Med Health Care and Philos
DOI 10.1007/s11019-012-9436-2

SCIENTIFIC CONTRIBUTION

The medically unexplained revisited

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Abstract Medicine is facing wide-ranging challenges concerning the so-called *medically unexplained* disorders. The epidemiology is confusing, different medical specialties claim ownership of their unexplained territory and the unexplained conditions are themselves promoted through a highly complicated and sophisticated use of language. Confronting the outcome, i.e. numerous medical acronyms, we reflect upon principles of systematizing, contextual and social considerations and ways of thinking about these phenomena. Finally we address what we consider to be crucial dimensions concerning the landscape of unexplained "matters"; fatigued being, pain-full being and dys-ordered being, all expressive momentums of an aesthetic of resistance.

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Keywords Medically unexplained disorders · Somatoform disorder · Functional somatic syndromes · Overlapping pains · Multi-morbidity · Medicalization · Colonization of lifeworld · Aesthetics of resistance

Introduction

To clarify the topic of our investigation we have chosen the headline "the unexplained". We wish to explore an object whose content primarily is declared through its unexplainability.[1] This topic has to an increasing extent become an object of interest, wonderment and engagement to us as authors. We have encountered it in various professional contexts, but primarily with regard to the specialty of *family medicine*. Facing the large group of patients who have comprehensive and complex symptoms for which there is no explanation, the general practitioner (GP) faces a formidable challenge. Furthermore, we have encountered it in the context of *occupational and environmental medicine*, in which a separate segment of unexplained disorders has been established.[2] The term 'segment' should here be interpreted as indicating that this speciality, like other specialities, has developed a "niche" of unexplained disorders that this specialty defines and caters to. The fact that many of the unexplained disorders that give rise to absence due to illness are related to the working conditions of those afflicted represents a further challenge (Kroenke 2003). In addition, this unexplained factor unavoidably and

[1] What is important here is not the lack of *explanations,* but the absence of meaningful and adequate *understandings*.

[2] In the specialty of Occupational and Environmental Medicine one refers to labels such as: Multiple Chemical Sensitivity (MCS), Idiopathic Environmental Intolerance (IEI), Sick Building Syndrome (SBS), Electromagnetic Hypersensitive Persons (EHS).

Published online: 29 September 2012

decisively impinges on several basic topics in the academic field of *philosophy*. As a topic, the things that elude explanation represent an invitation to reflection.

Our point of departure is that the unexplained is an obviously medical subject matter. This is based on medical literature regarding "medically unexplained symptoms", "functional somatic syndromes" and "somatoform disorder", in which the phenomenon has been discussed in a medical framework of interpretation.[3] The numerous contributions to research in this area have in their form sought to develop medical terminology in this area, clarify diagnostic criteria, expand relevant methodologies for examination and compare different categories and classes of conditions. We claim that these analytical and systematic endeavours only to a limited extent have helped clarify the "case" which we are facing. On the basis of a problem-oriented interpretation we would even claim that many contributions have produced a progressive confusion among medical professionals and especially among the patient groups concerned. Our contribution will *not* consist in an attempt to provide a complete overview of this "topical area" in a medical sense. For this, the landscape is far too comprehensive, non-transparent and complex. Our objective, however, in a general, descriptive and reflexive-exploratory form, is first to focus on *medical language as an expression of a mindset* pertaining to this topic, that we may assume will define the premises for large groups of patients as well as for the future of the medical specialties. This pertains to how bio-medical epistemology maintains the character of inexplicability of the inexplicable disorders, but even more decisively how this language can contribute to an alienation of the nature of the disorder that can enhance as well as maintain its form of appearance. Moreover, we will briefly touch upon how such ways of thinking and concomitant forms of language do not play out in a vacuum, but unfold within a societal context. By way of conclusion, we indicate a starting point. By this we refer to the start of a progression where we are searching for a landscape of phenomena beyond—or inaccessible to—the medical specialties' interpretation of unexplained disorders.

Following some epidemiological considerations of the unexplained disorders we account for their "affiliation" with various medical specialties, before presenting their main diagnostic names in a tabular overview.

[3] A special issue of the Journal of Psychosomatic Research from 2010 (vol. 68, nr. 5) is entirely dedicated to this subject. Furthermore, the Journal of the Norwegian Medical Association (Tidsskrift for Den norske legeforening) in 2002 published a series of 17 articles on the topic "functional disorders". In 2010, the same journal published 11 articles about the "musculoskeletal disorders" that include a majority of the "functional disorders", usually in the form of chronic pain.

Mapping

Confused epidemiology

Unexplained medical conditions are very prevalent. However, the lack of a well-defined object of study indicates that the estimates of prevalence must be regarded as epidemiological guesswork. Characteristically enough for this field of study, there is only fragmented knowledge on how various unexplained symptoms, diagnoses and syndromes are distributed in the population. We could mention one of the most frequently occurring, namely chronic musculoskeletal pains, which are reported by one in every four persons in the Norwegian population (Ihlebæk et al. 2010), as well as one of the most controversial, namely chronic fatigue syndrome (CFS), with a reported prevalence ranging from 0.2 to 2.0 % (Wyller 2007). All calculations of prevalence of the latter diagnosis must be regarded as estimates, since the existing documentation is based on at least four official definitions, making CFS epidemiology "confusingly non-consistent" (Wyller 2007). Fatigue is not an independent diagnosis, but a symptom which is invariably accompanied by several unexplained afflictions, mainly chronic pain and chronic sleep disorders. However, both pain and sleep disorders are included in a number of other "functional disorders", and the entire field is characterized by a large degree of what researchers within various medical specialties refer to as "overlap", i.e. overlapping symptoms. This fact renders clear distinctions between the assumedly different disorders impossible—with the consequence that all estimates of prevalence remain highly imprecise. Overlap has been reported between some of the most widespread pain syndromes—facial or temporomandibular pain (OFS/TMD), generalized muscular pain or fibromyalgia (FMS) and irritable bowel syndrome (IBS)—and CFS in 67, 77 and 92 % of the patients, respectively, or in other words, from between two of three to nine of ten patients (Aaron et al. 2000).

Blended specialties

A number of medical specialties have established an ownership of the topic of unexplained disorders. Conditions that are categorized as "unexplained" contribute to a significant proportion of the sickness absence, and could thus be perceived as a matter for *occupational and environmental medicine*. This is a significant challenge to the GP, who needs to address the patient's unexplained symptoms as a matter for *family medicine*. In terms of the anxiety, depression and the bodily afflictions without any objective findings that are referred to as somatization, we are also facing a matter for *psychology/psychiatry*. With reference to diffuse conditions of discomfort in an organ

Table 1 The medically unexplained

Diagnosis/subject matter	Diagnostic content/matter at hand
Complex somatic symptom disorder (CSSD)	"To meet criteria for CSSD, criteria A, B, and C are necessary" A. Somatic symptoms. B. Excessive thoughts, feelings, and behaviours related to these somatic symptoms or associated health concerns… C. Chronicity…[a]
Central sensitivity syndromes (CSS)	"Central sensitivity syndromes (CSS) comprise an overlapping and similar group of syndromes without structural pathology and are bound by the common mechanism of central sensitization (CS) that involves hyperexcitement of the central neurons through various synaptic and neurotransmitter/neurochemical activities" (Yunus 2007:339)
Multi-symptomatic disorder	"With the recent research indicating that fibromyalgia, IBS, and TMD are multisymptomatic disorders characterized by dysfunctions in central pain processing, other terms in current use include 'central sensitivity' or 'central pain' syndrome, 'non-nociceptive pain', and 'chronic multisymptom illness' (Clauw 2009:4)
Subjective health complaints (SHC)	"'Subjective health complaints' are complaints without a known pathology or where the pathological findings are less than expected". "They are 'subjective' because they are based solely on self-reporting. The term is not meant to imply that the complaints are not real, or indicating a mental dysfunction …" (Tveito 2006:5)
Medically unexplained (physical) symptoms (MUPS/MUS)	Medically unexplained symptoms (MUPS): physical symptoms for which no clear or consistent organic pathology can be demonstrated (although organ dysfunction may be an integral part of the symptom) (Burton 2003:232)
Body distress (BD)	"are characterized by patterns of persistent physical complaints for which adequate examination does not reveal specific pathology. We prefer the term BD as it directs attention to psychobiologic processes that underlie the symptoms and that need to be recognized and self-managed by the patient" (Bakal et al. 2008:1)
Bodily distress disorder (BDD)	"The study suggests that *bodily distress disorder* as defined here may unite many of the functional somatic syndromes and some somatoform disorder diagnoses. Bodily distress may be triggered by stress rather than being distinct diseases of noncerebral pathology" (Fink et al. 2007:30)
Body dysmorphic disorder (BDD)	"…body dysmorphic disorder or dysmorphophobia—is an under-recognized yet relatively common and severe psychiatric disorder. Body dysmorphic disorder affects as many men as women (see footnotes 3, 4) and consists of a preoccupation with an imagined or slight defect in appearance that causes clinically significant distress or impairment in functioning" (Phillips and Castle 2001:1015)
Functional somatic syndrome (FSS)	"Functional somatic syndromes (FSS) refer to a category of illnesses characterized by particular constellations of medically unexplained symptoms. These conditions are found in most areas of medicine, are often chronic, and may appear similar to known medical diseases" (Looper and Kirmayer 2004:373)
Physical symptoms disorder (PSD)	"Key diagnostic criteria: (a) one or more physical symptoms currently present and causing impairment in social, occupational, or other important areas of functioning; (b) symptoms are not fully explainable by another medical or psychiatric disorder, with the exception of syndromes manifested solely by symptoms (e.g. irritable bowel syndrome, fibromyalgia, tension headache, chronic fatigue syndrome, temporomandibular disorder, interstitial cystitis, etc.); (c) duration of at least 6 months" (Kroenke 2006:337)
Idiopathic somatic complaints and syndromes (ISCS)	"Besides bringing some conceptual clarity to the field, invoking the 'idiopathic' label in this instance may fit current thinking in the psychosomatic field, such as the distinction of 'neuropathic', 'inflammatory', 'nociceptive', and 'idiopathic' pain". (Escobar and Oye 2007:841)
Psychosomatic disorder	"The word psychosomatic stresses the importance of both body and mind in illness. Psychosomatic medicine is a way of looking at sickness, a theory of disease, seeking to shed light on the appearance, the form, and the course of the illness". (Leigh 1968:753).
Somatoform disorders/somatization disorder(SD)	"Disorders in this category include those where the symptoms suggest a medical condition but where no medical condition can be found by a physician. In other words, a person with a somatoform disorder might experience significant pain without a medical or biological cause, or they may constantly experience minor aches and pains without any reason for these pains to exist"[b]

[a] Homepage of the American Psychiatric Association: www.dsm5.org. Proposed revision April 2012

[b] Diagnostic and Statistical Manual of Mental Disorder (DSM IV)

system or a body region, such as irritable bowel syndrome (IBS), chronic pelvic pain (CPP), urogenital pain (UGP/interstitial cystitis), oral, facial or temporomandibular pain (OFS/TMD), this becomes a matter for *internal medicine* or a *gastro-medical, gastro-surgical, gynaecological, urological, sexological or odontological* concern. The high prevalence of unspecific musculoskeletal afflictions also indicates that we are facing a *physical-medical, neurological or rheumatological* concern. The widespread transition to disability in such conditions to a great extent also makes them a concern for *social-welfare medicine*. Finally, in light of their (assumed) prevalence and their impact on public health in general, these problems must be regarded as a concern for *social medicine*. We believe that it is unnecessary for our argumentation to prolong this list of concerned specialties, and we refer to the even longer, but still incomplete list presented by Malt et al. (2002). In other words, we do not wish to contribute to the inflation of explanatory hypotheses within the same epistemology; we wish to raise some issues that pertain to the epistemology itself. Before doing so, we provide an overview of this uncharted landscape by presenting a number of its key concepts, with a concomitant and delimited definition.[4]

Problematizing

Dis-order or dys-order?

Our intention with the "table" above is not to pretend that we present an overview of a complex, yet transparent, field of problems. We do not even want to claim that the number of listed "diagnoses" represent a certain number of diagnoses. A brief glance at the definitions of these "conditions" makes it evident that they are so similar that if they had switched places in the "table" this would be likely to have gone undetected. We are fully aware that this list is not a table, i.e. an ordered system with an implicit, logical structure ruled by the alphabet, chronology, evidence, scope, prevalence, severity or another ordering notion used for tabular presentations. In other words, we have allowed ourselves to construct an illusion, a tool for perception that plays up the ability of the human senses to perceive patterns and to "supplement" the elements that are absent in order to create a meaningful whole or allow for ascription to categories. *We have created an image that appears to be an ordered system, but which is neither a system, nor represents an order*. Similar the surrealist painter René Magritte (1898–1967), who added the written information "ceci n'est pas une pipe" to a painting of a pipe—thus calling attention to a triple illusion, since neither the painting, nor the characters forming the word for the pipe, nor the word "pipe" is the pipe itself—we are saying that "this is not a table; it is only an illusion of a tabular order".

The apparently ordered system and the simultaneous and undeniable disorder emerge from the development of medical language. In this sense, the multiplicity of names listed in the table indicates a conceptual *saturation* in relation to the explained universe. One can sense that further additions are superfluous. However, there is little to indicate that the medical-scientific world believes that it has reached such a saturation point in its encounter with this topic. Medical-terminological entrepreneurship and zeal for innovation seek continuously and unremittingly to name a "something" or a "thing". The dynamics of this saturation process includes continuous proposals for general diagnoses, perceived as linguistic meta-categories. Through this approach, all previous and assumedly dysfunctional descriptions of diagnoses are subsumed under the new meta-category. The most recent example is found in the new DSM 5 and the label CSSD (complex somatic symptom disorder). The essential feature of our "table" is thus that it in no way gives us access to the "best possible evidence" or a complete overview of the total available knowledge regarding "unexplained disorders", but rather it illustrates in a basic and decisive manner what emerges as a non-exhaustive terminological diversity.[5] This diversity reflects not only a linguistic *development*, but equally strongly a linguistic *bewilderment*. Thereby, the ground is prepared for (a) possible revealing progress regarding the phenomenon of "unexplained disorders", as well as even more decisively (b) *possible concealing and obfuscating regress* regarding the interpretation of the same phenomena.

With regard to the meta-categories, however, these are no more explanatory, precise or specific than the names for the groups of the syndromes. Nevertheless, they are being promoted as such. As a whole, they convey a serious meta-message: scientific knowledge with regard to these conditions has not proceeded any further than that medical science continues to be concerned with naming "something" that the science still fails to understand. This occurs without any simultaneous questioning of the methods used to gain understanding. Some researchers argue that their own

[4] The current terminology presented is obtained by a non-systematic research in PubMed using key words such as unexplained, medically unexplained symptoms, somatoform disorders, functional somatic syndromes, central sensitivity syndromes, multisymptomatic disorders, psychosomatics.

[5] In a more extensive examination one should first give an account of the numerous and various interpretations concerning the different concepts that are presented (cf. Table 1). Next, a more thorough investigation should also include the full range of all (diagnostic) terms that could possibly belong to this landscape of unexplained health issues. Finally, it would be necessary to explore the distinctions concerning different grades of medically unexplained symptoms (MUS) such as (a) normal to mild, (b) moderate, and (c) severe.

acronyms are superior to those of others, since a larger number of the conditions can be subsumed under the name preferred by them. Fink and Schröder recently documented that as many as ten syndromes can be included without omission in a concept they themselves launched in 2007 under the name Bodily Distress Disorder (BDD). At the same time, however, they divided these conditions into a "serious multi-organ type" and a "moderate single-organ type", with the latter type further subdivided into four sub-types: cardiopulmonary (CP), gastrointestinal (GI), musculoskeletal (MS) and general symptoms (GS). In these authors' opinion, this Bodily Distress Syndrome represents a better understanding, and simultaneously a transcendence, of the prevailing dualist approach (2010). However, each of the presently used acronyms still refers to a poorly delimited problem, and remains difficult to apply in a consistent manner for clinical practitioners in the health services. The researchers in this field keep discussing whether these disorders should best be understood as "several" or as a "single" functional condition, whether they should be studied as a whole and under a single concept, known as "lumping", or in increasing detail, known as "splitting" (White 2010; Moss-Morris and Spence 2006). In addition, a third group of researchers wish to approach these disorders in an even more "basic" manner, by only counting the symptoms and relinquishing diagnoses, since the number itself has proven to have predictive force in terms of health. In other words: this terrain can be called "contentious" and epistemologically "unfounded". What is most worrisome is that each of the acronyms refers to loss of function and health on a large scale. They describe cost-intensive categories in the social-welfare sectors in contemporary health services in most Western countries, including *those on long-term sickness leave, the new groups of disabled, the large consumers of health and care services and those who stand to lose their position in the labour market*. It is clear that medical science displays a considerable diligence with regard to conceptualizing, naming, ordering, categorizing, registering and classifying phenomena that occur frequently in the health sciences. Despite the fact that these efforts remain medically, scientifically and politically legitimate, it remains equally obvious that this activity does not steer the sciences towards a deeper insight or better knowledge concerning these phenomena. On the contrary, this field is characterized by the paradoxical nature of being hectically immersed, and at the same time rather helpless in the face of such phenomena. This could also be a hazardous helplessness, since the phenomena that medical science here addresses must be designated as what Ian Hacking refers to as "human kinds", and as such they are interactive and communicate with our method of interpretation. Some medical diagnoses will therefore have a potential to form and perpetuate the disorder they seek to remedy.

Text in context

Here it is essential to raise the issue of whether the diligence described and displayed by the medical sciences in the face of "unexplained", "complex" or "diffuse" disorders provides an example of the phenomenon of *medicalization*. Medicalization refers to an approach by which health problems that have a social, existential or emotional origin are named (diagnosed) and addressed (treated) as though they were of a medical nature. This approach is particularly evident in parts of modern psychiatry, where social and general human problems are translated and redefined as individual diseases and treated with psychotropic drugs. In 1983 Irving Zola was one of the first to use the concept of medicalization by defining it as "a process whereby more and more of everyday life comes under medical influence and supervision". In several well-known publications the British psychiatrist Joanna Moncrieff (2010) has criticized what she refers to as "psychiatric imperialism" and more generally "the medicalization of modern living". She is concerned with how humans are characterized by a wide range of emotions in response to changing circumstances and particular types of stress, often in the form of a complex psychosomatic reactions (stress that manifests itself bodily as stiffness in the joints, grief and sadness that drain the sufferer of energy and vitality, leading to increased receptivity to a multitude of diseases). Moncrieff warns against the tendency observed during recent decades that despair and other "non-productive emotions" have increasingly become less socially acceptable. She sees a number of indications that the medical paradigm, with its power of definition in relation to laypeople and patients, as well as in relation to political authorities, serves to weaken the legitimacy of "negative" emotions and states such as grief and despair. In turn, this serves to deflect attention—medical-scientific as well as political-social—from political and environmental factors that make modern life difficult and painful. This gives rise to an accelerating "therapeutic culture" (Madsen 2010) in which the individual, who may experience a situation characterized by disease, divorce or unemployment is told, and gradually becomes convinced, that these problems are self-inflicted and that he or she is responsible for this situation as well as for overcoming it, that is, to regain a manifest ability to cope and re-establish his or her autonomy. By force of their profession, social authority and scientific legitimacy, doctors play a significant role in portraying ordinary social circumstances and life situations as individual diseases with a somatic or psychological prefix.

We do not claim that the attempts made by medical science to gain a handle—in conceptual as well as therapeutic terms—on the so-called "unexplained" disorders follow exactly the course described by Zola and Moncrieff

with the term "medicalization". Nevertheless, certain common features are evident. In general, this includes an approach to the patient which in effect locates whatever will be subjected to treatment, alleviation or removal within the patient. Focus is placed on whoever or whatever in which the symptoms can be located, for example in a particular joint, in an organ or in the brain. In modern medicine there is a tendency, especially in the concentration on the "hard determinants" of a neurological or chemical character, to study and treat the brain and the body as the locus within which the intervention must take place, at the cost of paying attention to the interplay between the individual and his or her environment. The symptoms "within" the individual are not regarded as responses to influences from the society or the culture of which the individual is part, and from which he or she is exposed to expectations, demands or stresses that have a causal importance for the disorder in question. Even though here we are discussing disorders of a multifactorial nature, having a striking and elusive complexity as their most prominent characteristic (or rather anti-characteristic), the tendency to assume a narrow perspective in the form of a focus centred on the individual, although with a varying locus in the body or in the brain, remains the same.

As mentioned above, a repeated reading of the above table leaves one with a distinct impression that the medical mindset "butts against" an occurrence which in its vulnerability, frailty, unpredictability and redeeming complex nature escapes medical-scientific reason. We may here presume that well-known contributions from various thinkers on the rationality of the system world and its restricted area of application have relevance for this topic. The German philosopher Jürgen Habermas represents a natural place to start. Inspired by Max Weber, he has launched the two-part model of the *system world*, the market and the bureaucracy, and the *life world* characterized by everyday communicative interaction. Of particular interest in this context is Habermas' thesis of *colonization*, perceived as a process by which the purposive and instrumental rationality of the system world encroaches on the domain of the life world. Transferred to our contemporary times, we can regard the unstoppable advance into the health services as a possible expression of a realization of this thesis. Figuratively speaking, and as an instrumental and metaphoric starting point, we can use Habermas' basic concepts to understand the massive scientific advance into the unexplained as carrying certain colonization features. Features, that to a very great extent serve to characterize notions about the unexplained, on the part of medical science as well as on the part of the individuals concerned. It is exactly the medical mindset, here perceived as the carrier of a certain type of rationality based on the natural sciences, that we can perceive as threatening with regard to the possibly remaining remnants of a *normal, human interpretation of this type of conditions, disorders and afflictions.*

Phenomenon escaping

We should then raise the following question: Have this medical way of thinking and scientific rationality in reality established "authority" over the topic that we here perceive as unexplained conditions? We can ascertain that this has not happened. *The resistance emerges from the phenomenon itself*. The colonization thesis should nevertheless be understood in a wider perspective, in the sense that the language and mindset of the medical professionals and patients to a very large extent are being influenced by this manner of interpreting health and disease. According to Habermas, it is exactly the language itself, as a medium, that constitutes the decisive and integrating force in the life world. Language caters to functions such as mutual understanding, coordination of actions and socialization, and thereby the formation of personal identities (Eriksen 1999:121; Habermas 1987). Thereby, the three structural components of the life world are culture, society and personality. We can thus imagine that the logic of the system world, here represented by the research institutions that embody medical-scientific reason, leaves an imprint on these different structural components.[6] Accordingly, we may claim that in the worst case, a deficient insight into the limitations of the medical way of thinking will contribute to an impoverishment of the resources of the life world. In turn, this means that through colonization and objectification, the life world is gradually drained of its content.

This impoverishment means that a patient who sees a doctor for his or her afflictions, without understanding what they may "indicate" or from where they may stem, does not have a feeling of being helped by the doctor's approach on the basis of allegiance to the paradigm. The fact that the doctor is doing what the doctor is trained to do, what is being experienced, lived as suffering, with its characteristic and irreducible subjectivity (my pain, not yours; my history of and sensitivity to pain, not yours; my life-world-based horizon for finding/not finding any meaning in what is experienced and suffered, not your horizon) is being translated into whatever can be scanned, x-rayed and measured: the objectifiable and visible. This "translation" to whatever is suitable qua "medical data" is a translation and a measure of a dual character: that of the medical profession in relation to the individual practitioner, and that of the individual practitioner

[6] An exploration of Habermas' colonialization theses is, inter alia, found in Fredriksen (2003). He states that "Medical technologies colonise our lifeworld. They change the way we think and act. They make us all accept that we can become patients almost any minute, even if we feel perfectly healthy. Sense transcending technologies turn us all into proto-patients" (p. 287).

in relation to the patient in question. The result is alienation and loss of meaning, coherence, horizon and direction; isolation of parts (joints, organs), dis-juncture and abstraction from the co-herent and inter-active to which the parts studied/focused on belong and by which they are co-constituted, and only exist by virtue of being part-of and part-icipant.

When addressing the fact that "doctors do what they are trained to do", we are here referring to the medical professional as socialized into and representing the biomedical *system*, i.e. as deeply informed by and dependent on the mutually constitutive, multilayered medical systems of scientific research and knowledge production (evidence hierarchies), education and training, classification, technology, bureaucracy and health politics which imply various institutional constraints within every health-care system. However, this does not imply that every clinical practitioner represents a thoughtless human system module. We are simply describing a medical professional operating inside a system with very powerful constraints, while we are fully aware that many professionals try to—and are capable of—transcending such restrictive system-imperatives in their clinical encounters with diseased people (Peters et al. 2008). That is to say that they are responsive to the long-lasting efforts to humanize this branch through initiatives such as patient-centred and, recently, person-centred medicine (Miles and Mezzin 2011).

However, this recognition of practical reason among thoughtful practitioners does not reverse the fundamental challenge: the medical system(s) enforces strong limitations on medical practice and on the doctor-patient relationship (Kirkengen et al. 2012, in print). We find support for our statement in a thesis entitled "Morally bound medical work, an empirical study exploring moral conditions of doctor's everyday practice" by physician and philosopher Kari Milch Agledahl (2010). Although, based on data from two qualitative studies, she admits that some moral infringements may be unavoidable in medical work, she shares with us some provocative conclusions related to such *bounded* medical practice:

> The doctors focused exclusively on medical issues in the encounters, even if their patient's worries could be related to more personal parts of the patient's life, such as fear of losing one's job. Patients' personal worries were systematically ignored by the doctors. In order to help their patients by the use of their biomedical knowledge of anatomy and bodily processes, the doctors often handled their patients as objects (p. 7).

Pointing out these systematic constraints and using appurtenant labels such as colonization and objectification, we may evoke accusations of unilaterally assigning the medical system sole responsibility. For this reason we must ask: how should we place the "symptom-interpreters" in this picture, the persons searching for symptom-clarity? What about the factual patients' incessant demands on their doctors for a diagnosis—and not just any but preferably a "somatic" diagnosis? What about the patient organizations and their lobbying? What about different media serving daily major headlines about the latest dangers and risks concerning the challenging task of being a human being? We suggest that all these parties, in their own way, *participate* in—and *amplify*—a medicalized discourse that creates a disturbing and disproportional focus on disease issues.[7] *However, we consider neither the patients nor their organizations as engendering the premises for such a discourse*. These are designed and provided by the medical (research) community and administered by the medical professionals. Given such premises, patients, their interest organizations and the media participate in a reproduction and reinforcement of the bio-medical paradigm. Consequently, they are not co-colonization partners but actors *responding to,* yet in a certain sense *drawing profits from* these colonizing efforts. We do not intend to address all the activities inside the medical professional community, but we maintain that *our critique especially targets how this community has chosen to deal with the challenge we call the medically unexplained*.

Thus we are possibly facing socially embedded mechanisms which share *some* features of those processes we name medicalization and colonization. In addition, we are facing a terminological diversity that is included in an apparently ordered system of complicated and sophisticated medical symbolic language, which nevertheless is insufficient for gaining a real or effective "grasp" of this topic. On the contrary, the continuous conceptual expansions or amendments may contribute to science gradually losing its grip on and notion about the phenomenon it is facing. Not least because of the influence from modern Anglo-Saxon analytical philosophy, it has become a common notion, including within medicine, that *the relationship between the concept and the phenomenon is such that the concept constitutes the phenomenon*. All phenomena, qua something we can speak of and relate to in a cognitive and communicative manner,

[7] Thus, we suggest that persons and patients participate in a medicalized discourse. These individuals also put further pressure on the medical professional precisely on the basis of such a discourse. Consequently, the doctor faces a major challenge (major or minor depending on his experience and knowledge) in trying to support the patient in a necessary process of reconceptualization (or reattribution). It is however not only the patient who opposes such creative efforts. The authorities and the health bureaucracy are uncompromising in terms of approving diagnoses and evidence-based treatments. Nevertheless, such processing does not deviate from our main message: although the patient holds a prominent role in the clinical encounter, we call attention to *one* of the assumed primary sources of the patients conceptual bewilderment—the incessant supply of new diagnostic classifications in the medical field of unexplained conditions.

are verbalized: they both allow for and are "always already" comprised by—covered by or with—a linguistic denomination, a denomination "as something" opposed to everything else, all within a complex language system which in turn is a collective social construct, (re)produced and communicated as "institutions". If we have no word for it, it does not exist. The epistemic constitutes, awards a certificate of reality for, whatever has—or is ascribed, given—the character of reality, in short, the ontological is secondary to, is a product of and only conditional to the epistemic-linguistic, interpreted as an continuous collective practice. Are we here facing something entirely different? Does this concern experienced disorders without a denomination, or phenomena without a concept? The phenomenon has a head start, the concept strives to catch up; we are stumbling in the dark.

In a phenomenological sense, the numerous contributions to medical explanation and analysis have only to a little extent helped clarify the "case" that we are facing here. The phenomenologically grounded maxim—"to the matter"—renders us as observers of the table above able to ask: *What "matter" is being described here?* In a medical perspective, this question is to be regarded as an oddity, since many contributions to the diagnostic overview of the unexplained must be seen as exactly "to the matter", because the nature of the matter is a "disease matter". The matter or the matters are preconceived as manifestations of pathology or deviance. In using this realist or naturalist perception of disease, the profession overlooks the fact that there are other possible investigative pathways that lead "back to the matters themselves". The established medical ways of thinking, the elaborate terminology and the sophisticated, quality-controlled methodologies are perceived as sufficient for the investigation and handling of the matter. Our intention here is not to underestimate the power or the legitimacy of this way of thinking, but just to point out that it falls short.

Reinstating

So what is medical science trying to hold at bay by using linguistic artefacts? The answer is as inscrutably complex as it is apparently simple: the frail, vulnerable, unpredictable and irrational entity of the *human being*. The particularly human and human-like are hardly traceable in the sophisticated language and the painstaking exertions to find definitions of the unexplained. The various medical specialties' grasp of "the matter" each in their own fashion adheres to fragments in the form of specific organ systems or delimited mechanisms of the central nervous system in such a manner that the possible phenomenon of the exploration remains "untopicalized". In this context, it seems natural to bring in the well-known allegory of the blind men and the elephant. This story exists in a number of different versions, but is basically about how each of the blind men were introduced to various parts of the elephant and subsequently asked to describe the character of the animal. The interpretations and the concomitant answers differed widely (foot = a tree, trunk = a snake, etc.). We can choose to regard the numerous suggestions for explanatory models, hypotheses and conceptual constructions of the medically unexplained in a similar vein. The gastro-medical specialist "sees" the unexplained irritable bowel. The physical-medical specialist has an eye for the inexplicably painful lumbar region. The psychiatrist "sees" an unexplained mental disorder. In a benevolent perspective, we may imagine that the numerous fragments all form part of a scientifically ordered mosaic, which through continued painstaking research and modelling finally may turn into the "true and complete picture" of the phenomenon.

This recognition of the weaknesses of specialist knowledge is neither very conspicuous, nor of a very recent origin. Even prominent representatives of pioneering natural science have previously reached similar insights. As early as 1954, Erwin Schrödinger (2010) ascertained the following: "It seems plain and self-evident, yet it needs to be said: the isolated knowledge obtained by a group of specialists in a narrow field has in itself no value whatsoever, but only in its synthesis with all the rest of knowledge and only inasmuch as it really contributes in this synthesis something toward answering the demand 'Who are we?'" (p. 109). Schrödinger reminds us how this ability to have an eye for unity can be traced back to the philosophers of Antiquity in particular. They were able to develop specialized knowledge on dimensions and perspectives of the world, without losing sight of the totality of which this specialized knowledge was a part. In the same manner we are being challenged, by way of "non-determining" or "de-determining" strategies, to engage with the pre-specialized landscape to which the unexplained disorders belong. We will therefore briefly attempt to describe three different aspects that each impinge on an incipient exploration of phenomena beyond specialized medical knowledge. The first relates to the *phenomenon of fatigue*, which in the field of "medically unexplained disorders" is classified as the symptom of fatigue. The second relates to the *phenomenon of pain or "aches"*, which in the same field has been subdivided into various domains of pain belonging to the objectified body: "lower-back pain", "stomach pain", "upper-neck pain", "shoulder pain", "myofascial pain" and other similar ailments. The third aspect is related to the preceding one, and relates to the *phenomenon of embodied experience*. This concerns in particular how medically inexplicable symptoms can be interpreted in a biographic context beyond the modern bio-psycho-social,

i.e. multifactorial reality.[8] We allow ourselves to read these phenomena as *resistance*, and present them as aspects of an *aesthetic of resistance*.[9]

Aesthetics of resistance: fatigued being

Fatigue is a co-constituent of most of the described complexes of disorders. The term "fatigue" denotes a physical and/or mental exhaustion without any obvious cause, or in other words, an abnormal and permanent tiredness which is unaffected by rest. It is conspicuous and intriguing that *this fatigue in itself* or the *phenomenon of fatigue* fall outside the scientific field of study. First, this is because medical science restricts its investigations to the isolated symptom referred to as fatigue and to the manner in which this symptom may occupy a position in a diagnostic picture. Second, because the attention of medical science is fundamentally directed towards final conditions, i.e. to serious manifestations of fatigue that could nearly qualify for being labelled as disease [such as Chronic Fatigue Syndrome (CFS)]. Finally, the phenomenon of fatigue escapes the medical-scientific repertory of tools, for reasons that were fairly precisely formulated in a report from The Norwegian Knowledge Centre for the Health Services (Wyller et al. 2006): "The biological basis for fatigue, tiredness and exhaustion/loss of energy has only to a limited extent been identified. Nor are there any objective methods for measurement" (p. 9). Implicitly the subjective nature of the phenomenon renders it evasive for objectifying scientific investigation and unassailable in clinical medical practice. The Swedish historian of ideas Karin Johannison (2010) reminds us that descriptions of the tired and exhausted human being during the transition from the 19th to 20th century are characterized by the same symptomatic features as present-day case histories. A patient history from the practice of the French doctor A. Mathieu in 1894 may here provide an illustration:

> Young businessman, suffering from insomnia and agoraphobia, has for months been unable to undertake any intellectual work: "We work from 8 in the morning until 8 at night, and we have only a quarter of an hour for breakfast. In the evenings after work, several of us young men meet in a café, where we eat and drink happily until two or three in the morning. I never get enough sleep… Since I travel on business, I travel during the night to make better use of the daytime." (ibid. p. 210).

[8] In connection with the presentation of different acronyms (Table 1), we clarified that we have no intention of introducing or reviewing the full range of contributions from medicine, psychiatry or psychology. Correspondingly, and related to the subsequent introduction of an alternative perspective (the aesthetics of resistance), we have no intention of introducing or reviewing the extensive amount of contributions from non-medical disciplines. Nevertheless, we find it necessary to mention a few of those voices (in addition to those mentioned in the reference list) that have attempted to challenge the dominant bio-medical approach to these conditions and that represent fragments of the disciplinary background underlying our approach; *Sociology*; Greco (1998), Nettleton (2005). *Anthropology*; Martínez-Hernàez (2000), Cameron Hay (2008).

[9] The expression "aesthetics of resistance", involving such phenomena as fatigued-Being, pain-ful-Being and dysordered-Being, resides within human *experience*. The living body, Leib, constitutes the worldly arena wherein such experiential "events" are taking place and wherein *meaning* holds a crucial position. (Meaning should therefore not be seen primarily as a by-product of mental processes, (as in many interpretations of Descartes), but more fundamental as something arising from our embodied being-in-the-world). Throughout these meaning-ful events, human beings find themselves in the midst of an *aesthetic* realm. Every meaning-creating, meaning-receiving or meaning-relating involves qualitative and sensuous richness that belongs to aesthetics. (See e.g. Johnsons 2007). The experience of being fatigued, being painful, being disordered could be said to be accompanied with an (the) experience of resistance. Accordingly, within human experience, the experience of *resistance is.* How it is, or shows itself, is by no means self-evident. From the outset of Irving Zola's medicalization concept, Jürgen Habermas' colonization hypothesis and Foucauldian power analysis we can assume a kind of embodied reactive-ness, as "standing up against", "fighting back" or being "in opposition to" external and hostile forces. Furthermore, and from a *psychological* angle, the Swedish stress scientist Lennart Hallsten has launched the concept performance-based self-esteem (your value depends on your performance) and reminds us of the burned-out and fatigued body which rails/rampages against (in)human constraints. Even in the branch of *occupational medicine* one has found that a challenge like sickness absence could be seen as the concrete manifestation of resistance (Lipsedge and Calnan 2010). Although we both appreciate and acknowledge the importance of those perspectives mentioned, we will especially emphasize a dimension or an aspect of resistance which could be seen as the "aesthetic moment"—within experience. This approach is, among other sources, grounded in *philosophical hermeneutics*. We consider every genuine experience to represent some kind of "rupture". Through Leib, and inextricably connected to meaning, such a "rupture" always involves friction or resistance. In resonance with Gadamer's thoughts (2004. Truth and method. Continuum Publishing Group) experiences therefore could be seen as series of disappointments, i.e. every experiencing process is essentially negative. However, one should not misinterpret this negativity. "That experience refers chiefly to painful and disagreeable experiences does not mean that we are being especially pessimistic, but can be seen directly from its nature. Only through negative instances do we acquire new experiences, as Bacon perceived. Every experience worthy of the name thwarts an expectation. Thus the historical nature of man essentially implies a fundamental negativity that emerges in the relation between experience and insight (p.350)". Through this interpretation, one leaves behind a one-dimensional and common understanding of resistance, i.e. we must also acknowledge the pain-ful-Being and the fatigued-Being as being life-affirming resistance. What these events essentially offer are new experiences. The Gadamerian reader, Monica Vilhauer, adds the following; "Though our experience of negativity involves a kind of pain, and is something we undergo and suffer, it is the kind of growing pain proper to development, and from it we emerge with new insight" (p.64) (Vilhauer 2010).

This industrious person, assaulted by technology's merciless encroachment into everyday life, characterized by social upheaval and driven forward in a stressful daily existence, is not noticeably different from the people of our contemporary era, who in this country in earnest jumped on this carousel during the yuppie period of the 1980s and have subsequently continued to scramble further into what we conceive of as more advanced, morbid conditions of fatigue. This high-strung human being forgets or ignores the uncomfortable reality that history *is*, and possibly even more fatefully, the human being itself *is* a historic and final being (Gadamer 2004). Modern man's relationship to exhaustion, fatigue and tiredness unfolds in a language and in a context where tradition is unavoidably present. Therefore, we are and remain characterized by the last 100 years, a period when we have increasingly come to rely on medical science to save us from our tiredness. The imprints of this activity are found in the early diagnosis of *febricula*[10] (approx. 1750), later followed by *neurasthenia*[11] (Beard 1869) and *psychasthenia*[12] (Janet 1903), and in recent years followed up by the diagnoses *myalgic encephalopathy* (*ME*), *chronic fatigue* (*CF*), *burn-out, chronic fatigue syndrome* (*CFS*) and quite recently by *chronic fatigue syndrome/myalgic encephalitis*(*CFS/ME*).

These diagnostic labels bear witness to a search process whereby one to an increasing extent has come to rely on scientific rationality to relieve medical science of its burden of exhaustion and fatigue. This has not made the job easier, on the contrary, the side effect, an increasing alienation to the language of fatigue, has necessitated a constantly increasing research effort to exterminate the dysfunctional fatigue. With reference to this scientific confusion regarding the extermination of the inexterminable, Johannison remarks: "Together with the idea of degeneration, fatigue plays the role of the permanently present avenging goddess of progress" (ibid). Fatigue is therefore on a merciless collision course with our own expectations of human performance, as well as those of our ancestors. Thus, it becomes a synonym for poor health, morbidity and failure to perform. In this manner history has prepared the ground for obliviousness, not only with regard to history itself and the fact that we are historic beings, but also for how along this course we to an increasing extent have helped conceal the fact that fatigue—in its essence—is a fundamental phenomenon of human existence. It is inexterminable, as shown by history. It is inscrutable, even though the supply of explanatory models is comprehensive. This restricts access to it for scientific splitting and fragmentation. It can also be perceived as very uncomfortable when it restricts our normal and daily functions.

This interpretation of the peculiar character of fatigue is unsuitable for dissection and ought to be shielded from analytical endeavours. Fatigue passes. It has been granted a place in a life context. It interacts with life's events and practices. In this manner, we can regard this description as a defence speech from the depths of our humanity. This implies locating fatigue, by necessity, in human nature. The question remains whether modern humans have lost sight of this approach to fatigue. If so, in its most alienated form, fatigue is removed from the domestic sphere and into a technically instrumental world of muscular and cognitive overload with fatigue as a result. The increasing degree of precision and subdivision could thereby lead us to lose the identification, and the contact, with fatigue. It will no longer be understandable. However, this will not stop the body, or the body-mind, from protesting. Irrespective of the analytical endeavours or the strategic efforts of the body-host to ensure a supply of energy to the body (exercise!), the human aspect is "done away with". That is, the body's rejection, its protest, is of such a fundamental character that it cannot be brought under control with the aid of accustomed strategies. It is beyond the reach of discipline. Its protest must be sustained. At another level, a situation occurs where the language of medicine must be adopted by the individual in order to give legitimacy and recognition to the disorder. In a cultural situation where presentation of the self has become a key element of the construction of identity, the medical acronyms may constitute an existential last resort. This breakdown of identity has a dual function: the individual may legitimize its shortcomings in a "medically" acceptable manner, although on the "condition" that part of itself is accepted as defective. Hence, medical science may provide an ideological function: to conceal the social, cultural and existential basis of the disorders.

Aesthetics of resistance: pain-full being

How can we then from another and "human-based" perspective understand unexplained or undetermined pain? How should we understand "aches"? The ache in "it hurts" can be perceived as *resistance*: the head, neck or back where the ache sits is in my body and part of me, but what is occurring there—the ache—is not a product of my conscience, not a product of my intentionality and will. The ache "turns up", sometimes abruptly and violently, at other times imperceptibly and over time, perhaps even so gradually and successively that I fail to consciously note when the ache "started", when it first occurred. Over time, the ache, even the one that started abruptly and was acutely

[10] Light intermittent fever of unknown cause.

[11] Pathological condition with fatigue as the core symptom.

[12] "Psychasthenia is more distinctly a mental disease than neurasthenia, since its main symptoms are morbid fears, imperative ideas, doubting mania and morbid impulses" (p. 53) in Myerson 1976/1925.

painful when it came, can be incorporated into me and lived by me as a part of me of which I am not (or no longer) aware; it has become part of me, of existence such as it appears quasi-naturally; it just "is", inseparable from my life world. An ache is qua resistance a discomfort, non-chosen, something we need to relate to; one of several modes in this respect is no longer to be noticed, not paid attention to. One does not perceive oneself in contrast to, or in comparison to, a pre-ache and a non-painful being-in-the-world; the latter has assumed the character of being-with-pain-in-the-world (Vetlesen 2010). "I don't know when it first came, can't remember; it has been there for as long as I can recall." The body compensates without having been instructed by an act of consciousness to do so; I never lift anything heavy with my right arm, I always use the left, without even noticing.

The body has its own dynamics, it works autonomously, just like the sensory organs which can never forget the smell of granddad when he…; what occurred was inconceivable, unspeakable, but the senses have stored it, and still remain, 33 years after the occurrence, immediately on the alert when the same smell is noticeable in the room. Consciousness—I know what I am doing, I decide my directedness to elements of the world—is not my primary frontline in my orientation towards and my registration of reality, the senses are; they precede my conscious activity perceived as thinking, intention and will. What happens when the primary frontline, in its bodily-based sensuality, with differences/distances in time and space (linear causality) being suspended (such as in Freud's primary processes), is separated from consciousness? To have been inflicted with an ache in the form of abuse, a violation of the integrity of the body as well as of the psychological-moral integrity of the person concerned, could lead to self-alienation in the form of such a separation. Externally (socially) as well as internally (within me), this can be (mis)interpreted as coping, adaptation, that one "has gotten over it", since one does not keep thinking of it, suffers under it in that sense. No, but whatever happened, the ache that was inflicted has been inscribed in the memory of the body like so many subtle imprints, non-conscious memories which in turn create an alertness—of the bodily senses—to the same, i.e. to everything reminiscent, which—yes, exactly—brings back the memory.

Then one could say that abuse is one thing; "strains" are something completely different, just like "burn-out". In this case, it is not a single event (which can be repeated, to be sure, twice perhaps, or a thousand times that leave a mark in the bodily senses), but strains over time, often with a "diffuse" cause, not identifiable in time and space or to a specific other person or single situation. When whatever (whoever) caused the strain is not a (simply identifiable) external factor in the form of an object, a situation or another person, but *oneself*, the pain takes a different course. Internalized external demands for desired behaviour, performance, appearance, body, etc., appear to me, within me, as the demands that I set for myself. Their origin is not (any longer) external: I am two-in-one, the person inflicting the pain as well as the person feeling the pain, because the very life experience is painful. The body's natural proclivity to compensate acts in conjunction with the proclivity that consciousness has for rejection, depreciation, displacement, etc., (Freud again) in disintegrating the ache's potential for resistance as a consequence. *The fact* that something hurts is the ache's *no*, its sting, its protest against its cause, its sender, its origin. This "no" must be lived openly, articulated, not concealed in an individualized manner, because that would drain it of power, and turn it into the powerlessness of the sufferer, where the societal senders of the ache go free, remain unsituated and unaddressed, and the more so, the more structural (another round of New Public Management at the workplace) the nature of the origin, as opposed to personal (granddad).

How can we prevent the ache, interpreted as a protest with its concomitant sting, from being rendered invisible in the eyes of society, and remain silently suffered by yet another social-welfare client on long-term sickness leave? Can medical science play a role? Or the individual doctor (Kirkengen 2008)? We assert the following: The table shows, or represents, a medical-scientific attempt to *conceptualize a resistance* that cannot be articulated, which is "taboo" and in this very conceptualization is rendered unrecognizable, alien. What is alien is exacerbated in its alienation, because all names, all acronyms, represent an attempt to conceptualize the sufferer's unarticulated and unspeakable "this is resistance", "I am resistance". Such conceptualizations of unidentified and uncomprehended resistance must necessarily fail. *The* "no" is *not* redeemed. In the tabular format we also find that what really is resistance is conceptualized as an object, as a thing, and thereby relegated to alienation. What is alien—which is perceived and experienced as alien—is being alienated even further.

Aesthetics of resistance: dys-ordered being

The unredeemed "no" of fatigue and pain is incorporated into an even larger "no", namely the one which is expressed in complex pictures or patterns of diseases or organ failures, or other disorders. Such complex pictures, called multi- or co-morbidity, are an increasing concern for bio-medical clinical practitioners, since they are an increasingly prominent characteristic of the state of public health in Western countries. The terminology reflects the basic assumption that morbidity consists of a simultaneity of otherwise unambiguously defined, separate diseases of the body or the mind, often in combination with more

ambiguous forms of failure and health problems—within the same patient. This notion is based on a theoretical foundation inherited from the Age of Enlightenment. However, with regard to the complex, chronic and widespread diseases of our time (such as cardiovascular diseases, mental disorders, pain syndromes and cancer) the theory reveals its inadequacy. This is expressed in a lack of concordance between deed (clinical practice) and word (bio-medical theory) with regard to an increasing number of people who in a medical sense suffer from several diseases and disorders in addition to their chronic initial disease.

The subjective world of human life and experience has no given place in a naturalist bio-medical perspective, where objectivization and standardization are key concepts. The effects of psychological, relational and socio-cultural aspects on human health and morbidity have therefore remained systematically marginalized in the knowledge production of this science. Consequently, researchers as well as clinicians run the risk of helping to disregard, conceal or reject significant sources of disease (Kirkengen 2010). During the last decade, however, empirical documentation has shown that human *experience*—interpreted as everything that an individual is exposed to, acquires and processes by way of the senses, emotions and actions during the course of life—has a strong biological relevance for developing disease as well as for regaining health. However, "experience" is invariably an experience of *something*, for *someone*, in a unique *context*. Experience cannot be separated from the subject, and nobody can by definition have an experience on behalf of someone else. This knowledge indicates that the subject is the key source of knowledge, and that a systematic avoidance of subjective aspects in research on human disease renders the results of this research invalid with regard to treatment of people who are ill.

Interdisciplinary studies are currently helping provide answers to questions that we are accustomed to perceive as being "humanist" in nature—for example how care or neglect, trust or betrayal, inclusion or exclusion, power or powerlessness, justice or injustice can be linked to health or disease. Today multidisciplinary research confirms that strong and/or enduring threats to the integrity of an individual—regardless of the aspects concerned—are highly taxing, and over time lead to an exhaustion of the body's flexibility which is ensured through a physiological "defence" that preserves its integrity. This consists of a complex interplay of non-linear processes between a person's nervous, immune and hormonal systems, meaning that small changes at one level may give rise to major consequences at another level, and this systemic effect encompasses all levels of human existence, from the genetic to the metaphysical. Enduring overload manifests itself objectively in an increased risk of infections, systemic inflammations, hormonal disturbances and accelerated aging of cells. These phenomena are the origin of co- and multi-morbidity, and accordingly an entrance to a deeper understanding of the sufferers' disorders and the true nature of these disorders. This knowledge indicates that with regard to the causes of disease, the traditional and categorical distinction between objective facts—such as genes, nutrition and microbes—and subjective phenomena—such as experiences, relationships and respect—is untenable. This recognition implies that certain basic distinctions that are preconditions for the division of the health services into somatic and psychiatric medicine must be suspended. In addition, it implies that whatever remains medically "unexplained" may turn out to be explicable in the eyes of someone who is not blinded by theoretically based, but erroneous maxims concerning human nature. In such an explanatory framework the complex and chronic may prove to be a "chronic", but equally powerless, "no" to acceptance of an enduring, suppressed and socio-culturally conditioned experience of violation. Nor can this "no" be redeemed inside a knowledge horizon that has no place for a subject, which also must force itself to be silent and endure experiences that are perceived as intolerable.

Concluding remarks

Our point of departure for this article is in the increasing prevalence of medical conditions that appear to be "unexplained". However, there is no shortage of efforts on the side of medical research to find the correct concepts and diagnoses for the disorders in question, in spite of the vagueness and complexity of the symptoms. We even need to regard these efforts as legitimate and natural, given how the world and reality appear to the eyes of the medical specialists. In this disciplinary framework, the objectifying approach, the determining and delimiting attitude and the quest for causal explanations, are taken for granted. Nevertheless, our undertaking has been partly of a critical and partly of a constructive nature. With regard to "unexplained" disorders, the scientific rationality which forms the basis of modern medicine comes up against a *boundary*. Such disorders are immediately inspected through the spectacles of medical science: they are interpreted and explained as pathologies, and the genesis is located within the patient, who is thereby made responsible both for having fallen ill and for being healed. But what if this involves something completely different? Like the total human organism's response to overload or existential crises? Like a subjective total experience of the encounter with a demanding situation in life, in which grief, pain and paralysis, such as they manifest themselves in a

psychosomatic sense, should rather be perceived as healthy and adequate responses, and not as pathologies? Like the experience of a stressful existence, where the human being endures his or her symptoms of fatigue inside a machinery that constantly demands effectiveness? By using the insights of phenomenology into the irreducibility of subjective experience and of the situation of the subject in a life world we are taking tentative steps towards seeing the ache of the tired, overwhelmed, powerless and exhausted person as a sign of non-verbal, bodily situated resistance—as a "no" to a morbid pressure for adaptation and responsibility, whereby this "no" must be seen as an adequate response, a desperate boundary marker, instead of regarding this "no" as a pathology, causing medical science to lose sight of the extra-individual factors that create and maintain the disorders in question. In total, this concerns a restitution of what the hand of medical science has recast into something alien, but which irrefutably belongs in the human life world. We suggest that the experiences we have described here *reside* in this life world context. This foundation is crucial to how we possibly understand—or relate to that which we name medically unexplained symptoms. However, this does not imply that experiences/symptoms, or the expression of such, should be excluded from the opportunity of being subject to the medical gaze. Our main errand has been to emphasize how the medical method, criteria, observations and requirements of evidence together with a disproportional focus on medical diagnostic naming represents a possible barrier to an understanding of such symptoms. Wherever the medical *ways of thinking* come up against a boundary, we must by way of *uninhibitedness of thinking* constantly address this, in a phenomenological sense, urgent matter.

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