Social Science & Medicine 75 (2012) 2362–2369

Contents lists available at SciVerse ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

The classification and nomenclature of ‘medically unexplained symptoms’: Conflict, performativity and critique

Monica Greco

Department of Sociology, Goldsmiths, University of London, New Cross, London SE14 6NW, United Kingdom

ARTICLE INFO

Article history:
Available online 18 September 2012

Keywords:
Medically unexplained symptoms
Somatisation
Nomenclature
Classification
Uncertain illness
Psychologisation
Performativity
Social science

ABSTRACT

Persistent medically unexplained symptoms (MUS) – including the many syndromes that fall under this umbrella – involve a discrepancy between professional knowledge and lay experience and are often associated with latent or explicit dynamics of conflict. Although this conflictual dimension has been amply documented, little critical attention has been paid to how nomenclature and classification feed into the conflictual dynamic and are informed by it in turn. In this paper I engage with this question from a social-theoretical perspective informed by the concept of performativity. The paper offers a critical review of debates around the medical terminology in use, and a discussion of the alternative terminology developed by social scientists. Based on these, I argue that medical and social scientific discourse unwittingly collude in a disavowal of the psychological dimension of ‘MUS’. I then discuss the paradoxical character of this disavowal and suggest that it tends to perpetuate polemical modes of engagement around ‘MUS’. I conclude with suggestions on how further research might counteract this tendency.

Introduction

The expression ‘medically unexplained symptoms’ (MUS) has gained currency over the last thirty years and is now used routinely in the clinical literature (Nettleton, 2006). It refers to a wide range of symptoms when these are not supported by clinical or para-clinical findings, and are therefore ‘not attributable to any known conventionally defined disease’ (Fink et al., 2005: 772). The expression covers a wide spectrum of severity, from mild discomfort that many people accept as a normal part of living, to ‘clinically significant’ symptoms that may involve intense pain and serious impairment, often lasting many years (Katon et al., 1991; Kroenke & Price, 1993) – the latter are the focus of this article. People with unexplained symptoms are seen and managed in contexts that vary from primary care settings to the whole range of medical specialties, where they may receive different diagnoses. Examples include irritable bowel syndrome or IBS (gastroenterology); chronic pelvic pain (gynaecology); fibromyalgia (rheumatology); non-cardiac chest pain (cardiology); hyperventilation syndrome (respiratory medicine); chronic fatigue syndrome/ME (neurology/immunology); somatoform disorders (psychiatry). Many receive symptomatic treatment, repeated investigations, and multiple specialist referrals, suggesting that needs are not being met and that costly resources are being used ineffectively (Bass & Benjamin, 1993; McGorm et al., 2010). Unexplained symptoms are said to be a problem of significant clinical proportions, with their prevalence estimated at up to 50% of consultations in primary care (Ring et al., 2005) and at an average of 21% across secondary care specialties (Reid et al. 2003). Estimates however vary greatly, as the task of estimating prevalence is beset by particular difficulties in this field (Fink et al., 2005), since there is no consensus on how unexplained symptoms should be diagnosed, categorised, and named (McFarlane et al., 2008; Smith & Dwamena, 2007). Even basic taxonomical questions – such as ‘are we dealing with one or many phenomena when it comes to describing medically unexplained symptoms?’ (Deary, 1999: 51) – remain open to debate.

This article focuses on questions of nomenclature and classification in relation to the conflictual dimension of ‘MUS’. Medically unexplained symptoms – including the many syndromes that fall under this umbrella – involve a discrepancy between professional knowledge and lay experience, such that they can appear ‘medically suspect even when they are experientially devastating’ (Barker, 2008: 21). What I here call the conflictual dimension of ‘MUS’ stems from this predicament and is evident to various degrees across different sites, ranging from the clinic to patient support groups and the internet (Banks & Prior, 2001; Barker, 2008; Dumit, 2006; Salmon, 2007). Although this dimension has been amply documented, social scientists have paid little critical attention to how nomenclature and classification feed into the conflictual dynamic, and to how the conflictual dynamic in turn feeds into terminological choices and debates. In this paper I engage with this question from a social-theoretical perspective informed by the

---

E-mail address: m.greco@gold.ac.uk.

0277-9536/$ – see front matter © 2012 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.socscimed.2012.09.010

concept of performativity. The argument I develop is based on a critical review of medical debates around 'MUS' nomenclature and classification, and of the alternative terminology developed by social scientists. The paper has a critical and reflexive aim. It seeks to shift the research agendas of social scientists working in this field by highlighting how some of their current terminological choices – underpinned by specific methodological and political commitments – performatively feed into what can become a polemical deadlock.

In the philosophy of language, where the term 'performativity' originates, performative utterances are utterances that do not merely represent or describe a phenomenon, but rather enact or produce – indeed, perform – its reality. 'I pronounce you man and wife' is the classic example of such an utterance (Austin, 1962). Over the last two decades the concept of performativity has been developed and widely discussed across the humanities and social sciences, most notably within feminist and queer theory (Butler, 1990, 1993; Sedgwick, 2003) and in science and technology studies (Callon, 1998, 2007; Pickering, 1994). In these fields, the concept has become central to a more general critique of representationalism, and to alternatives based on conceiving reality (or ontology) in terms of process rather than substance (Barad, 2003; Whitehead, 1985). Despite different emphases and nuances, 'performativity' is thus used to address the reality-producing effects of all socio-material practices. Even when the practice under scrutiny is a practice of representation, as in academic or scientific accounts of a given phenomenon, the relevant question from the perspective of performativity is what that representation or description *does*, what it adds to the world in terms of possibilities or constraints, what reality it performs (Law & Singleton, 2000). My aim in this paper is thus to highlight the performative consequences of certain ways of framing the problem of 'MUS' within social scientific accounts and within medical debates on nomenclature and classification. I will propose that, in different ways, medical and social scientific discourse collude in a disavowal of the psychological dimension of 'MUS'. I will then discuss the paradoxical character of this disavowal and suggest that it tends to perpetuate polemical modes of engagement that are counterproductive. While my argument implies the reality-producing power of social scientific accounts, it should not be read as an empirical claim about the importance of these accounts relative to the multiple other forces at play in 'MUS'. It is rather an invitation to consider what possibilities for thought and action these accounts perform, and the quality (not quantity) of their contribution to the overall dynamics of 'MUS' as a field.

It is important to acknowledge at the outset that the expression 'medically unexplained symptoms' is by no means unproblematic, and has been an object of critique on the part of social and clinical scientists alike (Creed et al., 2010; Jutel, 2010). In what follows I shall use 'MUS' as a placeholder: as a noun that works as a pronoun (e.g. 'thingamajig'), in the sense that its referent is not fixed to a single concept but shifts according to context, taking on different connotations each time. I will examine some of these connotations later in this article, alongside those of several other terms employed to describe and categorise symptoms that are medically unexplained.

The polemical knot

The conflictual dimension of 'MUS' is familiar to those involved more or less directly in this field, whether as patients, clinicians or researchers, although empirically it is not a uniform or universal phenomenon. Conflictual dynamics are not always present, and when they exist they can be more or less explicit depending on the spaces in which they occur. For example, the notion that patients with unexplained symptoms tend to insist on the physical nature of their condition and to pressurise doctors into prescribing somatic interventions appears warranted in relation to secondary and tertiary care settings, more than in relation to general practice (Euba et al., 1996; Ring et al., 2005; see Salmon & May, 1995). In a secondary care context, doctors and patients have been said to interact as 'opponents who [use] specific strategies to assert authority by emphasizing contrasting areas of expertise: knowledge of subjective symptoms vs the inside of the body' (Marchant-Haycox & Salmon, 1997: 440). At the same time, studies of the self-reported experiences of doctors and patients in primary care demonstrate that intense feelings of mutual distrust, resentment and hostility exist on both sides, even if they may not be overtly expressed in the clinical encounter (Peters et al., 1998; Wileman et al., 2002). Such feelings are also reflected in the informal expressions that are commonly used among doctors to refer to patients who repeatedly present with unexplained symptoms: 'crocks', 'thick folder patients', 'frequent flyers', 'heartsink patients', and so on. The conflictual dimension of 'MUS' is probably most explicit and intense outside the clinic, in spaces such as internet support groups and forums, and in relation to certain conditions more than others. The cases of CFS/ME and fibromyalgia are among the most conspicuous and best researched in this sense; both have been discussed in connection with patient activism and direct challenges to medical expertise (Barker, 2008; Barrett, 2004; Wolfe, 2009; Zavetoski et al., 2004). However, none of these spaces or conditions exist in isolation. What goes on in clinical interactions is 'routinely echoed in a much wider political field' (Banks & Prior, 2001: 12) and vice versa. Last but not least, the conflict – whether latent or explicit – is clinically very significant. In response to it, patients may embark in a long career of multiple medical consultations (sometimes disparagingly referred to as 'doctor shopping') that not only may fail to provide a satisfactory explanation and care for the physical symptoms, but may also come to be seen as a symptom in its own right (of abnormal illness behaviour, indicating cognitive distortions as to the significance of the symptoms).

In *The Logic of Care* (2008), Mol powerfully demonstrates that in the domain of practice, as opposed to that of abstract treatment protocols or textbook medicine, situations of uncertainty and failure are not exceptional and marginal, but are rather routinely encountered and regarded as the norm. The conflict at play in practices around unexplained symptoms, however, stems from a very different kind of uncertainty and failure: one that concerns the very definition of the medical situation and what should follow from it, even in the abstract. On the medical side, the 'failure' is often described in terms of the use of expensive biomedical resources on patients who do not in fact need them (Barsky et al., 2005; Fink, 1992; Shaw & Creed, 1991; Smith, 1994; Reid et al., 2002). The multiple interventions offered to 'MUS' patients are not only perceived as disproportionate and unwarranted, but as part of the problem rather than the solution. These interventions are not devoid of medical risk and may give rise to biomedical problems where supposedly none existed in the first place. In some cases, interventions are said to directly feed into a patient's (psycho-)pathology, as in the example of a woman sexually abused in childhood seeking to 'repeat the trauma' by undergoing pelvic surgery (Walker et al., 1998).

Turning to the side of the patient, the study of sufferers' concerns and narratives in relation to 'MUS' as such is comparatively in its infancy (see Nettleton, 2006; Nettleton et al., 2004, 2005), but there is a wealth of literature on related conditions such as chronic pain, IBS, fibromyalgia, or CFS/ME, demonstrating that care appears equally problematic, albeit for different reasons, from the patient perspective. This literature has underlined the importance of a valid diagnosis for legitimating illness, be it for legal, insurance, and/or welfare purposes (e.g. Dumit, 2006; Mik-Meyer, 2010) or at an experiential level, for the purpose of creating meaning (e.g. Bülow & Hydén, 2003; Madden & Sim, 2006; Nettleton, 2006). In particular, the social scientific literature has underlined how psychological explanations of symptoms can be a source of delegitimation, in so far as they are taken to imply that the illness is not as ‘real’ as physical disease (Kirmayer, 1988). Psychosomatic explanations can be used by practitioners as a ‘blame-shifting’ device (Horton-Salway, 2002), while the reference to concepts like ‘masked depression’ can function discursively to undermine the status of sufferers’ experiential knowledge (Horton-Salway, 2004). Due to their stigmatizing character, diagnoses of mental illness have been described as an ‘attack against [CFS sufferers’] identity’ (Tucker, 2004: 155), which sufferers are keen to avoid by positioning themselves as having a ‘knowable physical illness’ (2004: 163; Horton-Salway, 2002).

In sum, we have a situation where each side of the doctor–patient relationship has reason to lament and to question the premises on which the understanding and care of MUS operate. Historically informed social analysis has further added to this picture by arguing that this conflictual predicament is rooted in the epistemological privilege accorded to the ‘visible’ within modern medicine (Foucault, 1973; Rhodes et al., 1999). This privilege results in the failure to account for ‘MUS’ – where ‘symptoms’ do not correspond to a demonstrable ‘sign’ – other than in psychiatric terms (Greco, 1998; Jutel, 2010). In this sense ‘MUS’, to paraphrase Horacio Fabrega, are ‘a cultural and historical product of Western medicine’ (Fabrega, 1990; see also Kirmayer, 1984, 1986).

Social research has made a vital contribution in articulating the concerns that stem from the patient experience of marginalisation and delegitimation. In what follows, however, I propose to focus on the performative dimension of this contribution to invite reflection on some of its potential unintended effects. I will suggest that, in giving voice to these concerns, social research has amplified the failure and the conflict associated with ‘MUS’. I use the word ‘amplified’ to convey an ambiguity: in the first instance, by adding the voice of academic analysis to that of lay experience and of organised activism, social research has made the conflict louder, its outlines more clearly intelligible, facilitating recognition and discussion of the difficult predicament of many patients. This has been both necessary and useful. But to the extent that this voicing settles on the reiteration of a number of established (pro)positions, the conflict is amplified also in a different sense, namely in the sense of being reinforced. The conflict acquires a certain solidity and factualness, it becomes itself a ‘datum’ of experience informing expectations, forms of identification, and corresponding strategies of lay and professionals alike. The risk in this latter sense, to extend the metaphor, is for social scientific research to amplify a broken record – to contribute to the sclerotisation of the positions involved, and to the stagnation of debate along unproductive lines.

A crucial aspect of this process, I contend, stems from how social scientists have engaged with questions of classification and nomenclature. Aside from cursory acknowledgements of the multiplicity and controversial character of the various terms in use, social scientific research has tended to address medically unexplained symptoms in abstraction from medical debates on diagnostic taxonomy and nomenclature. Instead, data relative to patients with specific diagnoses (e.g. ME/CFS, fibromyalgia, IBS) or with undiagnosed symptoms have been discussed in terms of sociologically defined categories and concepts, such as ‘contested’, ‘controversial’, or ‘debatable’ illness (e.g. Dumit, 2006; Horton-Salway, 2007; Tucker, 2004), ‘illegitimate illness’ (e.g. Cooper, 1997; Ware, 1992) or ‘illness without a label’ (e.g. Nettleton et al., 2004, 2005). Nettleton synthesises this trend in referring to this literature as an ‘emerging sociology of uncertain illness’ (2006: 1168). The use of this terminology is partly a reflection of methodological choices: a common feature of this work has been a focus on the discursive dimension, with empirical foci ranging from the rhetorical strategies of patient activists, to experiential narratives of illness, to analyses of practitioners’ and sufferers’ situated talk, in a broadly (social-) constructionist framework. In the task of illustrating these various forms of discourse the researcher draws on the language of participants, and supposedly adopts a position of epistemological neutrality as to the extra-discursive dimension of the symptoms. This extra-discursive dimension, by default, thus remains a matter for medicine to represent and define, in a division of labour faithful to the distinction between ‘illness’ and ‘disease’ (cf. Timmermans & Haas, 2008). Aside from a methodological commitment, the descriptive terms employed by social scientists also reflect, with few exceptions (e.g. Barker, 2008), a *political* commitment towards validating ‘lay’ narratives. This commitment is often underpinned by researchers’ own experience of the illness they study (e.g. Cooper, 1997). Narrative validation offers a measure of legitimacy to correct sufferers’ disenfranchisement by the medical system. This is done by avoiding the (medical) concepts and terms that are perceived, by many patients, to be loaded against them, and by producing, as we have seen, an alternative and parallel nomenclature – one that patients can recognise and accept, and that doctors on their part cannot argue with.

The problem with this approach is that it is too comfortable. Firstly, the vocabulary of epistemological neutrality takes no risks with the thorny question of (re-)defining the (extra-discursive) realities of ‘MUS’. Ostensibly at least, it leaves this task entirely to the parties directly involved in conflict, adding little or nothing to their linguistic and conceptual repertoire. This also means, of course, that the performative role of discourse (including the discourse of social scientists) in shaping the extra-discursive reality of ‘MUS’ remains beyond any possibility of articulation. Secondly, the political commitment towards validating lay narratives often reinforces, albeit implicitly and by default, an impression that ‘MUS’ nomenclature and classification (and the realities these are designed to convey) are uncontroversial among the medical profession itself. What is involved, in other words, is an implicit construction of ‘medicine’ as a singular and internally cohesive *other* (cf. Mol, 2002), and – with all due exception for the qualities of individual practitioners – an antagonistic *other* at that.

With this background in mind, using ‘MUS’ as a placeholder serves to describe what in Foucauldian terms would be called a *space of problematisation*: a space to be unpacked and articulated in terms of its internal differences, tensions, and paradoxes, and with a view to defining tacit assumptions that may hold across lines of apparent conflict. It is important to underline that approaching ‘MUS’ in this way also specifies an ethics of engagement, one that Foucault explicitly contrasted with the morality implicit in polemics. ‘The polemicist’, he wrote

> … proceeds encased in privileges that he possesses in advance and will never agree to question. On principle, he possesses rights authorising him to wage war and making that struggle a just undertaking; the person he confronts is not a partner in the search for the truth, but an adversary, an enemy who is wrong, who is harmful, and whose very existence constitutes a threat. For him, then, the game does not consist of recognising this person as a subject having the right to speak, but of abolishing him, as interlocutor, from any possible dialogue; and his final objective will be, not to come as close as possible to a difficult truth, but to bring about the triumph of the just cause he has been manifestly upholding from the beginning. The polemicist relies on a legitimacy that his adversary is by definition denied. (Foucault, 1984: 382)

Both the dismissive doctor (or 'medicine') and the 'difficult' patient can be recognised in the figure of the polemicist, respectively encased in the privilege of professional authority on the one hand, and of experience on the other. The move beyond this polemical situation in the search for a 'difficult truth' requires, in the first instance, that we look beyond these figures – not because they are purely fictional, since concrete instances of such types do exist, but because, in their deadlock, they constitute the most conservative elements of the configuration.

In what follows, I will disturb this simple contrast between the rhetorical figures of doctor and patient in the attempt to loosen the polemical knot that ties them together. I will begin by offering an overview of the lack of consensus *within* medicine with regard to how 'MUS' should be categorised and named, through an analysis and discussion of the different terms in current use. Focussing on the problem of nomenclature and classification serves to produce a more nuanced understanding of the multiple character of medical (pro)positions, in the interest of constructing medical expertise as a possible interlocutor rather than a polemical opponent. This lack of consensus is a complex phenomenon in terms of its historical genealogy, and my purpose here is not to account for it in terms of the events and power relations that have produced it. In describing these multiple (pro)positions, my aim is rather to present the lack of consensus itself as evidence of a form of *care* that is virtually unacknowledged as such. Ultimately, however, my aim is to highlight that a performative paradox characterises the medical response to lay concerns.

Caring for names and categories

'Medically unexplained symptoms' is only one among several terms used in the clinical literature – other terms include (but are not limited to) 'somatisation', 'functional somatic symptoms/syndromes' and 'somatoform disorder'. These are sometimes used interchangeably, but more often to acknowledge that different terminologies carry inbuilt assumptions about aetiology or connotations over which there is no consensus. Before examining the connotations of each of these terms, it is worth recalling that there are as yet no agreed clinical or research diagnostic criteria for patients with 'MUS' (McFarlane et al., 2008). Of the expressions just mentioned, only 'somatoform disorders' figures as a formal diagnostic category within DSM-IV and in ICD-10, and it is currently being revised in ways that I will discuss below.

MUS

'MUS' is a generic expression and one with a relatively recent history (Nettleton, 2006). As a label, it is increasingly used by practitioners and researchers particularly in the primary care context, and is often associated with (but not confined to) illness that remains undiagnosed. The expression is preferred because of its supposed neutrality, in that by definition it does not imply a causal mechanism. It is therefore neutral also in terms of attributing any error of judgement to either doctor or patient: the suggestion is that the symptoms are *as yet* unexplained, and that the patient could be right in supposing that they have a physical origin. 'MUS' in this sense anticipates a conflict and is designed to divert it, by deliberately leaving open the question of aetiology and thus theoretically removing the stigma associated with the notion that the symptoms are 'all in the mind' (Guthrie, 2008). On this basis, it is incorrect to assume that 'MUS' implies psychogenic illness, as some commentators in the social sciences have done (e.g. Jutel, 2010). To read the label straightforwardly in this way fails to acknowledge the problematisation of aetiological assumptions that it is designed to convey, and fosters what many clinicians would regard as a misunderstanding of the term (albeit a frequently encountered one). The reasons clinical researchers offer for positively adopting the label are akin to those I offered earlier in this paper, when I invited the reader to let 'MUS' function as a 'placeholder' – a noun without a clear and unambiguous referent. These reasons should not be ignored, not because the label is unproblematic (since it is, in ways that we shall see), but because in ignoring them we would elide some of the internal complexity of the medical (pro)position.

The very neutrality of 'MUS' as an expression accounts for some of the ways in which the label can be problematic from both doctors' and patients' perspectives. 'MUS' is not itself a diagnosis but rather a diagnostic no man's land; it does not perform any of the positive functions diagnoses are meant to perform, namely to explain, legitimise and normalise. As clinicians recognise, at a connotative level 'MUS' is far from neutral, and is often understood as meaning that symptoms are indeed 'all in the mind' (Stone et al., 2002). Accordingly, the expression 'medically unexplained symptoms' has been identified as a barrier to improved care, since patients tend to resent the label as dismissive (Creed et al., 2010). The placeholder function of 'MUS', however, also lends itself to an opposite interpretation: the suggestion implicit in the label that symptoms are *as yet* unexplained can reinforce the expectation that, given sufficient investment and research, a biomedical cause will be found.

In her sociological critique of the 'MUS' category, Jutel has argued that it 'reifies the notion that all physical complaints without explanation can be viewed in the same way … by framing them as a problem to be approached epidemiologically' (2010: 234). This is potentially a valid point but only on condition that such reification is not in fact useful – a judgement that cannot be made in the abstract, but only in relation to specific contexts, problems, and tasks (Mol, 2008: 62–66). In considering 'MUS' as an epidemiological category, we should rather be intrigued that not all physical complaints without explanation are viewed in the same way, or indeed addressed as 'MUS'. Doctors routinely treat conditions, such as migraine, with no known organic cause and for which explanations exist only at the level of hypotheses. What marks 'MUS' as different, presumably, is not a lack of explanation *per se*, but other characteristics shared by this category of symptoms and/or patients (e.g. the difficulties associated with the diagnostic process; the character of effective treatment; the dynamics involved in their care). In other words, what marks 'MUS' as different is the 'difficult truth' that remains implicit in the label.

Functional somatic syndrome

The expression 'functional somatic syndrome' is most relevant to secondary and tertiary care settings. It refers to symptoms that cluster in recognizable patterns, which 'suggest a shared underlying malfunction of a particular body system' (Guthrie, 2008: 432), hence the pertinence of corresponding medical specialisms. 'Functional somatic syndrome' is the umbrella term comprising specific diagnoses such as IBS, chronic pelvic pain, fibromyalgia and CFS/ME among others. Advocates of categorization in terms of 'functional somatic syndrome(s)' argue that there are significant similarities between these, both in terms of symptom overlap and in terms of underlying genetic, physiological and psychological mechanisms, and that these similarities outweigh the differences between diagnoses (Fink et al., 2007; Henningsen & Creed, 2010). Some go so far as to say that the different terms and diagnoses associated with 'MUS' can and do refer to 'a single syndrome that receives different labels depending on the medical specialty where it is encountered' (Brown, 2007: 772; see also Aaron & Buchwald, 2001; Wessely, 2004; Wessely et al., 1999). Theoretically, the alternative between considering ‘MUS’ as a single syndrome or as several different ones need not be so absolute, and indeed an intermediate position exists advocating recognition of different sub-groups of patients, ‘some of whom experience symptoms that are specific to a particular body system … and others who are polysymptomatic and who would meet criteria for many functional syndromes’ (Brown, 2007: 772; see Guthrie et al., 2003; White, 2010; Wilson et al., 2001). However, this intermediate position by no means resolves the challenge of classification: for the distinction between patients with symptoms specific to a body system versus those whose symptoms span across systems does not map coherently onto the distinction between existing diagnoses, such as fibromyalgia or CFS, associated with different medical specialties.

The term ‘functional’ literally refers to disturbance in *function*, both at the level of organs or body systems and at the level of desired or expected daily social functions, as opposed to a disturbance or anomaly in *structure*. Strictly speaking it implies the absence of a lesion rather than psychological aetiology, but the term has a long history of being used among doctors as code for ‘psychogenic’. These connotations, however, are not necessarily shared by patients, with at least one study arguing that patients found the term ‘functional’ less offensive than the expression ‘medically unexplained’ (Stone et al., 2002). A recent study of the meanings of ‘functional’ among UK neurologists has demonstrated the term’s significant ambiguity, with a majority of neurologists using it to convey that the illness is ‘not organic’ while a significant minority use it to indicate ‘abnormalities in brain or body function, or a psychiatric disorder’ (Kanaan et al., 2012: 249). The study also showed that this ambiguity was considered useful, at least by some, in helping to avoid ‘difficult discussion’.

Somatisation and somatoform disorders

Though often used generically and explicitly discredited as a scientific construct (Crombez et al., 2009), the term ‘somatisation’ points to the diagnostic category of somatoform disorders in DSM-IV, and shares some of the problems associated with that category. These have been widely debated for nearly a decade now in the process of consultation leading up to a new edition of the DSM, which is due to appear in 2013. While DSM has traditionally been addressed to an audience of mental health professionals, it is significant that in the context of this revision – and particularly in connection with the category of somatoform disorders – two further groups are being suggested as relevant stakeholders: firstly, clinicians in primary care and medical and surgical subspecialty settings, because these are the settings where the majority of patients with unexplained symptoms are encountered; and secondly patients themselves, who have an interest in the diagnosis they receive, and who find the implications of the current classification difficult to accept (Mayou et al., 2005).

DSM-IV is supposed to be a-theoretical: the diagnostic categories are designed to be descriptive, rather than reflecting commitment to specific aetiological theories. The term ‘somatisation’ and the category of somatoform disorders, however, carry strong connotations of psychological causation. The category of somatoform disorders includes conversion disorder, which bears a direct genealogical link with hysteria, and a direct association with Freud’s proposition that infrapsychic conflicts could be ‘converted’ into a somatic form. The term *somatoform* reflects this legacy, in that it literally describes the disorder as being ‘in the shape of’ something somatic (by implication: when in fact it is psychological). Diagnoses of somatoform disorder are also adjacent to the diagnosis of factitious illness and to the concept of malingering: a differential diagnosis of somatoform disorder requires excluding the conscious fabrication of symptoms, and the explicit possibility that the patient may be deviant rather than ill. As it is currently framed, the category of somatoform disorders points directly to the functions of forensic and moral arbitration that medicine and psychiatry socially perform, alongside and in addition to the function of providing care (Greco, 1998).

There are many ways in which the category of somatoform disorders is deemed problematic. The most important of these, perhaps, is the emphasis on the exclusion of organic factors as a main diagnostic criterion (Mayou et al., 2005). Despite the claim of DSM-IV to being a-theoretical, therefore, the category does imply an alternative between psychological and organic causation, suggesting that they are mutually exclusive. Another main point of criticism is that ‘somatoform’ diagnostic categories were developed in highly selected patient populations, namely in the field of psychiatry. The argument is made that they are ‘so narrowly defined that they defy clinical application, especially in primary care’ (Fink et al., 2005: 774). Last but not least, the nomenclature of somatoform disorders is typically unacceptable to patients. Patients’ perceptions of the diagnosis they receive and of the implications of their classification have been described as an important factor to be considered in the proposals for a revised edition of DSM (Mayou et al., 2005).

The proposed revisions, still not definitive, attempt to address some of these issues (APA, 2012). In the proposals the term *somatoform* has been abandoned, in favour of a new general category called Somatic Symptoms Disorders. Similarly, there is no longer an emphasis on the exclusion of organic factors as a main diagnostic criterion, on the basis that assessments of medical symptoms as ‘unexplained’ are unreliable. In a bold move, the new category subsumes (and redescribes) what were previously Somatoform Disorders and Psychological Factors Affecting Medical Condition into a single group, acknowledging the importance of physical symptoms and/or concern over medical illness across these presentations, regardless of presumed aetiology and (psychiatric or medical) co-morbidity. At the same time, the proposed revisions accentuate the emphasis on the importance of ‘cognitive distortions’ (such as high health-related anxiety, or a tendency to catastrophise) which, arguably, are no more reliably assessed than ‘unexplained’ symptoms themselves and may be exacerbated by conflict in the doctor–patient relationship. It is these cognitive distortions – defined as such not by the belief that an organic condition is present when in fact it is absent, but by an exaggeration of the significance of symptoms – that would warrant psychiatric referral and a psychiatric diagnosis. This opens the option for non-psychiatric diagnoses (typically, functional somatic syndromes) to retain their pertinence for all cases where cognitive distortions are absent, or namely where patients are able to live with the aetiological uncertainty of their condition without this causing them too much distress.

Symptoms ‘in their own right’

While critics of current classification and nomenclature often problematise specific aetiological assumptions implicit in certain terms – such as the assumption of psychogenesis that is implicit in the concept of somatisation – some researchers currently problematise the focus on aetiology as at a more general level. Sharpe et al. (2006) for example have argued that many of the existing diagnostic categories used in connection with unexplained symptoms imply hypothetical (i.e. unproven) underlying pathology, whether physical (as in e.g. fibromyalgia) or psychological (as in somatoform disorders). This is problematic because it perpetuates the erroneous assumption – among professionals and patients alike – that there is a simple causal relationship between bodily symptoms and underlying pathology, which runs contrary to 'emergent understandings of bodily symptoms as reflecting the brain's integration of multiple aetiological factors' (Sharpe et al., 2006: 355). These authors among others thus argue for a more radical reconfiguration of categorisation that would enable symptoms to be researched, managed and classified 'in their own right', not just as surface manifestations of either bodily disease or psychopathology (Kroenke & Harris, 2001; Sharpe et al., 2006).

Categories as performative tools

This overview of the ongoing discussion on the appropriate classification and nomenclature for 'MUS' illustrates a degree of reflexivity and internal critique on the part of medical discourse that may come as a surprise to many social scientists. In the repeated acknowledgements of the ways in which nomenclature – and particularly the unacceptability to patients of much of the terminology currently in use – interferes with the provision of satisfactory care, the medical research literature on 'MUS' displays an explicit awareness of the performative dimension of naming and categorising. We can read this reflexivity as an expression of the logic of care, where 'categories are not taken to be fixed reflections of a given reality, but tools to work with' (Mol, 2008: 63; see e.g. Hadler, 1997).

A closely related impression emerging from this overview concerns the caution with which the psychological dimension of unexplained symptoms is addressed. This caution is entirely understandable in light of the insights provided by lay experts, ranging from patient activists to social scientists, concerning the impact of 'psychologisation' on the experience of sufferers. Because it is entirely understandable, however, it is rarely critically examined, and this is what I propose to do in the next and final section. I will argue that an element of paradox is involved in the caution against the psychological, when this caution is performed uncritically and with a limited conception of the 'psychological' itself.

Colluding against the 'psychological': a performative paradox

While it is commonplace for doctors to speak of the unacceptability of psychological attributions to patients (sometimes rendered as patients' 'resistance' to psychological explanations), we should consider how current medical/psychiatric discourse itself displays a certain resistance to the 'psychological' as an explanatory and descriptive trope. Remarkable in this regard is the disclaimer we find in the introduction to the current edition of DSM-IV, where we read that

> the term *mental disorder* unfortunately implies a distinction between 'mental' disorders and 'physical' disorders that is a reductionist anachronism of mind/body dualism. A compelling literature documents that there is much 'physical' in 'mental' disorders, and much 'mental' in 'physical' disorders. The problem raised by the term 'mental' disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute. (APA, 2000: xxx)

What is striking about this statement is not the gesture towards acknowledging ontological (and aetiological) complexity. The statement is remarkable rather in light of the fact that comparable disclaimers continue to appear entirely superfluous in relation to established 'physical' disease, such that a mind/body dualism remains culturally unchallenged, in practice, for the majority of recognised biomedical conditions. Seen within this wider context of signification, and despite its literal meaning, the DSM disclaimer reads as a one-sided disavowal of the 'mental' in favour of a culturally reassuring, de-stigmatising suggestion that there *is* a physical dimension, however yet unspecified it may be, underlying every psychiatric condition. A similar disavowal of the psychological is at play in the preference accorded by researchers to 'MUS'. Like the DSM, the expression 'MUS' is theoretically neutral on the question of aetiology, while as we have seen it can suggest that a physical explanation, though not yet apparent, is still available as a theoretical hypothesis. In both instances we are dealing with connotative *suggestions* of a disavowal, not with literal meanings, but arguably it is precisely at this level that statements are effective in shaping expectations, modes of identification, and strategies.

The cautiousness apparent with regard to naming the 'psychological' is understandable, as we have seen, as an aspect of the reflexivity of medical discourse with regard to the performative dimension of naming and categorising. There is awareness, in other words, that the unacceptability of accounts framed in psychological terms – regardless of their potential pertinence – can compromise the relationship between patients and healthcare providers and thus contribute to an exacerbation of a patient's suffering, which may include an aggravation of their physical symptoms. Accordingly, terms and categories suggestive of a psychological account must be avoided. There is, however, a paradoxical dimension to this strategy: for the great care taken in not offending sensibilities or 'hurting feelings' is also, simultaneously, an acknowledgement and affirmation of the performative power of words and feelings. The DSM disclaimer itself – read as an affirmation of the complex nature of pathological processes – tells us that indeed *all* bodily processes and outcomes involve, are affected by, the 'mental'. In this sense, the disavowal of the psychological can be regarded as a strategy for the management of patients' suggestibility, based on a practice-based awareness of the performative nature of discourse.

The disavowal of the psychological is paradoxical, therefore, because it *implies a psychological account of the dynamics involved in symptom production*, but one that that is not explicitly articulated as such. Crucially, the dynamics that remain tacit in such an account are not exclusively infra-psychic and located within the individual patient, but relational and intersubjective – i.e. social. They implicate discursive (socio-material) practices more generally in the process of symptom-production, such that it becomes difficult to say 'whose' the illness or the problem then is. Here lies the paradoxical eye of the storm, the silence where the articulation of a 'difficult truth' might otherwise be. This truth is difficult in more than one sense: it is difficult because it requires the articulation of inherently *complex* processes, where recourse to simpler models designed to reduce complexity (e.g. mind/body dualism) is conspicuously failing; and it is difficult because its articulation is constrained by multiple obstacles and forms of resistance, of both a practical and a political/ideological nature.

In pointing to this disavowal of the psychological my aim is clearly not to insist on the psychological or 'mental' nature of symptoms to the exclusion of a physical dimension. Rather, it is to highlight a certain *collusion* at the level of discourse between clinicians, social scientists, patient advocates, and common prejudice – in other words, all the different voices at play in 'MUS' as a polemical field – in implicitly reinforcing the negative and reductive connotations of the 'psychological'. Amid controversy, conflict, and debate, one proposition seems to acquire ever greater solidity and (apparent) consensus: the absence of a biomedical explanation *must not* lead to an explicit inference that the 'mind' is involved in the production of symptoms themselves (only, at most, in the exaggeration of their significance). Yet this proposition flies in the face of every aspiration to a non-dualist medical epistemology – which ironically constitutes the other major point of consensus across discursive positions. Ideally, we should be able to articulate how the 'mind' – and all that is subsumed in this elusive concept – participates in the production of *every* type of symptom, and indeed of biomedical disease (Foss, 2002). But the familiar retort that symptoms are 'all in the mind', and especially its use as a way of dismissing symptoms as insignificant or motivated by secondary gain, haunts contemporary discourse on 'MUS' and charges any reference to the psychological character of symptoms with potentially explosive connotations. The question is whether the way out of this *impasse*, in the long term, is best served by conceding territory to those who would have the relevance of the psychological denied altogether, in favour of the continued search for purely physical or biomedical explanations. This concession lays the conditions for a perpetuation of conflict, not least because psychological interventions (coupled with the prescription of antidepressants, in many cases) remain the option recommended at the level of treatment and management strategies.

Is there an alternative to this strategy of disavowal? An alternative exists, but in turn it is neither simple nor necessarily immediate in terms of its translation into clinical applications. Its point of departure lies in a problematisation of what the psychological dimension of 'MUS' is, and can be, understood to mean. A number of psychologists in the pain field are already explicitly countering some of the prejudicial associations of psychological attributions by advocating a 'normal psychology of pain' (see Eccleston, 2011). At a different level of analysis, a number of critical psychologists are systematically re-evaluating the concept of 'suggestion' in terms of its relevance to all psychosocial and psychosomatic processes, while also articulating how it subverts the individualising implications of mainstream psychological discourse (see Blackman, 2007, 2008; Brown & Stenner, 2009; Chertok & Stengers, 1992; Despret, 2004; Motzkau, 2007, 2009, 2011; Wilson, 2004). The alternative to a disavowal of the psychological involves the slow work of enriching what we understand by this term by articulating differences – and by articulating the values involved in their (virtual and actual) enactments. As an anti-polemical strategy, it is diametrically opposite to a superficially reassuring disavowal: its aim would be to assert that the psychological is relevant *everywhere* and to render it *discussable* in its multiple versions and implications.

In asserting the importance of recognising different versions of the psychological I am making a point that is far from new. Writing in 1949, Viktor von Weizsäcker (1986) lamented the direction that the development of psychosomatic medicine was taking in his day. He claimed that the most conspicuous threat to the possibility of a non-dualistic medicine was not, as one might superficially expect, the type of medical thinking that is indifferent to the psychic domain; a much greater threat was posed by the uncritical endorsement of the *wrong kind of psychology*. This problem, I contend, is still with us today.

Conclusion

Few would deny that the MUS field is a conflictual space, where polemical styles of engagement inform the expectations of many healthcare professionals and sufferers alike. In this configuration, social scientists are not passive observers. Recent social research, I have argued, has amplified this dimension of conflict in both a positive and a negative sense: positively, it has lent its voice to the predicament of sufferers; but in so doing it has also often implicitly (re)produced a representation of medicine and medical (pro)positions as a polemical *other*, rather than a possible interlocutor. One of my aims in this article has been to complicate this picture, by looking at how 'MUS' classification and nomenclature are far from uncontroversial among clinical researchers and clinicians themselves. Moreover, an overview of the debates suggests that clinicians consider questions of taxonomy and nomenclature as much from the perspective of a logic of care as from the perspective of scientific validity.

Based on this overview, I also drew attention to what I called a *disavowal of the psychological* and suggested that, in so far as such a disavowal is apparent in the debates on nomenclature and classification, it reflects an explicit awareness of the performative dimension of naming and categorising. As a strategy to reduce clinical conflict, however, it is paradoxical in the long term, for it colludes with common prejudice in reinforcing the polemical connotations (and a reductive understanding) of the psychological. Similarly, the social-scientific framing of 'MUS' in terms of uncertain or contested illness, while supposedly neutral on the question of aetiology, does nothing to transform these reductive connotations. Against this tendency I proposed that the 'psychological' needs to be unpacked and made available for discussion in its multiple versions and in terms of the different values at stake within these. While it is unrealistic and perhaps unreasonable to expect clinical researchers to undertake this task, social scientists are well placed to do so.

Acknowledgements

My thanks go to Paul Stenner and to an anonymous reviewer for their comments on previous versions of this paper.

References

Aaron, L. A., & Buchwald, D. (2001). A review of the evidence for overlap among unexplained medical conditions. *Annals of Internal Medicine, 134*, 868–880.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (Text-revised 4th ed.).

American Psychiatric Association. (2012). *Somatic symptom disorder*. Available at http://www.dsm5.org/proposedrevision/Pages/SomaticSymptomDisorders.aspx Accessed 22.09.12.

Austin, J. L. (1962). *How to do things with words*. Oxford: Clarendon Press.

Banks, J., & Prior, L. (2001). Doing things with illness. The micro-politics of the CFS clinic. *Social Science & Medicine, 52*(1), 11–23.

Barad, K. (2003). Posthumanist performativity: toward an understanding of how matter comes to matter. *Signs: Journal of Women in Culture and Society, 28*(3), 801–831.

Barker, K. K. (2008). Electronic support groups, patient-consumers, and medicalization: the case of contested illness. *Journal of Health and Social Behavior, 49*(March), 20–36.

Barrett, D. (2004). Illness movements and the medical classification of pain and fatigue. In R. M. Packard, et al. (Eds.), *Emerging illnesses and society: Negotiating the public health agenda*. Baltimore & London: The Johns Hopkins University Press.

Barsky, A. J., et al. (2005). Somatisation increases medical utilisation and costs independent of psychiatric and medical comorbidity. *Archives of General Psychiatry, 62*(8), 903–910.

Bass, C., & Benjamin, S. (1993). The management of chronic somatisation. *The British Journal of Psychiatry: The Journal of Mental Science, 162*, 472–480.

Blackman, L. (2007). Reinventing psychological matters: the importance of the suggestive realm of Tarde's ontology. *Economy and Society, 36*(4), 574–596.

Blackman, L. (2008). Affect, relationality and the "problem of personality". *Theory, Culture & Society, 25*(1), 23–47.

Brown, R. J. (2007). Introduction to the special issue on medically unexplained symptoms: background and future directions. *Clinical Psychology Review, 27*, 769–780.

Brown, S., & Stenner, P. (2009). *Psychology without foundations*. London: Sage.

Bülow, P. H., & Hydén, L. (2003). Patient school as a way of creating meaning in a contested illness: the case of CFS. *Health, 7*(2), 227–249.

Butler, J. (1990). *Gender trouble*. London & New York: Routledge.

Butler, J. (1993). *Bodies that matter: On the discursive limits of sex*. London & New York: Routledge.

Callon, M. (1998). Introduction: the embeddedness of economic markets in economics. In M. Callon (Ed.), *The laws of the markets*. Oxford: Blackwell.

Callon, M. (2007). What does it mean to say that economics is performative? In D. A. MacKenzie, F. Muniesa, & L. Siu (Eds.), *Do economists make markets? On the performativity of economics* Princeton: Princeton University Press.

Chertok, L., & Stengers, I. (1992). *A critique of psychoanalytic reason: Hypnosis as a scientific problem from Lavoisier to Lacan*. Stanford, CA: Stanford University Press.

Cooper, L. (1997). Myalgic encephalomyelitis and the medical encounter. *Sociology of Health and Illness, 19*(2), 186–207.

Creed, F., et al. (2010). Is there a better term than "Medically unexplained symptoms"? *Journal of Psychosomatic Research, 68*(1), 5–8.

Crombez, G., et al. (2009). The unbearable lightness of somatisation. *Pain, 145*, 31–35.

Deary, I. J. (1999). A taxonomy of medically unexplained symptoms. *Journal of Psychosomatic Research, 47*(1), 51–59.

Despret, V. (2004). The body we care for: figures of anthropo-zoo-genesis. *Body & Society, 10*(2–3), 111–134.

Dumit, J. (2006). Illnesses you have to fight to get: facts as forces in uncertain, emergent illnesses. *Social Science & Medicine, 62*(3), 577–590.

Eccleston, C. (2011). A normal psychology of pain. *The Psychologist, 24*(6), 422–425.

Euba, R., et al. (1996). A comparison of the characteristics of chronic fatigue syndrome in primary and tertiary care. *British Journal of Psychiatry, 168*(1), 121–126.

Fabrega, H. (1990). The concept of somatization as a cultural and historical product of Western medicine. *Psychosomatic Medicine, 52*, 653–672.

Fink, P. (1992). Surgery and medical treatment in persistent somatising patients. *Journal of Psychosomatic Research, 36*(5), 439–447.

Fink, P., et al. (2005). Classification of somatisation and functional somatic symptoms in primary care. *Australian and New Zealand Journal of Psychiatry, 39*, 772–781.

Fink, P., et al. (2007). Symptoms and syndromes of bodily distress: an exploratory study of 978 internal medical, neurological, and primary care patients. *Psychosomatic Medicine, 69*(1), 30–39.

Foss, L. (2002). *The end of modern medicine: Biomedical science under a microscope*. New York: State University of New York Press.

Foucault, M. (1973). *The birth of the clinic*. London: Routledge.

Foucault, M. (1984). Politics, polemics and problemizations. In P. Rabinow (Ed.), *The Foucault reader*. Harmondsworth: Penguin.

Greco, M. (1998). Between social and organic norms: reading Canguilhem and "somatization". *Economy and Society, 27*(2), 234–248.

Guthrie, E. (2008). Medically unexplained symptoms in primary care. *Advances in Psychiatric Treatment, 14*(6), 432–440.

Guthrie, E., et al. (2003). Cluster analysis of symptoms and health seeking behaviour differentiates subgroups of patients with severe irritable bowel syndrome. *Gut, 52*, 1616–1622.

Hadler, N. M. (1997). Fibromyalgia, chronic fatigue, and other iatrogenic diagnostic algorithms. Do some labels escalate illness in vulnerable patients? *Postgraduate Medicine, 102*(2), 161–162.

Henningsen, P., & Creed, F. (2010). The genetic, physiological and psychological mechanisms underlying disabling medically unexplained symptoms and somatisation. *Journal of Psychosomatic Research, 68*(5), 395–397.

Horton-Salway, M. (2002). Bio-psycho-social reasoning in GPs' case narratives: the discursive construction of ME patients' identities. *Health, 6*(4), 401–421.

Horton-Salway, M. (2004). The local production of knowledge: disease labels, identities and category entitlements in ME support group talk. *Health, 8*(3), 351–371.

Horton-Salway, M. (2007). The ME Bandwagon and other labels: constructing the genuine case in talk about a controversial illness. *British Journal of Social Psychology, 46*(4), 895–914.

Jutel, A. (2010). Medically unexplained symptoms and the disease label. *Social Theory & Health, 8*, 229–245.

Kanaan, R. A., et al. (2012). The function of "functional": a mixed methods investigation. *Journal of Neurology, Neurosurgery and Psychiatry, 83*, 248–250.

Katon, W., et al. (1991). Somatization: a spectrum of severity. *American Journal of Psychiatry, 148*(1), 34–40.

Kirmayer, L. J. (1984). Culture, affect and somatization. *Transcultural Psychiatric Research Review, 21*, 159–188.

Kirmayer, L. J. (1986). Somatization and the social construction of the illness experience. In S. McHugh, & T. M. Vallis (Eds.), *Illness behavior: A multidisciplinary model*. New York: Plenum.

Kirmayer, L. J. (1988). Mind and body as metaphors: hidden values in biomedicine. In M. Lock, & D. R. Gordon (Eds.), *Biomedicine examined*. Dordrecht: Kluwer Academic Publishers.

Kroenke, K., & Harris, L. (2001). Symptoms research: a fertile field. *Annals of Internal Medicine, 134*(Part 2), 801–802.

Kroenke, K., & Price, R. K. (1993). Symptoms in the community. Prevalence, classification, and psychiatric comorbidity. *Archives of Internal Medicine, 153*(21), 2474–2480.

Law, J., & Singleton, V. (2000). Performing technology's stories: on social constructivism, performance, and performativity. *Technology and Culture, 41*(4), 765–775.

McFarlane, A. C., et al. (2008). The conundrum of medically unexplained symptoms: questions to consider. *Psychosomatics, 49*(5), 369–377.

McGorm, K., et al. (2010). Patients repeatedly referred to secondary care with symptoms unexplained by organic disease: prevalence, characteristics and referral patterns. *Family Practice, 27*(5), 479–486.

Madden, S., & Sim, J. (2006). Creating meaning in fibromyalgia syndrome. *Social Science & Medicine, 63*(11), 2962–2973.

Marchant-Haycox, M., & Salmon, P. (1997). Patients' and doctors' strategies in consultations with unexplained symptoms: interactions of gynaecologists with women presenting menstrual problems. *Psychosomatics, 38*(5), 440–450.

Mayou, R., et al. (2005). Somatoform disorders: time for a new approach in DSM-V. *American Journal of Psychiatry, 162*(5), 847–855.

Mik-Meyer, N. (2010). An illness of one's own: power and the negotiation of identity among social workers, doctors and patients without a bio-medical diagnosis. *Journal of Power, 3*(2), 171–187.

Mol, A. (2002). *The body multiple*. Durham, NC: Duke University Press.

Mol, A. (2008). *The logic of care*. Abingdon and New York: Routledge.

Motzkau, J. F. (2007). *Cross-examining suggestibility: memory, childhood, expertise*. Unpublished doctoral thesis, Loughborough University.

Motzkau, J. F. (2009). Exploring the transdisciplinary trajectory of suggestibility. *Subjectivity, 27*, 172–194.

Motzkau, J. F. (2011). Around the day in eighty worlds: Deleuze, suggestibility and researching practice as process. In P. Stenner, J. Cromby, J. Motzkau, J. Yen, & Y. Haosheng (Eds.), *Theoretical psychology. Global transformations and challenges*. Concord: Captus University Publications.

Nettleton, S. (2006). "I just want permission to be ill": towards a sociology of medically unexplained symptoms. *Social Science & Medicine, 62*(5), 1167–1178.

Nettleton, S., et al. (2004). Enigmatic illness: narratives of patients who live with medically unexplained symptoms. *Social Theory & Health, 2*(1), 47–66.

Nettleton, S., et al. (2005). Understanding the narratives of people who live with medically unexplained illness. *Patient Education and Counseling, 56*(2), 205–210.

Peters, S., et al. (1998). Patients with medically unexplained symptoms: sources of patients' authority and implications for demands on medical care. *Social Science & Medicine, 46*(4–5), 559–565.

Pickering, A. (1994). After representation: science studies in the performative idiom. In *PSA: Proceedings of the biennial meeting of the Philosophy of Science Association, Vol. 2* (pp. 413–419).

Reid, S., et al. (2002). Frequent attenders with medically unexplained symptoms: service use and costs in secondary care. *British Journal of Psychiatry, 180*, 248–253.

Reid, S., et al. (2003). Frequent attenders in secondary care: a 3-year follow-up study of patients with medically unexplained symptoms. *Psychological Medicine, 33*(3), 519–524.

Rhodes, L. A., et al. (1999). The power of the visible: the meaning of diagnostic tests in chronic back pain. *Social Science & Medicine, 48*, 1189–1203.

Ring, A., et al. (2005). The somatising effects of the medical consultation: what patients and doctors say and do not say when patients present medically unexplained symptoms. *Social Science & Medicine, 61*(7), 1505–1515.

Salmon, P. (2007). Conflict, collusion or collaboration in consultations about medically unexplained symptoms: the need for a curriculum of medical explanation. *Patient Education and Counseling, 63*(7), 246–254.

Salmon, P., & May, C. (1995). Patients' influence on doctors' behaviour: a case study of patient strategies in somatization. *International Journal of Psychiatry in Medicine, 25*, 319–329.

Sedgwick, E. (2003). *Touching feeling: Affect, pedagogy, performativity*. Durham, NC: Duke University Press.

Sharpe, M., et al. (2006). Bodily symptoms: new approaches to classification. *Journal of Psychosomatic Research, 60*(4), 353–356.

Shaw, J., & Creed, F. (1991). The cost of somatisation. *Journal of Psychosomatic Research, 35*(2–3), 307–312.

Smith, G. R. (1994). The course of somatisation and its effects on utilisation of healthcare resources. *Psychosomatics, 35*(3), 263–267.

Smith, R. C., & Dwamena, F. C. (2007). Classification and diagnosis of patients with medically unexplained symptoms. *Journal of General Internal Medicine, 22*(5), 685–691.

Stone, J., et al. (2002). What should we say to patients with symptoms unexplained by disease? The "number needed to offend". *British Medical Journal, 325*, 1449–1450.

Timmermans, S., & Haas, S. (2008). Towards a sociology of disease. *Sociology of Health & Illness, 30*(5), 659–676.

Tucker, I. (2004). "Stories" of chronic fatigue syndrome: an exploratory discursive psychological analysis. *Qualitative Research in Psychology, 1*, 153–167.

Walker, E. A., et al. (1998). Understanding and caring for the distressed patient with multiple medically unexplained symptoms. *Journal of the American Board of Family Practice, 11*(5), 347–356.

Ware, N. C. (1992). Suffering and the social construction of illness: the delegitimation of illness experience in chronic fatigue syndrome. *Medical Anthropology Quarterly, 6*(4), 347–361.

von Weizsäcker, V. (1986 [1949]). Psychosomatische Medizin. In. *Gesammelte Schriften, Vol. 8*. Frankfurt: Suhrkamp Verlag.

Wessely, S. (2004). There is only one functional somatic syndrome. *British Journal of Psychiatry, 185*, 96.

Wessely, S., et al. (1999). Functional somatic syndromes: one or many? *Lancet, 35*, 936–939.

White, P. D. (2010). Chronic fatigue syndrome: is it one discrete syndrome or many? Implications for the "one vs. many" functional somatic syndromes debate. *Journal of Psychosomatic Research, 68*(5), 455–459.

Whitehead, A. N. (1985 [1929]). *Process and reality: An essay in cosmology*. New York: The Free Press.

Wileman, L., et al. (2002). Medically unexplained symptoms and the problem of power in the medical consultation. A qualitative study. *Family Practice, 19*(2), 178–182.

Wilson, E. (2004). *Psychosomatic. feminism and the neurological body*. Durham/London: Duke University Press.

Wilson, A., et al. (2001). What is chronic fatigue syndrome? Heterogeneity within an international multicentre study. *Australian and New Zealand Journal of Psychiatry, 35*, 520–527.

Wolfe, F. (2009). Fibromyalgia wars. *Journal of Rheumatology, 36*(4), 671–678.

Zavetoski, S., et al. (2004). Patient activism and the struggle for diagnosis: Gulf War illnesses and other medically unexplained physical symptoms in the US. *Social Science & Medicine, 58*(1), 161–175.