Medicine of the Person
75th International Meeting
20th - 23th August 2025
CH - MONTMIRAIL

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23/08/2025

Understanding symptoms can open the way to a more meaningful life

About the meaning of mental complaints

I once saw a severely depressed woman who told me she was depressed because she felt guilty about 4 shameful things in her life:

1. That she had to get married. She told her mother this after 7 months of pregnancy. Her mother had previously said: “If my child told me she was pregnant before marriage, I would die of shame.”
2. That she is divorced
3. That she had an abortion
4. and that she’s now living with someone.

In her view, these 4 shameful things were the reasons for her symptoms and making it difficult for her to find a purpose in life.

It struck me that she didn’t mention the incestuous relationship with her father as a possible cause of her problems. Neither did she mention her husband's alcoholism and infidelity.

People are wired to make assumptions and look for causes in order to somehow gain control over their lives. These causes may differ from the way therapists evaluate their problems. The above is an example.

How do we deal with this in healthcare?

Psychiatry focuses mostly on the question: WHY does THIS patient have THESE symptoms at THIS moment? With psychotherapy the therapist together with the patient tries to find the background of the symptoms. A patient is for instance depressive because of losing his or her partner, or because he never felt accepted by his father etc.

But there is another possible question: What does the patient see as the purpose, the meaning of his existence? Or, like someone said: *Does his life have a window in the front*, like in a car.
Sometimes the why-question is not enough for cure.

An example: This client was an elderly lady, a former dancer. She was severely depressed and refused medication and food. She was transferred to the infirmary of the psychiatric hospital and lay in bed. Her husband had had enough of it and felt powerless. We as healthcare workers didn't really know what to do next.

The woman didn't speak but seemed to be alert to what was happening around her. Together with her husband and her two young adult children, we sat around her bed. I presented them with all sorts of hypotheses as to why she didn’t speak: "perhaps she feels it no longer matters what she says anymore", “perhaps she’s longing for her previous existence as a celebrated dancer", "perhaps she gradually feels invisible to others", ... *Questions which had an impact on her future life and meaning of that life.* The lady listened to this conversation, that was visible. After one or two of such conversations she suddenly started

taking her medication and eating her meals. Her depression cleared up completely and she was able to go home in good condition.

Were her complaints taken seriously in these sessions? Did she feel more attention from the family? Did something in the family's interaction change? Did her life regain meaning? All hypotheses, but anyway: it seemed she could see through the window in the front again.

Another case -- a psychotic boy

During his psychosis, this boy was terrified and saw fearful scenes with snakes in front of him. He was treated with medication. Afterwards we looked back on this period together with him to understand what these fearful thoughts might have meant to him. This helped him connect more with this period in his existence instead of forgetting under the motto: "then I was crazy". This period in his life then gained a certain meaning and purpose.

If people can regard their symptoms as something that belongs to them, not just something they want to forget as quickly as possible, but something that offers clues relevant for their wellbeing, then sometimes this creates an opening for change. Perhaps alternative possibilities in life can open, giving them more control. When change is not possible, people can benefit from accepting their situation.

The latter we saw in women who had been severely traumatized in the past. Symptoms became more bearable by an in-depth understanding of the background, even if the symptoms didn't diminish or vanish.

Many people have the urge to give life a vertical dimension, sometimes in a spiritual sense or in a more religious sense. This can open a new perspective of a meaningful life, a life with purpose creating satisfaction and self-respect

What role do we as professionals play in this process?

How do we consciously, or perhaps unconsciously, influence the way our clients understand their symptoms?

Some background:

The meaning given to symptoms by professionals changed in the last century. It is not long ago that we as professionals diagnosed hysteria as a personality disorder associated with a "floating womb" or when we attributed complaints to an imbalance between the various body fluids: black bile, red blood, etc.
The first time we gave attention to a possible intrapsychic meaning of symptoms was with Freud and psychoanalysis. This yielded new insights. The past possibly played a role in the current symptoms and the patient was invited to consult his or her own world of experience.

Not long after this, the systems theory started to pay attention to the influence of the (direct) environment of the client. We began to realise that an ill person sometimes contributes to a family system remaining intact. The ill person can become the centre of attention in the family and the other, possibly greater, problems and differences are put aside.

Later on, we began to realise that norms and values in our multicultural society may play a role in the meaning of symptoms and complaints. Our personal norms and values may influence the points addressed in treatment.

Are we sufficiently aware of our own internalised norms and values, opinions and prejudices?

I will illustrate this with an example:

An example of male/female differences.

There is literature stating that the 'average' therapist uses a different health standard for men and women in terms of attitude and expectations. Therapists (women as well as men) were asked to indicate, using a list of characteristics, which characteristics are appropriate for a healthy man, which characteristics are appropriate

for a healthy woman, and which characteristics are appropriate for a healthy adult. This demonstrated that the profile of a healthy man and a healthy adult coincided, but that the profile of a healthy woman looked different.

A healthy woman was viewed as more emotional, more preoccupied with her appearance, less objective, less independent, less enterprising and more easily influenced. A healthy woman would also be less competitive and less fond of mathematics and science. This assessment by the therapists reflects the stereotypical images of men and women and the value that is attributed to them within society.

The implication is that a woman is not considered a healthy adult when she conforms to the expected role pattern of a healthy woman. However, she is not considered a healthy woman when she conforms too much to what is expected of a healthy adult. Put another way: It is not possible to conform to the expected role pattern of a healthy woman and at the same time conform to that of a healthy adult.

In the above case, it could mean that women are diagnosed as unhealthy more often, because from this perspective, a woman is either not fully mature or not feminine enough.

Our own internalised values and norms therefore play a role in the way we view our clients.
But are these internalised values and norms the same everywhere and in different periods?

Cultural anthropologists have said a few things about socio-cultural norms.

In many non-Western cultures, the 'self' is not clearly demarcated from the environment. People sometimes speak of a 'collateral self', a 'diffuse self' or a 'non-individualized self'. From a Western perspective, in which individualization, differentiation, autonomy and independence are positively valued, this is considered an immature self. In these other cultures, on the other hand, a person who operates too autonomously will be seen as deviant.

When people define themselves differently across cultures, there will also be major cultural differences in the prevalence of mental illness.

Within anthropological descriptions, so-called 'culture-bound syndromes' are described. The complaints and symptoms of an individual are explicitly linked to the culture in which they occur. Someone who suffers from a culture-bound syndrome usually occupies a marginal position in the society concerned. During the 'illness' episode, the 'sick' person shows behaviour or symptoms that represent a direct reversal or exaggeration of the behaviour that is normally expected of a person in his or her position in that culture.

For example, mental possession occurs mainly among women in North African societies. It is a state of mind with extreme anger fits, screaming, and has frequently been interpreted as a legitimate way for women to express their frustrations, fears, demands and criticisms in male-dominated societies.

Isn’t the same state of mind valued differently in different cultures? Is an international standard for ‘normal’ possible?

Cultural anthropologists also describe culture-bound syndromes in Western culture.

These are mainly found in women. For example, 'multiple personality' is considered a culture-bound syndrome rather than a universal mental illness. Like mental possession, it is embedded in the circumstances of time, place and culture. This is also true of hysteria and conversion, which were particularly common in women in the 19th century, and of agoraphobia, bulimia, anorexia nervosa, depression and drug abuse as they occur in women in the 21st century.

According to this theory, women occupy a more marginal position in society and their illness therefore constitutes a reversal or exaggeration of the behaviour expected of them. The woman does gain attention (medicine, psychiatry) but structurally nothing changes. A form of legitimate resistance perhaps?

The culturally bound syndromes that cultural anthropologists describe in Western culture are mainly found in women. They say that women and non-Europeans stand in a similar relationship to the dominant norms in Western culture.

Cultural anthropologists are therefore raising questions about the international applicability of the DSM.

Like all classification systems, the DSM is a concept that is bound to time and place.
Marcie Kaplan argues in an article entitled “A woman's view of DSM” that implicit norms about human, male and female behaviour are present in the DSM

She shows that in the criteria for histrionic, borderline and dependent personality disorder, several criteria overlap with what emerged from Broverman's study as characteristics for a "normal woman": dependent, emotional, preoccupied with appearance, impressionable. She describes an "independent personality disorder" that, if present in the DSM, would occur more often in men. This is not present in the DSM. This could lead to overdiagnosis in women.

When we are working together with our clients in search of some meaning of their complaints and symptoms, our own internalised ideas about male/female differences and roles play a part. The same can be said about cultural differences in our multicultural society. We are dealing with the lenses we wear.

It is important to realise what our own implicit ideas are. In contact with our clients, there is a difference between stimulating them (unconsciously perhaps) to adjust themselves to certain role patterns, or, helping them explore other alternatives.

I would like to elaborate on traditional feminine values as an example here

Literature expresses traditional feminine values in Western society. Their sacrifices and benefits are elaborated.

1. Dependency

Trust in a man who provides maintenance and status.

Benefits for women: economic security, less pressure to perform.

Costs for women: subordination to men, less autonomy than men.

The advantage of relying on a man is clear: It offers security but being dependent on a man possibly means that a woman develops fewer skills to survive in life. As a woman alone it is essential that she has these skills. The traditionally feminine value then costs her more than it offers her.

2. Another traditionally feminine value is: living for and through others (husband and children, for example), caring for them.

Benefits for women: Emotional security, meaning and purpose in life, development of positive feminine activities such as warmth, sympathy, nurturing function, etc.

Costs for women: Loss of personal identity, emotional dependency, depression and helplessness when there is no one left to care for.

The balance can tip negatively for a woman, meaning that it costs her more than it benefits her.

3. Another traditionally feminine value is: Taboo on assertiveness, aggressiveness and striving for power.

Benefits for women: being cared for and protected by men, being spared from the fear of incompetence and risk taking.

Costs for women: Feelings of powerlessness, dependence on the honesty of others.

4. Emphasis on physical attractiveness and erotic qualities

Benefits for women: Covert personal power over men

Costs for women: Crisis in aging, limited personal development, feelings of inferiority due to unrealistic stereotypical standards of beauty and sexuality.

For women, feelings of self-worth are strongly linked to appearance.

The traditional values for men can also be elaborated in this way with advantages and disadvantages.

An example of a traditional value for men is "I must not let myself be carried away by emotions, I am above that. If emotions do affect me, I hide them. I do not show feelings of sadness but am free to show anger."

Traditional values for both sexes are shifting. You can also work out alternative values with advantages and disadvantages.

Regarding male/female differences, it may be helpful for clients to participate in a gender-homogeneous group, a men's group or a women's group, as part of their treatment.

As an example from my own experience, a women's group:

A women's group:

In an admission ward, we worked with a women's group that met once a week. Women participated who were no longer acutely psychotic or so depressed that they completely locked themselves in. Each meeting had a theme. Themes that were discussed were traditional feminine values as described above.

Women recognised a lot in each other, and it became a lively group. Women, who in other situations often remained silent, made themselves heard. They recognised in particular having negative thoughts about oneself, being sub-assertive and having no influence on their complaints. Summarized as experiencing oneself as worthless, helpless and powerless.

During the meetings, a certain group cohesion quickly developed. The women felt less alone and contacted each other outside the group.

Due to the trust that developed, subjects related to intimacy were discussed. This is also mentioned in literature. One member said: "I feel less inhibited than in a group with men" and another: "In this group, I feel safe to discuss my good and bad qualities."

After recognizing the common problems, the relationship of these problems to societal expectations was often discovered; "I was surprised that we showed so much similarity in our ideas about the ideal image of a woman" "I used to consider all those expectations as normal, but not anymore".

We concluded that this approach could empower women to embrace and understand their true selves, enabling the development of their knowledge and talents beyond traditional gender roles. It helps women identify the shared challenges they face with others, rooted in socio-cultural values and norms, fostering greater awareness and solidarity.

Women can learn to break through their social isolation and learn to show solidarity in working on changing their attitudes towards themselves and others. In mixed groups, intimacy between women is sometimes limited by mutual rivalry in interactions with men and by the low opinion they have of themselves and other women.

Our experience showed that women can more quickly shift their attention from initial symptoms to possible underlying problems, ultimately finding meaning. The safety of the group, the feeling of not being alone, and the realisation that "not everything is my fault" may play roles in this process. By choosing the common ground in women's problems as the first point of attention and exploring this further, you offer women a model with which they can at least address part of their difficulties. For those women who tend to choose the position "it's all my fault", this approach can have a positive effect.

Concluding:

Searching for the meaning of certain symptoms can be very fruitful for a client. Complaints or symptoms are usually experienced as something to get rid of. If a client can embrace his or her symptoms as something

belonging to his or her identity, it can create an opening to a better understanding of the why, the cause, of the suffering. It can even lead to a more meaningful existence: the window in the front.

We as therapists are skilled to look together with our client for the cause of their complaints, but less skilled at looking for a more meaningful existence. At the same time, many people have the urge to give life a vertical dimension. Sometimes in a spiritual sense or in a more religious sense. Sometimes the spiritual field opens the perspective of a meaningful life, with purpose in life, creating satisfaction and self-respect.

In this process of searching with the client, it is possible that we consciously or unconsciously influence the way our clients understand their symptoms. Particularly our own internalised norms and values can play a role. We are dealing with the lenses we wear.

Norms and values are not universal. We illustrate this by paying attention to male/female ideas and norms. It was shown that therapists, men and women, have different norms for a healthy woman then for a healthy man. At the same time, cultural anthropologists describe different ideas about health and sickness in different parts of the world together with psychiatric syndromes in specific regions in the world. They name this: cultural bounded syndromes, which are mostly encountered in women.

Traditional feminine values in western society and the implications for women are discussed together with the way this was used as a therapeutical tool in a women therapy group.

It illustrates the importance of giving attention to these norms and values as something that may give meaning to symptoms and may in the end create choice.

The same can be said for traditional male values, for the changing norms and values in modern society and for cultural differences in our multicultural society.

By paying attention to internalised socio-cultural norms, such as male/female ideas and norms from other cultures (and having knowledge of these yourself), we help the client to give meaning to his/her symptoms which may create choices. It is important to realise what our own implicit ideas are.

In contact with our clients, there is a difference between stimulating them (unconsciously perhaps) to adjust themselves to certain role patterns, or, helping them explore other alternatives.