "scientifically unproven" (Stenbäck, 1976, p. 58). His critique was not aimed directly at Siirala but rather Oiva Ketonen, a notable philosopher engaged in Therapeian activities. Ketonen believed he was chosen as a target because Stenbäck did not want to "openly disagree with a fellow physician" (Ketonen, 1976, p. 60). For Stenbäck himself, achieving a high status in academic psychiatry had required a degree of dissociation from religious beliefs. As shown in article I, he elaborated theories about the interconnections between the soul and the body only among like-minded Christians (notably, he did not publish in the theological journal *Vartija*, in which the Siirala brothers were active during the 1950s). When Stenbäck was ridiculed about his reported belief in demonic possession and exorcism in the 1970s,

he assured that everyone remained "positivist" at the University of Helsinki psychiatric clinic (Mäkelä, 2006, p. 75).

So, there were a number of strategies to combine Christian faith with medical science. One could use concepts like suggestion or psychosomatics to bring religious matters into the medical realm or compartmentalise science and faith into separate categories. It was also possible to blanket religion and ideologies from medical proceedings in favour of scientificity, which has been a persistent tendency in the history of medicine (e.g., Leclercq, 2021, March). A more antagonistic approach was to question prevailing standards of knowledge and to build on a whole other fundament. This view dominated in the Therapeia Foundation.

The objective to fully reconceive the relationship between science and the spiritual world was also the driving force behind the Gyllenberg Foundation's quest to boost research into mind-body interactions in medicine. The idiosyncratic agenda had its roots in the esoteric currents that had reached Finland in the early twentieth century, in particular the anthroposophical movement, which actualised when Rudolph Steiner left the international Theosophical Society due to disagreements about Christ's divine status. The issue reflected Steiner's growing inclination towards Christian esotericism (Leijenhorst, 2006a, pp. 1089–1090; see also Leijenhorst, 2006b). In 1913, Steiner established the *Anthroposophische Gesellschaft* and visited Helsinki the same year, which sparked approx. 100 members of the Finnish Theosophical Society into joining the *Gesellschaft*. The bilingual Finnish anthroposophical society (*Antroposofiska Sällskapet i Finland*) was established ten years later, but it split into multiple communities already in 1924. In all of them, activities included studying Steiner's writings, discussions and sometimes meditation (von Boguslawski, 2021, pp. 22–23).

Having acquainted himself with Steiner's writings early on, Ane Gyllenberg found the doctrines of anthroposophical medicine resonant with his personal spiritual convictions, which drew from Freemasonry and broad philosophical "learnedness". Indeed, religious books are well represented at the Gyllenberg museum. In 1926, Ane became a member of both *Sällskapet* and *Gesellschaft*, and he and his wife Signe visited Goetheanum, the anthroposophical headquarters in Dornach, in 1934. There they were introduced to experiments in spiritual science that convinced Ane that anthroposophical research could have practical value. In Finland, Ane sought out doctors knowledgeable in anthroposophy and became a personal friend of Hilja Michael (née Muinonen, 1932–2016), a pioneer in this area, who also gave the Gyllenberg family access to anthroposophical medicines (Nylund, 2018, pp. 77–83). It was as late as 1993 that the Medical Professional

Association for Anthroposophical Medicine in Finland was founded, accepting only certified medical doctors, dentists and veterinarians as members. There have never been anthroposophical hospitals in Finland, the nearest one being in Sweden (Granholm, 2016).

There is no record that the Gyllenbergs ever met Steiner, who passed away in 1925. However, they fully embraced Steiner's vision to expand the realm of science so that it could again comprise the spiritual realm and make it comprehensible to the modern person. To this end, Ane Gyllenberg sought cooperation with notable Finland-Swedish physicians. Psychosomatic medicine, with its connections to stress research, was something that these "serious" doctors, in particular the Professor of Internal Medicine Bertel von Bonsdorff (1904–2004), felt they could support. The question of anthroposophical medicine was far trickier, as it, among other things, gave spirit precedence over material laws and regarded blood as an instrument of the ego, a physical phenotype of humans' inner lives. This discrepancy between scientific and spiritual understandings posed a threat to medical reputation of the doctors involved. For instance, von Bonsdorff was reproached by his successor Otto Wegelius for cooperating with Gyllenberg, who was "overly fascinated with questionable healing processes" (Nylund, 2018, pp. 106–107). This problem, which defined the first decade of the foundation, was at least ostensibly overcome when a separate anthroposophical funding division was established after heated discussions by the board in 1960.

The Gyllenberg Foundation also brought together proponents of disparate specialties, and thereby aided the communication between them. The foundation, particularly its psychosomatic wing, funded research ranging from experimental biology to psychiatry, although this may signal academics' chronic shortage of research funding rather than a burning desire to cooperate. Nevertheless, thanks to the concept of stress, the potential for cooperation was there. This capacity was perhaps most clearly realised in the actions of the renowned Finnish endocrinologist and Professor Bror-Axel Lamberg (1923–2014). In 1986, he edited *Finska Läkaresällskapets handlingar*'s special issue on stress. Lamberg, who was the chair of the Gyllenberg Foundation's board at the time, went as far as to try to dismantle reservations towards anthroposophy by stating that it was about "more profound" matters than "the potential health effects of mistletoe" (the anthroposophical remedy for cancer) (Lamberg, 1986, p. 162). Here, as well as in interdisciplinary seminars organised by the Gyllenberg Foundation, the stress framework was crucial to arguing for psychosomatic connections in a manner that was acceptable to somaticists.

However, Ane Gyllenberg felt utterly misunderstood by medical doctors, even compliant ones like Stenbäck. In a letter written to Gyllenberg in 1956, Stenbäck equated research on how "psychological illnesses are influenced by culture, religion and life philosophy" with anthroposophical medicine (GA, A. S to A. G., August 24, 1956). Gyllenberg's private notes comment on the letter: "Horrible. All dead wrong. Knows apparently nothing about anthroposophical medicine. Later talks about how not 'with good conscience' gives support". In a later letter to Allan Johansson, a psychiatrist affiliated with the Therapeia Foundation, Gyllenberg regretted that nobody was bold enough to pioneer the new science, which would be "just as scientific [as biomedicine] but in a different way". He also did not like to see the word *andevetenskap* ("spiritual science") used to describe his neo-scientific aspirations, since the word *ande* ("spirit") could be easily misunderstood and then "abused by detractors" (GA, A. G. to A. J., February 2, 1958). It is clear that Gyllenberg was more interested in the medical promises than in the ethical guidelines of anthroposophy. His own life was organised around the moral ideals of Finnish Freemasons who, like anthroposophists, stressed self-improvement but put greater emphasis on fraternity, compassion and neighbourliness (Nylund, 2018, pp. 65–75).

The correspondence between Ane Gyllenberg and Johansson leads one to believe that anthroposophy and analytical psychotherapy were united not only by their interest in psychosomatic questions but also by their criticism of too strict a definition of what counted as "scientific". Residing on the outskirts of medicine, having a shared enemy, so to speak, could mediate different perspectives. When details of world-readings are put aside, Gyllenberg and the psychiatrists that the foundation funded had common interests. One joint pursuit was immunology, which fuelled psychiatric studies on autoimmune diseases, psychoses and cancer, but was also linked to Gyllenberg's apparent fascination with the idea that cancer was an infectious disease to be diagnosed with biocrystallisation and treated with mistletoe preparations (GA, Medicine and Steiner in the foundation, F8). To Ane Gyllenberg, psychosomatic medicine remained a means to an end. Although it may be that he simply did not want to invest in any expensive and long-standing enterprises, his rejection to finance a professorship of psychosomatic medicine at the University of Helsinki indicates a degree of detachment from a strictly psychosomatic agenda (publication I).

So far, we have been preoccupied with the different standards of knowledge that were built in anthroposophy, existential psychotherapy and Christianity. However, it should also be recognised that their world-readings supported different

moral imperatives. Lutheran Christianity fostered a clear set of rules for collective action, the strictness of which varied in Christian subcultures. Anthroposophy emphasised individual growth that operated through cycles of reincarnation. In this framework, a wrong-doing was not so much a sin as a chance for moral improvement. The goal of self-improvement was also present in Freemasonry but perhaps secondary to a strong sense of communality and fellowship. Therapeian ideas of social pathology, according to which organs become diseased because individuals bear the traumas of the community, voiced both an individual and collective need to come to terms with existential issues. Standards of knowledge, illness and moral order could be brought together by the psychosomatic concept.

As we can see, opinions on psychosomatic medicine diverged along multiple axes, but also shared the intention to improve the existing praxis of medicine. To follow Greco and Mizrachi, perceived connections to "fiction" and "nonsense" taxed the credibility of the psychosomatic concept, but also added a layer of meaning that could not be accessed through the biomedical perspective. As argued in article I, feelings and sensations associated with faith are not the only way in which health and beliefs come into contact. Attention to religion and other transcendental systems of meaning that go beyond the individual helps to decipher what the disagreements around psychosomatic research were really about. The approval of biomedicine would give legitimacy to the spiritual but receiving this approval might mean giving up too much. Further, while it is clear that the perspectives discussed above were defined by their contrast to biomedicine, it is important to recognise that the issue was nuanced. Like the non-scientific groups themselves tended to underline, the devil was in the detail.

4.2 Specialty demarcation and dialogue

The groups discussed in the previous section seemed pulled to two opposite directions. They simultaneously wanted to distinguish themselves from and to find common ground with other medical scientists. Even when psychosomatic ideas were included in the mainstream of medicine, there was an interpretative variation between specialties. As noted in the introduction, the 1950s was a tumultuous time for Finnish psychiatry. Psychodynamism was gaining ground among the younger generation and seeking a place in the medical establishment, which it eventually gained in the 1960s. The development that shifted the emphasis of psychiatry from biology towards psychogenesis drew a wedge between it and other medical disciplines. The broader trend of medical specialisation further differentiated

approaches to illness and thus hindered dialogue between doctors (see Peltoniemi, 1996, pp. 49–55). In thyroid diagnostics, discussed in article II, somaticists commonly used biochemical measurements to determine the nature of the complaint, whereas psychiatrists continued to speak for the relevance of patient observation – now with a distinctly psychodynamic slant.

Methodological differences were evident in the handling of patients suffering from functional complaints, often neurotics, who were customary visitors of the clinics of internal medicine. Psychosomatic illnesses first became part of textbook knowledge in internal medicine when von Bonsdorff wrote a chapter on them in *Inre medicin* (1949). In a chapter title, he used "psychosomatic illnesses" (*psykosomatiska sjukdomtillstånd*) interchangeably with "vegetative neuroses" and started with the truism that up to half of patients in the clinical practice did not suffer from a somatic disease, but from a psychosomatic illness. The psychosomatic concept was then linked to existing knowledge of "vegetative" symptoms, although von Bonsdorff added that these disturbances in the autonomic nervous system – as in the case of peptic ulcer – could even lead to organic lesions (von Bonsdorff, 1949, pp. 23–24). In a time when Finnish psychiatrists were few and mostly preoccupied by serious mental illnesses treated in asylums, neuroses, and organ neuroses in particular, had been an internal medical rather than a psychiatric concern. However, in the 1950s, the number of psychiatrists was growing, new medicines were introduced and the optimistic preventive mental health care agenda directed attention to warning signs of brittle psychic balance. It is easy to see why some regarded adding the neo-Freudian lexicon to organ neuroses, traditionally treated by reassuring the patient of the benign quality of their ailments, as an unnecessary complication at best and an unwanted intrusion from the psychiatric side at worst.

For the most part, psychoanalysts were left to pursue their interests in peace – in other words, ignored. According to the psychiatrist Martti Paloheimo (1913–2002), an ardent advocate of psychosomatic medicine to whom we will return to in section 4.3, this was due to negligence and disinterestedness on behalf of other physicians (Ihanus, 2000, p. 133). Comments made in a 1951 meeting of the Finnish Medical Society *Duodecim* speak for a reading that the predominating silence masked contempt to psychoanalysis in particular and "psychologisation" in general. After a presentation given by Paloheimo, somaticists barked that claiming a distinct group of illnesses was "idle self-aggrandisation" on behalf of psychosomatic medicine. Psychological understanding was deemed important, but mostly to the extent that physicians "could compete with charlatans and psychologists". At the same time, psychosomatic medicine did not seem to have

done a very good job in formulating its scientific basis, which was judged too "heterogenous" (Hallman, 1952, pp. 243–244). Interestingly, many of these statements included cautious optimism about including psychology in medical practice, while they saw psychosomatic medicine too immature for the task.

Where somaticists laid their cards on the table, the psychiatric side did not mince words either. Henrik Carpelan (1921–2000), a psychiatrist who would become affiliated with the Therapeia Foundation, lambasted surgeons for "blindness to the patient's psyche" and "possibly…unconscious sadistic impulses" (Carpelan, 1956, p. 190). In his dissertation *Mental Disorders in Thyroidectomized Patients* (1957), Carpelan added that the lack of psychosomatic approach in diagnostics had led to unnecessary surgeries of neurotics and demonstrated the pressing need for more psychiatric consultation in surgery (publication II). In fact, the use of the impersonal and technical word "thyroidectomised" in the title might be an intended swipe at dualistic medicine that allegedly likened patients to nonhuman test subjects. Carpelan's dissertation was scarcely referenced by somaticists, although he published his findings in both *Finska Läkaresällskapets handlingar* and *Nordisk medicin* and sent his dissertation directly to William Kerppola, an internist interested in functional cardiac troubles (an essential symptom of hyperthyroidism). Hence, antagonism between medical specialties undermined the credibility of psychosomatic claims, exacerbated by harsh rhetoric.

The critique of surgical practices by fellow somaticists at times shared an iconoclastic tone. Publication II shows that the surgeon Erkki Saarenmaa noted the psychosomatic nature of thyroid disease, warned about excess thyroid surgeries and regarded those conducting them as quacks. Another Finnish surgeon regretted that non-specialist doctors referred neurotics to thyroid surgery too often. Moreover, the internist Pentti Peltola lamented that a combination of functional symptoms and a goitre could really lead to unnecessary surgeries (publication II). However, these observations were not employed to reinvent medicine but were simply associated with calls for more careful practice with apparent trust in "self-correcting" medicine.

There is also some evidence that the proponents of "rat medicine" (laboratory rather than clinical medicine) were interested in differentiated psychological knowledge. One intriguing example is a 1957 study by Olavi Eränkö and Antero Muittari, who suggested that subtle psychogenic stress could alter both the function and structure of endocrine glands (publication II). Further, this study on "experimental neurosis" reflected contemporary attempts to connect human psychopathology with laboratory testing. The authors produced a neurosis in test

subjects by first creating a conditioned motor reflex and then breaking it, as suggested by the American experimental psychologist Norman Maier. Yet, reminiscent of critiques of "experimental neurosis" that had emerged already in the 1940s, Eränkö and Muittari questioned whether conditioning really produced states similar to human neuroses, which had a distinct psychological content. The authors themselves were undecided (Eränkö & Muittari, 1957; on Maier, see Koch, 2019). Either way, neurosis, if real, would be psychologically more specific than "stress". As described by Robert Kirk and Edmund Ramsden, studies on experimental neurosis centred on finding a way to combine the Pavlovian physiological experiment and Freudian inner psychic experience. Deliberations of this kind had implications beyond medicine, as the social applications of knowledge produced on the mother-child-bond in physiological and ethological studies would come to illustrate (Kirk & Ramsden, 2018).

The role of psychosomatic hypotheses in medical specialties was more differentiated than the above description of disputes around thyroidectomy imply. I have already mentioned that the professors of internal medicine Pauli Soisalo and Bertel von Bonsdorff were interested in psychosomatic medicine and that the FPA organised educational seminars for dermatologists and general practitioners. Paediatrics holds a special place among psychosomatic discussions: the psychosomatic approach was recurrently brought up with regard to children's illnesses, and it is illustrative that the textbook *Lapsen psykosomatiikka* [Psychosomatics of the Child] (1984) appeared the same year as the first general textbook on psychosomatics. The prominence of paediatrics links to an increased interest in children's health and the psychologisation of that discussion, as described in publication III. The published material also supports the sociologist Ilpo Helén's contention that psychosomatic theories found support in gynaecology (Helén, 1997, p. 298). Openness to psychosomatics was not restricted to psychiatry. Rather, it emerged from a mixture of medical education and professional commitments, clinical experiences, personal qualities, trends in discussions on health and other sources of influence.

Neither should the psychiatric establishment be regarded as an unproblematic refuge of psychosomatic considerations. Despite the prefix psycho-, Robert Powell has suggested that American psychosomatic medicine was never a "true branch of psychiatry" (Powell, 1977, p. 139). Severe mental illnesses and different forms of maladjustment, issues newly magnified by social critiques and the deinstitutionalisation tendencies of the 1960s and the 1970s, were still the overriding concern of many psychiatrists. If psychosomatics was an oddity to non-

psychiatric specialties, its situation was doubly unfortunate since attention to soma pushed it near the margins of psychiatry. This is true for most individuals discussed in this dissertation, with the possible exception of Rimón, who diverged from his contemporaries by propagating not only the psychological basis of organic disease, but also, conversely, biological psychiatry. His studies on psychoses and depression on the one hand and rheumatic diseases on the other shared an immunological framework (Hyrkäs, 2021).

It is also misleading to think of physiological and pharmacological advances and psychological perspectives as necessarily distinct medical spheres. A 1969 article by the rheumatologist Veikko Laine offers a good example of how different strands of research were interconnected. After describing how chemical studies, new instruments and cortisone had elevated the scientific status of connective tissue, Laine continued by stating that this more exacting research would soon uncover the neural and hormonal mechanisms through which psychic factors influenced "collagen diseases" (including rheumatoid arthritis, atherosclerosis, various skin diseases, some tumours and exophthalmos, the protrusion of eyes characteristic of autoimmune hyperthyroidism) (Laine, 1969; see also publication IV). This holistic outlook was linked to Laine's overriding clinical concern as the long-time head of the Rheumatism Foundation Hospital. Furthermore, psychosocial research on the musculoskeletal disease group, the topic of publication IV, was born out of the same science-political interest in the increasingly expensive diseases of connective tissue that supported also histochemical studies on collagen.

To reflect a little further on the relationship between biomedical and psychological illness explanations, consider, for example, a distinct group of psychosomatic diseases – ulcerative colitis, rheumatoid arthritis, asthma, hay fever and hyperthyroidism – that were, following their individual trajectories, recast as autoimmune diseases during the twentieth century. The medical historian Robert Aronowitz has underlined that the special characteristics of these diseases, chronicity and labile cycles of exacerbation and remission, were compatible with first psychosomatics and then autoimmunity. Aronowitz intriguingly asks what other "macro developments" than the accumulation of medical knowledge could account for so many autoimmune diseases attracting psychosomatic hypotheses (Aronowitz, 1998, pp. 172–173). As I see it, this was due not only to the distinct clinical pictures of these ills but also to the fact that the psychosomatic and autoimmune disease concepts were quite similar. The historian Ohad Parnes has described how the idea of an individual's potential to self-destruct became a new explanation for chronic disease from pathology and immunology to psychiatry in

wartime and immediate post-war America. In this framework, chronic diseases were characterised by healing functions – inflammation and scar tissue formation – becoming excessive (Parnes, 2003, pp. 443–447). The idea of stress in Selye's clinical physiology entailed the same principle that "the very efficiency and rationality of the body … giving us … the ability to respond to shock and disease, can also destroy the individual" (Cantor & Ramsden, 2014, p. 2). Psychodynamic theories also presumed a maladaption of inner emotional forces. What I wish to convey is that psychosomatic and autoimmune hypotheses – focusing on trouble rather than cure from within – were not so far removed on a conceptual level. They were responses to chronic disease in modern societies with new mental and environmental challenges, with plenty of opportunities for adaptation to turn maladaptive and self-destructive.

The significance of the psychosomatic concept as a mediator appears more subtle than transformative. It could be used to introduce alternate hypotheses and, relatedly, as a vehicle for critique. To the very least, the concept helped the historical actors to clarify what their take on mind-body interactions was *not* about. This phenomenon is analogical to a feature of boundary-work that Thomas Gieryn has described as the sociological equivalent to the literary device "foil": just like the qualities of the protagonist become clearer when contrasted with those of another character, the juxtaposition with non-science draws out the boundaries of science (Gieryn, 1983, p. 791). As demonstrated above, a rhetoric that deemed the opposing view either non-sensical or insensitive could also be used in demarcating between specialties (see also Gieryn, 1999, chapter two). However, as a medical concept, psychosomatics was also sensitive to shifting trends and fashions of explanation in medicine; it lent itself to ubiquitous associations and fostered connections. Acknowledging multidirectional influences and convoluted motivations complicates any simple narrative of the concept's utilisation.

4.3 Medical theories and the political double-edge

So far, we have examined the psychosomatic concept mostly in debates between doctors. Now we enter the public realm to disclose the social and political applications of the psychosomatic concept, which opened up realms of ideology, emotion and experience that could be used more or less analogically to "mind". Greco has coined the term "political double-edge" for the potential that psychosomatics has either to blame the victim or to call for social change (Greco, 1998, pp. 107–110). This notion, as demonstrated in publications I and III, shows

that the psychosomatic concept could become imbued with ideology. A case in point are the post-war psychological theories, which resonated with contemporary social and cultural climate. Maternal deprivation, a term coined by Anna Freud, was one of the topical medical concepts of the time, and the British psychoanalyst John Bowlby (1907–1990) is often named as its most influential advocate. Bowlby's report for the WHO synthesised many contemporary separation studies, asserting that separation from the mother due to, for instance, hospitalisation or living in a foster home, caused severe somatic, intellectual, emotional and social disturbances in the offspring (Bowlby, 1952[1951]). The idea was quickly adapted to discussions on less serious separation situations, for instance, those relating to the increasing levels of maternal employment in Western societies (publication III). The psychosomatic concept and maternal deprivation were connected by their psychoanalytical roots and by their insistence on the mother-child-relationship being the most important determinant of mental health. In her history of mind-body medicine, Harrington has regarded Anna Freud's, Benjamin Spock's and John Bowlby's emotional theories of stunted development as ideologically salient examples of "bodies behaving badly" (Harrington, 2009[2007], pp. 189–194, 251–252).

Psychosomatic medicine and maternal deprivation arrived in Finland following the Second World War. The two overlapped in the thinking of Martti Paloheimo, who already as a medical candidate had wanted to combine psychological understanding with general medicine (Paloheimo & Väänänen, 1942). At the turn of the 1950s, he spent one and a half years in the US learning about psychosomatic medicine. After his return in 1951, he elaborated, in a medical journal oriented to social problems, on the pathological consequences of failed mother-child-interaction. Future pathologies ranged from schizophrenic psychoses and delinquency to somatic diseases like asthma and ulcerative colitis, leading Paloheimo to parallel interpersonal relationships with bacteria in their aetiological significance (Paloheimo, 1951). He also regarded paediatrics as a field that benefited greatly from psychosomatic medicine and named Benjamin Spock as an example of a paediatrician whose thought had been enriched by psychoanalytical perspectives (Paloheimo, 1952, pp. 915–916). Paloheimo was greatly concerned about the dissolution of social norms in Finland, which prompted him to harness both maternal deprivation theory and the psychosomatic concept to argue for a society that he regarded as conducive to children's health (publication III). In the first edition of a textbook aimed for nurses, reprinted seven times, Paloheimo classified the every-day phenomenon of maternal employment as one form of

maternal deprivation, with all its psychophysiological afflictions (Paloheimo, 1958).

Publication III joins previous studies to show that the theory of maternal deprivation was appraised in the 1950s for its support to the traditional ideal of family (Vicedo, 2013, pp. 91–92), but was deemed a relic in the liberal political climate of the 1970s (also Duschinsky, Greco & Solomon, 2015a, 2015b). In Finland, the changing status of maternal deprivation theory stirred anxiety about the uncertain scientific foundations of political decision-making. If mothers had been told to stay at home, it "should have been based on research, not belief" (Tolsa, 1968, pp. 26–27). The rhetorical potential of maternal deprivation seems one-sided, whereas the psychosomatic concept was fluid enough to reflect the social values of interlocutors. It is illustrative to contrast the views of the conservative Paloheimo to those of the leftist and liberal child psychiatrist Vappu Taipale (1940–). When Paloheimo insisted that modern culture had created the "denial of the woman's role" that jeopardised children's health, Taipale argued that it was precisely the out-dated idea of women as homemakers that created neuroticism in mothers and eating disorders in their daughters (see respectively Paloheimo, 1961, p. 27; Taipale, Tuomi & Aukee, 1971, p. 24). These remarks, made ten years apart, indicate that the psychosomatic concept could be used to support opposing goals.

The reading public was not a mere bystander in debates around maternal employment. The historian Elisabeth Siegel Watkins has noted, regarding stress discussions in the American vernacular, that the "top-down" dissemination model is inadequate in seeking to understand the popularisation of science. Instead, non-scientists should be seen as being able to generate and interpret medical knowledge (Cooter & Pumfrey, 1994; Watkins, 2014). In Finland, the lay audience was an important link between political and medical arguments too. Paloheimo, who was perhaps the most zealous advocate of Bowlbyan theories and who had constructed the child as a "psychosomatic organism" (Yesilova, 2009, pp. 78–81), disseminated these ideas through textbooks, popular articles, columns, TV shows and radio programmes as well as through institutional channels such as the Mannerheim League for Child Welfare. However, his popularity dwindled in the late 1970s, when his licence to practice medicine was temporarily revoked because he was suspected of having an inappropriate relationship with a female patient (Korppi-Tommola, 2019[2006]). The psychiatrist Klaus W. Karlsson (1931–1992), likewise interested in psychosomatic questions, was another avid populariser of health knowledge on both TV and in a health column he held in *Apu* magazine for fifteen years (Karlsson, 1972). Through such channels, medical research in a simplified

form became known to larger audiences, and theories about children with severe deprivation and loneliness began to concern well-off Finnish mothers. These decontextualised theories resurfaced on the political level and were used as bludgeons by conservatives. In the 1970s, Vappu Taipale's husband Ilkka, a psychiatrist and MP, decried in the Finnish parliament that emotion-provoking "mental health hysteria" was being used to resist day care (RPS 110/1972, ps, 2605).

Furthermore, experts and "working mothers" cannot be distinguished from each other in any clear-cut way. A good example is the renowned Finnish midwife Leena Valvanne (1920–2008), who recounted in her memoirs how Paloheimo's lecture on children's psychosocial development had opened her eyes to the potential frustrations that her own occupational endeavours could have caused in her young son (Valvanne, 1986, pp. 131–132). In a somewhat contradicting manner, Valvanne also wished to relieve the readers of *Terveydenhoitolehti* of the impression that maternal employment equalled maternal deprivation and caused "serious psychiatric and somatic disorders" in children (Valvanne, 1961, p. 561). Valvanne seemed to experience the same guilt that psychological claims elicited in the wider readership of popular medical and women's magazines, yet she was also in a position to share and modify information for herself and other concerned mothers.

The social uses of the psychosomatic concept were also connected to questions of gender and class. In publication III, Myllykangas and I observe that the medical discussion on the stressors of women from lower and higher social strata differed to some extent, although children's health was a point of concern across the board. Middle-class mothers were condemned for working out of vanity, whereas those in economic penury did so out of necessity and were therefore regarded as less culpable. Differences in motives changed the moral value allocated to the stress that followed from attempts to combine working life and home. In addition, the very template of "double demands" in which women's stress was discussed was based on gender difference, as men's stress was usually associated with the high pressures of work itself (publication III). More generally, the psychosomatic concept has been used to articulate both the stress of the exploited worker and that of the middle-class executive (see respectively Figlio, 1982; Hayward, 2017; Riska, 2002).

It is interesting that the transcendental propositions of some Finnish psychiatrists were divided along the political axis. Stenbäck attached the psychosomatic concept to a Christian conservative political reform, whereas Siirala's social pathology was taken up by some leftist anti-psychiatric thinkers to argue that illness was a sign of the unhealthy state of the world (publication I). As

the case of the Taipales also shows, scientific statements and social actions were often ideologically coherent, particularly in the 1960s and the 1970s when the general consensus was undecided whether it was the sick person or sick society that most needed to be "adjusted".

The establishment of day care was a process where the concepts of stress and psychosomatics, alongside a host of other ideals and commitments to action, contributed to the re-evaluation of proper childcare and gender norms. Parliamentary discussions would mention psychosomatics in relation to various topics in this tangential sense. A more elemental nexus for the ethical work of the psychosomatic concept was the mind-body boundary-work, that is, drawing a line between psychiatric and organic disease. In 1979, a written question was addressed to the President of the Finnish Parliament about the contemporary definition of occupational diseases that bestowed reimbursements only to conditions that followed from direct exposure to a physical, chemical or biological agent. Here, the faster pace of modern working life and associated mental strain became an argument for broadening the definition of occupational diseases to psychiatric and psychosomatic illnesses (Written question [WQ] 292/1979). A decade later, the issue remained unresolved which sparked the psychiatrist and novelist Claes Andersson, also MP (1987–1990, 2007–2008) and the chair of the Left Alliance for the 1990s, into contributing. He repeated the view that technology had made working life more frantic and less humane, but also criticised the overall "out-dated and mechanistic conception of illness" evident in the legislative accent on chemical substances and the neglect of conditions like "burn-out syndrome" (RPS 96/1988, ps, p. 2820).

That Andersson spoke for a more inclusive conception of illness is not surprising in the light of his background in the November Movement, an anti-psychiatric organisation that criticised the perceived medicalisation of deviance in 1967–1971 (for more, see publication I). However, that psychiatric and psychosomatic illnesses were and still are not counted among occupational diseases testifies to the tricky nature of contested illnesses. The psychosomatic concept could importantly be used to promote an empathetic orientation towards those with a non-mechanistic form of suffering. This reading differs from the popular perception in which psychosomatic explanations are often taken to belittle patients' suffering, discussed further in the next subchapter.

That the psychosomatic concept could be used to advance different, even opposing social causes is not a new observation. Many have argued that psychological or social attributes articulated in a theory can be chosen to fit the

goals of the speaker (Greco, 1998; Jackson, 2013). As Charles Rosenberg has well summarised regarding the concept of stress, it has been "useful to analysts and advocates of every persuasion" (Rosenberg, 1998, p. 730). The medical, public and political feed-back loops modified the interpretations of the psychosomatic concept as it became attached to different goals of persuasion. Some claims, like the pathogenic mother-child-bond, gained cultural currency, whereas others, such as the effort to change the definition of occupational disease, were passed by. The psychosomatic concept, through its relational work, could reconfigure philosophical mind-body ponderings so that they had a real potential to materialise in new practices and regulations. Naturally, the most immediate place where the mind-body problem could take a tangible form was clinical practice. Next, I will examine how the psychosomatic concept figured in the dialogue between doctors and patients.

4.4 Mediating expert and experiential knowledge

As Collins and Pinch have pointed out, medicine differs from other forms of knowledge-production in that health is "more personal and immediately consequential" (Collins & Pinch, 2005, p. 205). The dialogue between doctors and patients is built around these high stakes. Although present sources do not give much room to patients' voices, through reader comments, we can glimpse at the reception of psychosomatic theories and how experiential and experimental ways of knowing were contrasted in print. The doctor-patient-relationship entails a hierarchy of knowledge in which subjective ways of knowing become subsumed to objective ideals of medicine. Subjective knowledge, which builds on personal experiences, seems less real, whereas objective knowledge appears unbiased by virtue of not being dependent on individual evaluations and perceptions (see Sharpe & Greco, 2019).

In article IV, the proliferating back complaints of the 1970s and the 1980s seemed to have no objective cause. Objectivity was a keyword; contemporary rehabilitation experts stated that treatment and compensation practices were challenging because of the discrepancy between felt dis-ease and objective findings. The perceived lack or inadequacy of organic lesions also left room for hypotheses about individual psyches and the sorry state of the social system. That these claims were positioned as something directly derived from medical objectivity worked also as a rhetorical reference point. According to Alexa Geisthövel and Volker Hess, explicit appeal to objectivity can be a communicative act and a tactic of conflict

resolution. It underlines that medical practitioners not merely adhere to the scientific method and ethos but are in a place to offer impartial judgments in the social sphere (Geisthövel & Hess, 2017, p. 22).

How, then, did doctors describe their "psychosomatic" patients? Publication IV shows that Finnish arthritics were characterised as pain-sensitive, dependent, depressed and apathetic. Rheumatoid personality theories, introduced to the Finnish discussion during the 1960s, made it possible to interpret both fits of anger and compliance as signs of underlying aggression. Social conditions could play quite a literal role in personality theories. Poor working mothers with the disease could appear self-sacrificing by nature. In the 1970s and 1980s, doctors deemed backache patients lonely, suicidal and lacking in self-esteem or suspected them of nurturing exploitative pension wishes. Patients were "implicated actors" in the dialogue between doctors, whom the medical commentators could construct as they saw fit (cf. Clarke & Star, 2008, p. 119).

Psychological interpretations had two interrelated consequences. First, to quote Susan Sontag, they undermined the "'reality' of a disease" (Sontag, 1978, p. 55). Second, they condemned the patient (see Segal, 2008, p. 52). It is therefore not surprising that psychological theories recurrently sparked inimical reactions in the public. For instance, a reader of *Reuma*, the journal of the patient organisation Finnish Rheumatism Association [FRA], characterised physician Erkki Valtonen's claims that back pain patients were shirkers and psychologically disturbed as a "tightly cropped black and white photograph" (Siirtola, 1981, p. 25). Another reader felt that she might as well cease to participate in the activities of FRA, given that she would either way be deemed "socially and psychologically disturbed, work-shy and oversensitive to pain" (Perkola, 1981, p. 25).

The personality hypotheses were of course not confined to persons with musculoskeletal afflictions alone but were construed for all "psychosomatic" diseases, with peptic ulcer and asthma in front. As time passed, theorisations of specific personality constellations or psychological conflicts for each disease became replaced with multifactorial models. American discussions on ambitious and competitive type A behaviour (in contrast to mellow type B conduct) as a risk factor for cardiovascular disease in the 1960s and the 1970s illustrate how psychosomatic hypotheses benefited from an association with quantitative measurements and the language of risk. As Aronowitz has observed, the type A hypothesis became distinguished from prior psychosomatic correlations when it was seen as contributing to rather than single-handedly causing heart disease (Aronowitz, 1998, pp. 152–153). The promise of paying attention to psychosocial

risk factors was noted in Finland and the prevalence of type A behaviour was even mapped as a part of the influential Mini-Finland health survey (1977–1980), carried out by the Finnish Social Insurance Institution [KELA] (Hanses et al., 1982). Enthusiasm spilled over to other conditions – was maybe back pain too precipitated by a measurable vulnerability? (Sievers & Klaukka, 1985, p. 2316) Although the type A hypothesis lost its main claim to scientific fame by the end of the twentieth century, remnants of its former appeal are still there. As recently as 2015, the results of the prospective Kuopio Ischemic Heart Disease Risk Factor Study, started in the 1980s, were published with the resigned-sounding title: "Type A Behavior Pattern is not a Predictor of Premature Mortality" (Šmigelskas et al., 2015; on the history of Finnish research on cardiovascular diseases, see Jauho, 2021).

The concept of alexithymia, another example of a late twentieth-century psychosomatic formulation, did not associate patients' personalities with a specific disease. Instead, it suggested that all psychosomatic manifestations had a common psychological cause. The concept had similarities with the psychiatrist Jurgen Ruesch's 1940s' impression that psychosomatic patients were "infantile" and the French psychoanalysts Michel de M'Uzan and Pierre Marty's construct of *pensée operatoire*, meaning concrete thinking and a lack of imagination. In the early 1970s, Peter Sifneos (with his teacher John Nemiah) coined the term "alexithymia for a trait which caused repressed emotions to manifest as bodily symptoms (see Borck, 2019). Alexithymia was concurrent with somatisation, and with difficulties in finding words and the "overall impression of being dull", alexithymic patients appeared to have primarily cognitive defects in handling emotions rather than difficulties in experiencing them in the first place (Sifneos, 1973, pp. 255–256). The psychosomatic patient therefore differed from a neurotic one by a lack of emotional intelligence. What makes the alexithymia construct even more curious is that it explained patients' apparent lack of psychopathology with psychopathology and, as such, left room for speculation. However, this room was needed, as patients' symptoms did not make sense otherwise – and so the concept was put forward at KELA in the 1980s (publication IV).

Turning to complementary and alternative medicine [CAM] is one way to challenge medical propositions which are perceived as unbefitting. Although alternative practices and underlying philosophies are not discussed at length in the original articles, the boundary between them and the psychosomatic concept was often blurry and at times non-existent. For instance, anthroposophical mistletoe preparations disputed the cytostatic treatment of cancer, and people with pain frequently sought relief in diets, chiropractors, folk healers and Eastern medicine.

Their attachment to equally unconventional conceptions about the causes of illness is characteristic of alternative cures. The early 1960s debate on geomancy, a lay belief that radiation emanating from the earth is a source of disease and unhappiness, is a good example of different reasoning. Replying (condescendingly) to a reader worried about the dangers of geomancy, the internist responsible for the Q&A column in *Terveydenhoitolehti* stated that the phenomenon was scientifically unproven and had no health effects. Many readers disagreed, claiming that their health had improved when beds were moved away from radiating zones (Letters to the editor, 1963a; 1963b). Such extracts display a discrepancy between the experimental knowledge that modern physics had produced on radiation and readers' experiential ways of knowing. The psychosomatic concept was used to discuss lay beliefs in the medical domain. For example, the neurophysiologist Erkki Huhmar had written in 1953 that "contemporary psychosomatic currents" had raised medical interest towards geomancy by pointing out the health effects of beliefs and suggestion (Huhmar, 1953).

The placebo effect, a psychobiological mechanism that alleviates symptoms, shows that beliefs may be clinically significant. As Achté wrote in 1969, one could increase the effectiveness of medicines by changing the way they were administered. Patients seemed to regard red pills as more potent than regular pills and mixtures that tasted bad more conducive to healing (Achté, 1969, p. 397, 399). The idea of interplay between beliefs and health allowed doctors to address also the "magical" meanings that patients could ascribe to illness. The need for such a framework becomes clearly visible when doctors and patients come from different cultural backgrounds. In these cases, problems of translation can be literal, but also pertain to broader structures of meaning where, for instance, the evil eye or bad spirits are eligible causes of illness (see Puustinen, 2011, p. 30). For example, the transcultural psychiatrist Antti Pakaslahti, who frequently co-edited Finnish psychosomatic anthologies, studied how Indian religious folk healers treated "spirit afflictions" that patients often expressed "psychosomatically" (Pakaslahti, 1998, p. 132; also Pakaslahti, 2006, October 5). Pakaslahti's cultural awareness also influenced the conceptions of Achté, who firmly believed in the therapeutic benefits, and conversely, self-destructive potential, of beliefs within so-called primitive cultures (Achté et al., 1981, pp. 242–243, 254–258).

Explaining illness through beliefs continues to be an incendiary topic, which is also shown in patients' disdain for the very word "psychosomatic". Article IV illustrates that patients with musculoskeletal pain, particularly those diagnosed with fibromyalgia, rebutted psychosomatic theories. Fibromyalgia is a contested illness,

and the doctor-patient dialogue around it clearly aspires to reconfigure clinical authority. Some readers of *Reuma* insisted that patient experience should guide medical research, others applied their own specialised expertise (e.g., in metallurgy) to educate medical practitioners (publication IV). Lisa Keränen has analysed the rhetoric around Morgellons, another contested illness with small fluorescent fibres emerging from skin sores. Doctors and patients have fundamentally disagreed about the framing of its symptoms. While the medical side has spoken about delusional parasitosis of psychological origin, patients have contended that their disease is an infection or infestation unknown to date (Keränen, 2014). The medical discussion on fibromyalgia displays similar opposing camps, in which psychological explanations have been felt to devalue the experience of ill health (publication IV).

Yet, the problem of aetiological attribution goes deeper. Illnesses become contested in the first place because both doctors and patients operate on imperfect knowledge about the origin of real symptoms – particularly in primary care where appointments are brief and resources scarce. Relatedly, Judy Segal has described medical history as a sequence of rhetorical opportunities, viewing rhetoric as something that "enters to fill gaps of knowledge" (Segal, 2008, p. 39). Segal has argued that patients' attempts to persuade others about the organicity of their illness "make hypochondria a rhetorical disorder in its own right" (she includes fibromyalgia, chemical sensitivity and chronic fatigue and whiplash syndromes into term "hypochondria") (Segal, 2008, p. 75). Still, doctors too needed to persuade patients, and had little chance of succeeding if they assumed that "objective" observations would simply speak for themselves. It is necessary to recognise that under the "stubborn" resistance of contested beliefs often lies the persuasive power of personal life narratives and experiences that may, if not fully refute, then become interwoven with evidence-based medicine.

Using the word "psychosomatic" as a shorthand for certain clinical phenomena could be a way to disregard symptoms as well as to make the clinical encounter more "humane". However, in the majority of cases, it was appropriated and employed by doctors, not embraced by patients. The doctor-patient dialogue in print then underlines that the psychosomatic contact zone was a regulated space after all. It could incorporate beliefs, experiences and emotions, but in the form that fit the world-readings of medical experts or psychologists. As the examples in this section show, sometimes doctors "listened" so keenly that they heard things that might not have been really there; on other occasions they dismissed explanations that patients readily offered. The contrast between modern medicine, swearing by

the name of quantification, and the patient's experiential way of knowing is akin to that between science and non-science. Once again, seemingly irreconcilable knowledge systems came into contact through the psychosomatic concept. Yet, doctors and patients seemed to disagree on *how* exactly medical knowledge should be renewed. Patients' propositions built upon their idiosyncratic world-readings that could not very well be standardised for common use. This discrepancy cannot be brushed off as irrelevant to medical practice, but solutions are hard to find.

For multiple reasons, the weight of the patient's view has increased in the late twentieth century. Patients are less dependent on a single doctor, and if communication is fully disrupted, they are freer to choose another licensed or unlicensed healer. The freedom of choice has led to patient lobbying (e.g., Shorter, 1992), the effectiveness of which has increased not least thanks to the broadening and diversification of media (see, e.g., Torkkola, 2014). The dissatisfaction with biomedical interventions and the rise of post-modern consumerism has also moved CAM studies towards questions of how health knowledge is co-produced in the changing social context, not simply generated and applied by healers and reprimanded by doctors (Brosnan, Vuolanto & Brodin Danell, 2018). Most recently, health debates have moved away from opinion columns to cyberspace and social media platforms. The COVID-19 pandemic has demonstrated that the participation of sufferers can mould medical diagnoses and prompt political action (Callard & Perego, 2021). With these developments, the uses of the psychosomatic concept also seem to have moved away from marginal critiques to more diversified descriptions of patient experience.

4.5 Maps, mirrors and psychosomatics

In this chapter, I have entertained the view that the psychosomatic concept was defined by its divergence from biomedicine. It articulated an overarching form of dualism, a divide between the gold standard of scientific medicine and the miscellaneous group of "other". Following the vehicle has taken us to realms of faith, philosophy, beliefs, ideology, feelings and experiences that fitted poorly to evidence-based medical knowledge. With the psychosomatic concept, historical actors tried to renew, broaden or justify the status of these perspectives in medicine. The concept was used to bring out the shortcomings of practices that actors tried to reform, and, in doing so, to hold a mirror up to biomedicine. At times, putting psychosomatic claims in a more attractive wrapping in tailored seminars, lectures, articles and books made them accessible to more sceptical medical scientists. More

often, the efforts to rethink medicine failed to recoup true change. While the psychosomatic contact zone was broad, the breadth of discussions was not paralleled by the establishment of new medical practices or institutions.

The psychosomatic concept was a vehicle for making connections. However, problems of communication were integral to psychosomatic debates, so much so that it is worthwhile to ask whether the spiritual, psychoanalytical, experiential and biomedical worlds could be in a meaningful dialogue. What was their extent of mutual understanding? Fleck famously argues that, as differences between thought styles accrue, communication becomes more difficult; but it is not a given that the other perspective is noticed at all (Fleck, 1979[1935], p. 109). Engaging in a discussion already presumes a degree of interest in the others' thinking. Critiquing in harsh terms shows even more investment and embeds conflict as a form of communication. Therefore, the psychosomatic concept provided important openings for re-evaluating the standards of knowledge endorsed in modern medicine. Moreover, it had the capacity to take apart traditional hierarchies by asking who had authority in questions of health; what made for real suffering and real recovery; how to heal; and to what ends should medical knowledge be used. Yet controversies persisted, as the interpretations of the concept reflected in many ways distinct world-readings.

In addition to the concept's controversial dimension, it should be recognised that part of the argumentation was directed "inside". The late sociologist and historian Olga Amsterdamska has emphasised that disciplinary boundary-work happens, not only in defence against external critiques and because of territorial ambition, but also in response to a field's perceived internal instability. Creating a "virtual enemy" may serve to overcome "status anxiety" and to reassure the practitioners in a field of the legitimacy of their approaches. I would claim that the strawman of biomedicine functioned in such a way for the proponents of psychosomatic medicine, although they admittedly lacked in disciplinary cohesion. The psychosomatic approach was claimed to be socially more responsible than biomedicine. The argumentation that rested on ethical superiority rather than epistemic authority of psychosomatics strengthened the identity of and helped to manage the heterogeneity among the so-called "psychosomaticists" (cf. Amsterdamska, 2005). In other words, mirroring was part of their identity-work.

The history mapped in this dissertation is a pale reflection of the real complexity of the phenomenon, but it is still enough to show that the psychosomatic contact zone was heterogenous and ever-changing. Change occurred in participants of the debates as in diagnostic practices, connotations of the word "psychosomatic"

(from psychosomatic disease to lesionless illness), causal hypotheses (from specificity to non-specificity), and the social problems the concept was associated with. Attention to the patient's view, drawing from various ideational strands, became more common at the expense of a strictly psychoanalytical critique. Some elements within the contact zone, such as general hospital psychiatry, followed their individual trajectories towards stronger cohesion. However, during the twentieth century, the principal function of the contact zone as a site where connections could be formed and boundary-crossings could happen remained largely unchanged. As a whole, the zone did not become more interactive or cooperative. In fact, it became less integrated, since the area of the concept's application became more and more crowded over time.

The Results chapter shows that the history of psychosomatics invites ambivalent readings. The same goes for evaluations of the current status of the psychosomatic concept. Is it a hollow echo of the past, restating the worn-out phrase that reductionism has taken over biomedicine? Or does it continue to be a dynamic vehicle for rethinking medicine? I skirt this dichotomy and instead believe that the initial issue of dualism (to whatever degree it existed beyond rhetoric) has long since been overcome by increasingly differentiated approaches that tackle mind-body interactions in medicine (just see the special issue of *BMJ Medical Humanities* in June 2019 for this variety). Put another way, the psychosomatic concept has been made progressively unnecessary, but it does remain a valuable historical reference point. Newer perspectives continue to benefit from reflecting on the lessons, both good and bad, of psychosomatic medicine: Are there things that fall out of the medical gaze? Should they be included, and if so, how? Perhaps the most important aspect of such reflections is to recognise that world-readings become weaved into individual reasoning and start to configure the appeal of suggestions. Although a lack of "scientificity" may have given grounds to repudiate psychosomatic hypotheses, conversely scientific evidence rarely explains why these hypotheses were taken up in the first place.

5 Conclusion

The history of psychosomatics may appear, and to some extent is, formless and shapeshifting. In 1997, the neurologist Markku Hyyppä reprimanded Finnish textbooks on the topic for being "intellectual patchworks" (Hyyppä, 1997, p. 10). As it happens, Harrington has also described the history of mind-body medicine as a "complex patchwork world" (Harrington, 2009[2007], p. 29). Literally, patchwork means a craft in which different designs and textures are sewn together, while when used as a metaphor, it implies a hodgepodge of incongruous parts. Nonetheless, the idea of a patchwork suggests a thread that sews the individual patches together. This conception captures neatly the idea of a contact zone, where different groups and contexts were brought together by a unifying idea.

In this dissertation, I have argued that different medical (sub-)disciplines and alternative and unorthodox approaches were able to meet and exchange ideas in the contact zone. Following the psychosomatic concept through time and space revealed its changing dimensions. This dissertation sheds light on the standards and limits of medical knowledge, arguing that they have an integral relationship to world-readings of actors.

Research questions were answered through a cross-case analysis that built on conceptual history methods and relational mapping. The first question (1.3) was related to who participated in psychosomatic discussions and to whom was argumentation directed. The participants came from both professional and public spheres and comprised various spiritual and intellectual groups, different specialties, ideological advocacies, experts, patients and policymakers. This variety caused argumentation to have multiple targets. However, opposing the "virtual enemy" of dualism and its alleged proponents was a recurring theme that also worked to strengthen the identity of "psychosomaticists".

Following this, the second question was how different world-readings influenced the meanings of the psychosomatic concept and what the actors had in common and what separated them. Differences in world-readings defined the meanings given to the concept. The prefix "psycho-" acted as a placeholder for a preferred insertion. Moreover, there were clear temporal shifts in the ways the concept was used. Over time, it became more strongly associated with lesionless symptoms, and unidirectional views of causation were replaced with less obligating, non-specific or multifactorial considerations. Dissimilar interpretations often shared an outsider perspective but there was great variation within the psychosomatic "other". Most commonly, actors disagreed on the standards of

medical knowledge, the moral value of illness and on what concrete actions psychosomatic hypotheses should call forth. These disagreements would also undermine the success of the relational work of the psychosomatic concept. The concept fuelled a powerful moralistic engine that could serve political and ideological ends in the public sphere. Therefore, this dissertation reinforces Greco's argument that the psychosomatic concept carries politically double-edged potential.

Returning to the last research question: why did the psychosomatic concept remain salient so long despite challenges and controversies? We could settle for the assertions that the concept was relational, fluid and applicable and as such facilitated dialogue, or that it allowed medical experts to give their political, ideological and moralistic views a degree of scientificity. However, I believe that the question needs rewording. The concept persisted not only despite, but, in part, *because* of the controversies surrounding it. Although we tend to view conflict negatively, it is a sign that a discussion is not stagnant. The psychosomatic concept encouraged interlocutors to go towards disagreements, sparking new ideas and alternative ways of thinking – to colour outside the lines, if you will. While its importance was overstated from time to time, the concept was indeed used to bring to the fore more marginal issues, such as patient experience, emotions and transcendental hypotheses and to seriously evaluate their bearing on health. Viewing controversy as a creative opportunity rather than a failure of communication is something that today's interdisciplinary endeavours can learn from the history of psychosomatics. In fact, the enterprise had a lot in common with present-day medical humanities that struggle to tread the delicate line between being so conciliatory as to be negligible and so iconoclastic as to evoke only unwelcoming responses in biomedical practitioners (cf. Viney, Callard & Woods, 2015, p. 4).

Negotiations around the psychosomatic concept managed at times to articulate the social significance of mind-body boundary-work in a tangible way. As the discussions on occupational diseases and contested diagnoses show, there are still unresolved questions in this area. Thus, it might be time to re-examine, in the light of historical material, whether inequitable compensation policies are truly warranted or whether they rest on historical fiction where somatic symptoms are assessed by different criteria than psychological ones. What is taken and then applied from heterogenous discursive spaces, such as the one around the psychosomatic concept, should be carefully evaluated. We might want to pay more attention to patient experience but still be ill at ease when someone condemns vaccinations based on a peripheral belief system. The heterogeneity of

psychosomatics makes both disregard and uncritical appraisal of otherness problematic. Borderlands should not be thought of as roaming sites of unlucky losers or powerful champions of marginalised views, but rather as valuable spaces for negotiation that offer vantage points to the mainstream.

Much more historical work is required on psychosomatic topics, and this dissertation leaves many territories uncharted. There are many points that are only briefly raised here that would warrant their own articles or books. These include but are not limited to the relationship of psychosomatic hypotheses to epidemiological knowledge production, esotericism and clinical and laboratory practices. Yet another area in need of further historical inquiry is the interdependence of psychosomatics and social sciences or humanities, for instance, medical anthropology, philosophy and sociology. Fortunately, as shown in the literature review, many first-rate scholars find this area worth investigating. Communication and connections as the organising principles of this dissertation have answered some questions but raised others. One of the latter would be a more in-depth exploration on how ideas of communication have figured in psychosomatic theories themselves. Recurrent notions of psychosomatic illnesses as messages from various realms – from the heavens, from the social body or from within – underline that the concept was relational in an inextricable way. What sort of views of the body, the person and the world did different communicative hypotheses promote and ascribe to? To this end, it would be important to go beyond medical discussions to consider the role that technologies, practices and institutions had in uncovering an interactive view of illness.

The history of psychosomatics is not a history of abstract ideas but that of grounded meanings. A deep understanding of psychosomatics requires the researcher to pay attention to the non-medical personae of doctors, since, as noted above, psychosomatic theories bore traces of the world-readings of contemporaries (cf. Powell, 1977, p. 148). They could pertain to social ideals and values but also to personal search of deeper meaning and redemption. Psychosomatic claims always appeared to rest more on common-sense appeal than scientific rigueur. Therefore, assuming a clear-cut distinction between scientific and other ways of knowing may mislead analyses of medical knowledge production.

To conclude, I will illustrate with a quote from Achté's illness memoir (1993), in which he reflects upon the origins of a severe infectious endocarditis that forced him to abandon his position as the head of psychiatry at the University of Helsinki after twenty years of service:

> More and more studies suggest that big life changes precede serious diseases, such as severe infections, cancer or myocardial infarctions … In light of this, I reflected on my own illness. Why did the mitral valve that had been damaged by a Lemierre's syndrome I had in the 1930s … gather harmful bacteria and try to kill me precisely at the time I got sick? ... Why do some people get sick? Why exactly then? Others do not. Why? It must be the immune resistance. I have seen in my patients that urinary or other infections return at stressful times, not otherwise … Six months before I fell ill there was a big change in my interpersonal relationships, the biggest in decades. It turned out to be temporary. I did not experience it as stressful. But it was a life change, which psychosomatic medicine regards decisive … Did it trigger my illness? Did it set in motion the deadly bacteria that had remained dormant for decades? No one can say for sure, but many surmised this to be the case … The ones who treated me were experienced clinicians and spontaneously brought up this possibility. Personally, I am inclined to agree. (pp. 31–32)

Achté was known as an untiring man not too concerned about stress, which he reportedly called "the salt of life" (Lönnqvist, 2019). This perception notwithstanding, Achté regarded the relationship change as the straw that broke the camel's back – rather literally, since the infection spread to his spine, eating away vertebra and putting an end to Achté's running and skiing days. After a series of complications, the psychiatrist recovered. However, to paraphrase the title of his illness memoir, "when the doctor gets sick" there is a moment when medicine intersects with life. Psychosomatic connections can become personal realities for doctors and patients alike.

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Appendices

Full list of periodicals

Full list of journals and inspected timeframes in alphabetical order. The variations result from differences in journal appearance, availability and/or temporal locus of the original publications.

Acta Societatis medicorum Fennicae: Serie A, 1931–1947
Acta Societatis medicorum Fennicae: Serie B, 1931–1946
Ad Lucem: tidskrift för kultur och livsåskådning, 1930–1983
Annales chirurgiae et gynaecologiae Fenniae, 1946–1965
Annals of Clinical Research, 1969–1988; *Annals of Medicine* 1989–2000
Annales medicinae experimentalis et biologiae Fenniae, 1947–1963
Annales medicinae internae Fenniae, 1946–1968
Annales paediatriae Fenniae, 1954–1968
Avioliitto ja lääkäri, 1950–1966; *Lääkäri ja yhteiskunta*, 1967–1972
Duodecim, 1885–2018
Eeva, 1950–1972 (random sample)
Epione, 1950–1955
Finska Läkaresällskapets handlingar, 1948–2000
Församlingsbladet, 1955–1969; *Kyrkpressen*, 1970–1981
Huoltaja, 1945–1975; *Sosiaaliturva*, 1976–1990
Journal of Psychosomatic Research, 1956–1996
Kotiliesi, 1950–1973
Kätilölehti, 1944–1981
Medisiinari, 1945–1998
Mielenterveys, 1961–2000
Nordisk medicin, 1939–1998
Nordisk psykiatrisk tidsskrift, 1956–1987
Psychiatria Fennica, 1970–2000
Psykologia, 1966–2000
Psykoterapia, 1982–2000
Reuma, 1953–2000
Sairaanhoitajalehti, 1944–1989
Sosiaalilääketieteellinen aikakauslehti, 1962–2017

Sosiaalivakuutus, 1966–2000
Sosiologia, 1964–2000
Sotilaslääketieteellinen aikakauslehti¸ 1939–1963
Suomen lääkäriliiton lehti, 1922–1944; *Suomen Lääkärilehti*, 1946–2000
Suomen sairaanhoitajain kristillisen seuran viesti, 1948–1982 (*Suomen kristillisen lääkäriseuran/Suomen sairaanhoitajain kristillisen seuran viesti*, 1971–1977)
Terveydenhoitolehti, 1945–1975; *TH/Kotilääkäri*, 1976–1978; *Kotilääkäri*, 1979–2000
Vartija, 1945–1982

Original publications

This dissertation is based on the following publications, which are referred to throughout the text by their Roman numerals:

I Hyrkäs, E-R. (2021). Sin Embodied: Priest-Psychiatrist Asser Stenbäck and the Psychosomatic Approach to Human Problems. *History of the Human Sciences*, forthcoming.

II Hyrkäs, E-R. (2021). "A Transverse Scar on the Neck" – Psychosomatic Approach in the Differential Diagnosis and Surgical Treatment of Hyperthyroidism in Post-War Finland. *Medical History*, 65(2), 140–156. https://doi.org/10.1017/mdh.2021.4

III Myllykangas, M. & Hyrkäs, E-R. (2020). Adaptation to the New Normal – Maternal Employment in the Framework of Psychosomatic and Stress Discourse in Finland from the 1950s to the early 1970s. *Social History of Medicine, 34*(3), 984–1004. https://doi.org/10.1093/shm/hkaa052

IV Hyrkäs, E-R. (2021). Psychosomatic Pain? The Meanings of Musculoskeletal Affliction in Finnish Medicine, c. 1950–2000. *European Journal for the History of Medicine and Health, 78*(1), 128–154. https://doi.org/10.1163/26667711-bja10004

Original publications are not included in the electronic version of the dissertation.

180. Käsmä, Marjukka (2020) Social difference as action : a nexus analysis of gender and ability in World of Warcraft game culture

181. Sokol, Robin (2021) Taking the next step in a collaborative project: a multimodal analysis of verbal and embodied actions at the computer

182. Koivumäki, Kaisu (2021) Fragmented science communication : mapping the contemporary challenges of organizational science communication

183. Partanen, Lea (2021) Communication, narration, and reading and spelling skills in primary school-aged children born with fetal growth restriction

184. Nuortimo, Kalle (2021) Hybrid approach in digital humanities research : a global comparative opinion mining media study

185. Hakonen, Aki (2021) Local communities of the Bothnian Arc in a prehistoric world

186. Martikainen, Anna-Leena (2021) Intra-word variability in children acquiring Finnish

187. Keränen, Teija (2021) Everyday energy information literacy : defining the concept and studying it empirically in Finland

188. Vehkavuori, Suvi-Maria (2021) Early lexicon : associations to later language skills and screening

189. Cooke, Taina (2021) Culture on trial : an ethnographic study of the de/ constructing of culture in Finnish law courts

190. Grasz, Sabine (2021) Mehrsprachige Praktiken beim Lernen im Tandem : eine empirische Untersuchung zu deutsch-finnischen Tandemgesprächen

191. Nyfors, Mervi (2021) Lapsen kuolema : traumaattinen suru kotimaisessa omaelämäkerrallisessa kirjallisuudessa

192. Multas, Anna-Maija (2022) New health information literacies : a nexus analytical study

193. Kanto, Kati (2022) Pohjoisen nuorten tilat ja paikat Anna-Liisa Haakanan 1980-luvun nuortenkirjoissa

194. Molnár-Bodrogi, Enikő (2022) ”Kieli on sielun sormenjäljet” : Pohjois-Fennoskandian ja Romanian suomalais-ugrilaisten vähemmistöjen kielinarratiivit identiteetin rakentajana

195. Matila, Tuuli (2022) Seeing the war through a Finnish lens : Representation and Affect in the World War II photographic heritage

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