What is called symptom?

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Editors-in-Chief
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Editorial

BERT GORDIJN and HENK TEN HAVE / The enhancement debate 1–2

Scientific Contributions

MICHAEL J. SELGELID / Moderate eugenics and human enhancement 3–12

JAN-CHRISTOPH HEILINGER and KATJA CRONE / Human freedom and enhancement 13–21

GAVIN G. ENCK / Pharmaceutical enhancement and medical professionals 23–28

HUB ZWART / *Limitless* as a neuro-pharmaceutical experiment and as a *Daseinsanalyse*: on the use of fiction in preparatory debates on cognitive enhancement 29–38

JAN HELGE SOLBAKK / The whole and the art of medical dialectic: a platonic account 39–52

LINUS BROSTRÖM and MATS JOHANSSON / Involving children in non-therapeutic research: on the development argument 53–60

STEPHEN WILMOT / First Nations health care and the Canadian covenant 61–69

RABEE TOUMI / Globalization and health care: global justice and the role of physicians 71–80

ANDERS RYDVALL, NIKLAS JUTH, MIKAEL SANDLUND, MAGNUS DOMELLÖF and NIELS LYNØE / To treat or not to treat a newborn child with severe brain damage? A cross-sectional study of physicians' and the general population's perceptions of intentions 81–88

THOR EIRIK ERIKSEN and METTE BECH RISØR / What is called symptom? 89–102

GIUSEPPE SCHIAVONE, GABRIELE DE ANNA, MATTEO MAMELI, VINCENZO REBBA and GIOVANNI BONIOLO / Libertarian paternalism and health care policy: a deliberative proposal 103–113

(*Continued on back cover*)

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SCIENTIFIC CONTRIBUTION

What is called symptom?

Thor Eirik Eriksen · Mette Bech Risør

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Abstract There is one concept in medicine which is prominent, the symptom. The omnipresence of the symptom seems, however, not to be reflected by an equally prominent curiosity aimed at investigating this concept as a phenomenon. In classic, traditional or conventional medical diagnostics and treatment, the lack of distinction with respect to the symptom represents a minor problem. Faced with enigmatic conditions and their accompanying labels such as chronic fatigue syndrome, fibromyalgia, medically unexplained symptoms, and functional somatic syndromes, the contestation of the symptom and its origin is immediate and obvious and calls for further exploration. Based on a description of the diagnostic framework encompassing medically unexplained conditions and a brief introduction to how such symptoms are managed both within and outside of the medical clinic, we argue on one hand how unexplained conditions invite us to reconsider and re-think the concept we call a "symptom" and on the other hand how the concept "symptom" is no longer an adequate and necessary fulcrum and must be enriched by socio-cultural, phenomenological and existential dimensions. Consequently, our main aim is to expand both our interpretative horizon and the linguistic repertoire in the face of those appearances we label medically unexplained symptoms.

Keywords Symptom · Medically unexplained symptoms (MUS) · Basic human conditions · Sensations

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Introduction

What is a symptom? Consulting different medical encyclopaedias, reference works and syllabuses we find that a symptom warns of possible disease. The appearance of the symptom usually involves the verbal articulation of the patient's subjective experience of the symptom(s) and the possible bodily manifestation that accompanies it. The patient's information represents the descriptive and narrative background from where the clinician launches his analytical investigation. Furthermore, and following the presentation of the symptom, the medical investigation aims to uncover the causes of the disease or abnormal condition. These investigative elements, belonging to a medical setting, serve us with a brief sketch of what takes place in a clinical encounter. Accordingly, this is a process wherein the symptom represents the core component of the diagnostic process, the crux of the matter that is taken for granted. This perspective, however, leaves us unsatisfied as if something is missing from the picture, when entering the empirical study of the plurality, the significance, the diversity and the nuance and sheer volume of symptoms, not just in health care but in everyday life. We are intrigued by this self-confident and "homelike" approach which we suggest must be extended and enriched by *socio-cultural, phenomenological and existential* dimensions. Our claim is that the acknowledgement of the symptom as a

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phenomenon has potentially far-reaching consequences for medicine.

We do not suggest that this extended interpretation of the symptom is particularly relevant or necessary in situations where clinicians are confronted with a heart-attack, a bleeding nose or a broken leg. Neither do we suggest that it is the primary task of medicine to explore these mentioned dimensions. Instead, we want to emphasize that the simplistic medical understanding of a symptom is a 'natural fact' and a given unit of meaning within this discipline, but is not restricted to being 'at home' in that context—neither materially nor philosophically. *We find this to be especially relevant and crucial in situations where medicine finds itself challenged by "indefinable" or inexplicable health conditions*. That is, our interest in the subject of "the symptom" arises from our dealing with medical classifications like "subjective health complaints (SHC)", "medically unexplained symptoms MUS)", "complex symptoms syndrome (CSS)" and "functionally somatic syndromes (FSS)", just to mention a few of the terms that are often applied. The extensive body of medical literature concerning these diagnostic labels confirms and demonstrates how the symptom stands out as the centre of rotation. To be at the centre of rotation here refers to the *constitutive role symptoms have in the construction of such diagnostic classifications.*

In this paper we explore this subject along four different dimensions. The first two should be read as a setting of the scene, a contextualization of the studied phenomenon and its clinical consequences: (1) What do we mean by "unexplained" diagnoses, and in which classificatory framework are these embedded? (2) What dilemmas emerge when the doctor, with such classificatory guidelines and other remedies at hand, is faced with the symptomatic experience of the patient? Both the diagnostic framework and the clinical encounter are familiar contexts to a GP dealing with such conditions. The following explanatory step in the text aims at gradually broadening a restricted medical-clinical concept of the symptom. By searching "prior to" or "beyond" we introductorily and briefly turn to a third question: (3) How do we make sense of presumed symptomatic experiences in a non-clinical context? Finally we add rather more abstrusely and crucially: (4) What "is", before it becomes a clinically perceived and interpreted symptom?[1] All these questions and problems to be addressed finally lead us towards the possibility of re-thinking the theoretical basis and the clinical reality in which the phenomenon of the symptom is negotiated.

[1] Inspired by how the German philosopher Heidegger in his book "*What is called thinking*" dealt with an inscrutable theme such as thinking, we will try to "open up" that phenomenon we name symptoms. By launching the title "What is called symptom" we want this to serve as an invitation to reflection and re-thinking of this matter.

The classificatory framework

Primary unexplained conditions

Approaching the multifaceted landscape of the medically unclarified, unresolved or unexplained, we find that all the different medical specialities have a particular grip on "their" unexplained conditions. For example, in the medical speciality named *gastroenterology* we find the specific diagnosis Irritable Bowel Syndrome (IBS), in *physical medicine* Low Back Pain (LBP), in *psychiatry* General Anxiety Disorder (GAD), in *occupational medicine* Multiple Chemical Sensitivity (MCS) and in *rheumatology* Fibromyalgia (FM). We must furthermore add a contested diagnosis such as Chronic Fatigue Syndrome (CFS) which appears to have a no natural given affinity to any of the medical specialities. In different ways and with different degrees of overlap, such conditions relate to a comprehensive list of symptoms such as; back pain, joint pain, extremity pain, headache, weakness, fatigue, sleep disturbance, difficulty concentrating, loss of appetite, weight change, restlessness, thoughts slow, chest pain, shortness of breath, palpitations, dizziness, lump in throat, numbness, nausea, loose bowels, gas/bloating, constipation and abdominal pain (Burton 2013, p. 2)

What is common to these and other unexplained conditions not mentioned here are: (a) The lack of clear aetiology (the underlying cause(s) remain undetected), (b) the possible biological mechanisms involved are unknown, (c) the patients suffer a diversity of diffuse symptoms/signs difficult to describe and changing over time (d) most of them are highly contested diagnoses (they are not internationally classified), (e) they are based on subjective patient reports (self-reported symptoms), (f) cognitive behavioural therapy is often considered to be an effective intervention aimed at symptom relief, (g) they altogether affect a significant proportion of the population (although the estimates of prevalence are highly uncertain). Let us then turn our attention to what we tentatively describe as 'meta-diagnoses' (or higher-order diagnoses) which are presumed to shed light on this medically bewildering terrain.

"Meta-diagnoses"

Terminology and descriptive definitions have not succeeded in clarifying the classifications in terms of applied diagnoses. Patients are given different diagnoses, depending on a variety of factors including the physicians' clinical speciality and scientific orientation and the popularity of a particular diagnosis (Kanaan et al. 2007; Wolfe 2009; Henningsen et al. 2007). Some of these are as shown in the above section. One of the fundamental challenges of those

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primary and common unexplained conditions is that they are both specialized, fragmented and numerous. Even more intriguing is the considerable *overlap* regarding the symptomatic picture that emerges within the different conditions. Several researchers from different sub-specialities in medicine have responded to these challenges by creating some kind of higher-order *or meta-diagnosis.* Meta-diagnoses try to subsume the contested conditions we deal with, each with its own emphasis and standpoint, under the core dimension of what they want to designate and a hint at a presumed aetiology. Furthermore, and even more crucial, are these efforts aimed at creating a conceptual foundation that may serve as a navigation system in the over-complex landscape termed 'the medically unexplained'. A prominent marker of such higher-order or meta-diagnostic labels is *functional somatic syndromes* (FSS). 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 et al. 2004, p. 373).[2]

A second example is Bodily Distress Syndrome (BDD). BDD was developed by Fink and colleagues from research on symptom patterns. In general, medical definitions and terms address symptoms as something that both presumably invokes inner sensations and induces actions on behalf of these sensations. One definition of such conditions has been phrased as: 'Conditions where the patient complains of physical symptoms that cause excessive worry or discomfort or lead the patient to seek treatment but for which no adequate organ pathology or patho-physiological basis can be found' (Fink et al. 2002). A more recent definition that leaves out care-seeking and focuses even more on the symptoms as the dominating phenomena is "medically unexplained or functional somatic symptoms are complaints defying the clinical picture of known, verifiable, conventionally defined diseases and unbacked by clinical or paraclinical findings. They are prevalent in all medical settings and may be persistent, disabling, and costly" (Fink et al. 2007).[3]

To the above-mentioned categories FSS and BDD we could also add acronyms like central sensitivity syndrome (CSS), subjective health complaints (SHC), somatoform disorder (SD) and perhaps the best-known term Medically Unexplained Symptoms (MUS). If we then return to the underlying framework of the more common and known diagnoses such as IBS, CFS, MCS and several others, we are in fact confronted with a two-level acronym-complex assumed to be an adequate response to—or in resonance with—patient narratives or experiences concerning the "unexplained". This brings us to our second aim with the presentation of primary diagnoses which concerns the 'idiom of distress' employed by the patient (Nichter 1981). So far, when talking about the symptom, we have actually submitted to a medical understanding of this and not asked ourselves who 'owns' the symptom and how may it be presented. But extracts from patients' own stories vividly expose the diffuseness of presenting complaints, ailments, troubles, worries, constraints etc. that are far from delimiting a clear medical symptom and much closer to lived experience and the essence of what is the matter with the patient (Ware and Kleinman 1992, Ware 1999). Along the way, patients may learn to speak the language of the clinic but in many consultations the personal 'idiom of distress' dominates the communication about contested conditions, often showing that different idioms may be incompatible and belong to different contexts (Risør 2009). In the next section we will explore the dilemma of the patient's idiom of distress on the one hand, and the tools at hand for diagnosis, i.e. the classificatory frameworks, on the other, by directing our attention to the clinical encounter.

Symptomatic experiences in the clinic

The diagnostic apparatus as discussed above has been developed in a theoretical health-research setting, although informed by research on empirical cases. However, the theoretical level and the resulting diagnostic designations are debatable and contested when applied in clinical settings. Especially we will argue—with a specific focus on the symptom construction in the doctor–patient relationship—that certain dilemmas either become evident or are precluded but still present. The dilemmas that become obvious merge into at least five areas: (1) When people suffer from subjective symptoms, *the clinical encounter often creates adverse effects*, e.g. somatizing effects (Ring et al. 2005) in the effort to diagnose and clarify the condition. That is, somatic symptoms and syndromes are not only limited to individual bodily sensations but are also processed and developed in relational clinical contacts and health encounters, e.g. by the doctors' inclinations to pursue somatic explanations and interventions (Page and Wessely 2003) or the patient's need for an acknowledged diagnosis. Somatic interventions do not necessarily benefit the patient if their somatic complaints are not justified by a pathophysiological disorder. Several studies show that the

[2] Besides IBS, other conditions subsumed under this label are food intolerance, CFS/ME, burnout, fibromyalgia (FM), somatoform disorder (SD), vertigo, hypochondria, whiplash and non-cardiac chest pain (NCCP).

[3] The latest results from Fink's group showed an overlap of symptoms and symptom patterns among a huge sample of patients and resulted in the development of the term BDD which refers to symptom experiences, is aetiology-neutral, leaves out behavioural dimensions and does not reinforce a mind–body dualism (Fink and Schrøder 2010).

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GP tends to pursue a line of somatic intervention also if he does not have a clear idea about the aetiology of the problem and (Salmon et al. 2005, 2008; Ring et al. 2005). This emphasizes the tendency to a somatizing effect of general practice and for the health professional to become fixed upon the 'whatness' of the symptom. (2) Several dimensions increase the *risk of 'dysfunctional encounters' and iatrogenic harm*, such as physicians' attitudes to patients presenting with medically unexplained symptoms (Åsbring and Närvänen 2003; Page and Wessely 2003). A core dilemma here is that of the health professionals attributing the complaints primarily to psychopathology. This attribution is a widespread attitude but compared with the first mentioned dilemma, somatic interventions are still the preferred treatment actions taken. The patients experience the attribution of psychopathology as a rejection of the reality of symptoms (Salmon et al. 1999), since the patient has a very physical experience of his/her symptoms such as stomach pain, nausea or fatigue. (3) This relates to a third topic, which illustrates the dilemma of *shifting physician strategies* and approaches when managing patients (Woivalin et al. 2004; Olde Hartman et al. 2009). These are approaches that have consequences for treatment and prognosis and that are based on situational and contextual factors in the clinic and during a consultation. It is a challenge that only few studies deal with, that of how the patients react to these approaches and what the patients themselves see as important clinical issues. A study by Salmon et al. (2005), however, shows that patients with medically unexplained symptoms sought more emotional support than others, but they did not ask for more explanation, reassurance or somatic intervention, that is, they did not pressurize the GP for the latter but they still received more of it and only little emotional support. (4) A fourth dilemma concerns how *diagnostics are dependent upon which medical speciality is consulted* (Nimnuan et al. 2001). This relates to how referrals and system-initiated patient trajectories create an excess of examinations and hospitalizations (Henningsen et al. 2007). Somatic interventions and their dominance in clinical consultations as already mentioned play a huge part in the process of somatization. But the consequence of e.g. blood tests, tissue tests, X-rays etc. and referrals to other specialists or examinations is often to take the patient onto a journey of being a 'frequent attender' or through a pathway of numerous hospitalizations, solving nothing but the GP's need for referral. (5) The last but perhaps the greatest dilemma concerns *patients having difficulties explaining the complexity of their complaints and being heard* (Peters et al. 2009; Kirmayer et al. 2004; Salmon et al. 2004; Risør 2010). A study by Salmon et al. (2004) illustrates this and maintains that patients with unexplained symptoms actually express and cue psychosocial problems and explanations at consultations but are not heard by their GP.[4] From the patients' viewpoint, the explanations of the illness are not always or only somatic. Several studies show that the patients have multiple explanatory models that are used for grasping the complexity of their conditions. Such models cover the whole spectrum from physical, psychological, social and existential explanations, none of them being necessarily dominant (Soderlund and Malterud 2005; Risør 2009; Kirmayer et al. 2004). Summing up, this tells us that the presumed centrality of physical symptoms in medically unexplained symptoms is questionable, that is, the emphasis on the physical aspects of symptoms. Instead it is shown that *patients think of their symptoms in complex ways—somatically, psychologically, culturally, socially and existentially,—and they do not even necessarily think of their symptoms according to a medical understanding, but in the 'idiom' that is closest to their own experience,* while they also integrate several explanatory models of their conditions to try to understand what is the matter with them. Symptoms are still fundamental to this, not only as symptoms in themselves, but also as modalities of explanations and as a result of interpretations of body, self and illness being made before entering the clinical setting.

Beyond the clinic

What tends to be forgotten in medicine and psychiatry, is that patients are involved in several decision processes that precede the events and the diagnostic process that take place in the clinical setting (Kleinman 1980). We know very little about how bodily signs and early symptoms of ill-health are *managed in the course of everyday life* outside the clinical setting and how this informs and influences how people become patients and how clinical encounters develop. That is, we have limited knowledge about the presence of symptoms in the "popular sector" (ibid). Nevertheless, several survey studies have shown that the majority of a population experiences signs or symptoms of which only a small part are ever presented to a health professional. Overall, it has been estimated that up to 80 % of all potential health problems are never presented in a clinical setting, but are either ignored or dealt with by the individual, the family or within the immediate social network (Kleinman 1980; Janzen 2009). Furthermore, Alonzo (1984) long ago pointed to the prevalence of symptoms that did not reach medical care because they were either

[4] A similar conclusion is reached by Olde Hartman et al. (2013), showing that although patients had time for extensive explanations, the GPs did not engage these in their own interpretation. This also relates to communication problems regarding patient expectations and incompatible explanatory models of disease (Salmon et al. 2005; Kirmayer et al. 2004).

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'contained' or dismissed over time. Also it is recognized in somatization research that symptoms that are unexplained are experienced by everyone to a greater or lesser degree, and what the health professionals see is only the tip of the iceberg of normal transient changes (Merskey 2004).

In accordance with the above line of reasoning, we will extend our examination of the world outside the clinic by turning our attention to a phenomenological study conducted by Larsson (2008). Taking as its basis an essential concept such as *lived experience*, she carried out a study conducting in-depth interviews with patients suffering from medically unexplained physical symptoms (MUPS) (corresponding to MUS). One of the major themes that emerged from this study was "pain and suffering: expressions of loss and loneliness". She elaborates on this dimension as follows: "All of the study participants identified pain as a distinctive response that *communicated meaning* in their lives. For many, the pain revealed the profound nature of personal experiences of *loss and loneliness*. Pain, for the participants, expressed what words alone could not convey about who they were as people. Pain was the *embodiment* of life experiences, the manifestation of each individual's struggles, social isolation, and hurt" (p. 93). Due to this study by Larsson, we are again reminded of the particular idiom of distress that belongs to the world of lived experience and of how the "medical gaze", the tools, the professional knowledge and medical-institutional guidance provide a framework that has not been primarily designed to deal with "communicated meaning", loss and loneliness and pain as an embodied phenomenon.

While Larsson approached the landscape of unexplained conditions through the concept MUPS, another study conducted by Dickson et al. (2007) explored how people experienced a more common or known diagnosis such as CFS. By conducting in-depth interviews with 14 persons, they also focused on the *experience of living* with a condition like CFS. Besides the expected difficulties related to the clinical encounter, the participants describe the challenges they face in carrying their fatigue-symptoms through daily life. Some of them experience a loss of friendships, and for this reason their stories express both loss and regret (p. 858). The authors therefore emphasize, in resonance with the study performed by Larsson, that "many of the participants reported feeling both isolated and lonely as a result of CFS". It was even more challenging to face the mistrust of their partners. The authors add: "This was also perceived to be a form of rejection, and in consequence, almost all participants experienced a loss of confidence in defending their illness to others: "If he [my husband] doesn't believe me and he can see how ill I am, why would other people believe me? [Anne]"(s. 859). This and several other studies concerning how people experience different unexplained conditions, truly illuminate other arenas than merely the clinical encounter as accommodating de-legitimizing processes of ill-health. It furthermore confirms that a wealth of life-related issues manifest themselves when people are struck by what we call unexplained conditions.

Beyond medicine—and health?

Let us summarize so far. *Firstly,* we have described some essential components of the diagnostic structure that is considered to be a response to the large number of existing unexplained symptoms in the population. This diversity of medical acronyms reflects not only a linguistic development, but also a linguistic bewilderment. Thereby, the ground is prepared for a potentially concealing and obfuscating regress regarding the interpretation of such phenomena (Eriksen et al. 2013). *Secondly,* we have indicated how both the person with unexplained symptoms and the doctor face major communicational and other challenges in the clinical encounter. *Thirdly,* we have focused our attention on the obvious fact that symptoms necessarily and evidently reveal themselves in people's life-world outside the clinic. The fundamental symptom experience is embedded in a cultural context, affects families and relationships and will be subject to communication and interpretation.

Based on these three aspects, we must maintain that unexplained conditions *still* largely resist medical approaches focusing on explanation, diagnostics and treatment, which is shown in the above sections. Based on the empirical research dealing with these issues, it is obvious that the aforementioned conditions concern life-world related phenomena which largely fall outside the 'medical gaze', i.e. the medical practitioner is of course not professionally prepared (through his training) to respond to patients' thinking of their *symptoms* in a radically different way—*existentially, culturally and socially.* Trying to deal with this challenge from an interdisciplinary standpoint, an adequate response could be to receive and interpret such thinking by applying philosophical/existential and socio-cultural theories and models. This possible and presumed alternative approach to the *symptom* is, however, challenging, as the concept of symptom is inevitably and coercively applied and understood as a medical 'property'.[5] Symptoms are either threatening, i.e. possibly related to an *underlying disease*, or troublesome-harmless, i.e. associated with *undetected disease* or *non-disease*. For this reason we believe that the concept of symptom, to the extent

[5] Although the term "symptom" is a part of our everyday language in a diversity of spheres, we maintain that this wording primarily is identified with health/disease and the branch of medicine.

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that this wording is used as an "unproblematic given" and a neutral term, potentially *reinforces and maintains a process of medicalization if confronted with challenges that turn out to be unexplained*.[6]

In an effort to somehow transcend the concept we label symptom we choose to enter this challenge from different perspectives and traditions of thought. The search process for other knowledge sources, however, includes no ambitions of replacing or eliminating such a concept. This concept is far too important, decisive and adequate when it comes to describing and dealing with health imbalances. Our ambitions are more modest, in that we seek to open up a landscape whereby fundamental ideas about what is human or a human being can be challenged, *and whereby the concept symptom is no longer a necessary fulcrum.* That is, we suggest that such an opening can support a necessary rethinking and reinterpretation of what we consider to be *human nature*. This does not necessarily imply or indicate an inventing or creative process, but more decisively a returning, remembering or recalling—of that which is forgotten or lost sight. The first element in this explication concerns the presumed "scene" or arena where the presumed "phenomena" (and symptoms) are expected to show themselves. This of course involves the concept body, but also unfamiliar terms such as Körper and Leib. Based on this grounding, the second step concerns a re-introduction of what could be seen as specific "human-like" *appearances* involving a dimension such as *meaning*. In the third step we will reflect on a few possible implications following the arena-discussion, attempting to achieve a renewed understanding (i.e. the recalling of a possible repressed understanding) of "what is" or "takes place" before it turns into a medical symptom. Specifically, we will briefly touch on two exemplary appearances, *anxiety and pain*. In the following sections we will give a brief presentation of respectively socio-cultural, linguistics and psychoanalytic approaches to this subject.

Körper and Leib

Regardless of disciplinary affiliation, we all agree on the fact that we have a body or that we are a body. We are bodily beings. From this baseline, it is obvious that different academic branches have launched quite diverse conceptions of the 'body' or 'physicality'. In our approach, we choose to avoid the mandatory addressing of presumed Cartesian bewilderment regarding the impossible psyche-soma division as a starting point. We will instead turn directly to the German expression 'Körper und Leib' to shed light on the introductory elements. In a brief explication we will focus on these ideas as they have been presented by Edmund Husserl and Martin Heidegger.[7] According to Husserl (1973), 'Körper and Leib' signifies the difference between the experience of a body–object (as we see ourselves in the mirror or the person standing next to us) and the lived or living body as experienced (through our senses) from a first-person perspective. The former being a physical system available for accurate description, the latter being what Baldwin (2004), with reference to Husserl, describe as "the expression of 'spirit', the personal self, and also the vehicle for the human psyche ('soul')" (p. 25). Accordingly, with the term 'Leib' Husserl emphasizes how consciousness is inextricably connected or *bound* to the body (ibid). Furthermore, Heidegger addresses these concepts in his "Zollikon seminars" (2001). He states that the corporeal entity, 'Körper' (which stems from the Latin 'corpus'), stops with the skin. For Heidegger this conception is highly problematic and narrow since we always find ourselves in relation to something else. It is therefore of crucial significance when he claims that "the bodily limit is extended beyond the corporeal limit" (p. 86). He expands:

> Is the body in the 'I' or is the 'I' in the body? In any case, the body is not a thing, nor is it a corporeal thing, but each body, that is, the body as body, is in each case my body. The *bodying forth (Leiben) of the body,* is determined by the way of my being. The bodying forth of the body, therefore, is a way of Dasein's being. But what kind of being? If the body as body is always my body, then this is my own way of being. Thus, my bodying forth is co-determined by my being human in the sense of the ecstatic sojourn amidst the being in the clearing (gelichtet) (p. 87)

This bodying forth voices our relational character as human beings. Heidegger adds: "I myself am this *relationship*…" (p. 185). For this reason we must understand bodily being (das Leibliche) as founded upon a response to a world. Arriving at such an understanding brings us face to face with the essential challenges concerning "medically unexplained" conditions. Heidegger quite precisely states:

> The phenomenon of the body as such is especially concealed to physicians because they are concerned merely with body as a corporeal thing (Leib–Körper). They reinterpret (the body) as corporeal function. The phenomenon of the body is wholly unique and irreducible to something else, for instance, irreducible to mechanistic systems. *One must be able to accept the phenomenon of the body as such in its intact being* (our italics). I cannot 'understand' something merely

[6] Cf. Irving, Zola (1983).

[7] Carel (2011), Leder (1990) and Csordas (1994) are examples of similar deliberations on the body and illness which also build on those philosophers.

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> causal. That means that I can have no insight into how one thing is derived from something else, that is, how it originates *out from it*… (p. 186)

The incessant search for causal pathways concerning the true origin of my fatigue, the related (comorbid) anxiety and the appurtenant sadness, certainly appears, in the light of das Leibliche in Heidegger, to be a Sisyphean task. The body (Leib) seemingly defies our systematic and analytical approaches. It resists, at least when we are dealing with unexplained issues, the 'grasping' with the help of advanced terminology and classificatory remedies. The giving and expression of meaning emerge from a source that is both 'Körperliche' and 'Leibliche'. Accordingly, these expressions cannot be reduced to mere 'expressions of certain inner states'. They are more likely to be seen as linguistic formations which emerge from our 'living body' and our bodily being-in-the-world. *Accordingly, the medical professional is not only confronted a 'mental' or 'psychiatric' symptom/condition, but bodily/Leibliche appearances.*

Appearances, holding—and giving meaning

These above statements do not create a harsh critique of the efforts of medical practice, but should instead be received as a reminder of the possible limits of the medical catchment area. Once again we propose that the word 'symptom' designates a legitimate form of medical reasoning or way of thinking, which one should admit is only a derivate of more fundamental *phenomena* concerning life that poorly fits the medical framework. As phenomena, they are restored as human matters. However, frequent use of the term human in this presentation represents an issue in itself. To defend such a use of wording and at the same time shed light on what are called medically unexplained symptoms, we choose to highlight Heidegger's response to The World Health Organization's (WHO) 1965 report on *psychosomatic disorders* (which was one of the earlier medical terms used to describe unexplained conditions). The WHO here describes the individual as a complex, dynamic system with appurtenant systemic processes. In his "Zollikoner seminars" (2001), Heidegger notes the following: "In such a conception *being human* is not there at all. Everything is switched over to a system of processes, to a state of equilibrium of such processes, determined by the environment and by so-called inner subjectivity". (p. 199). Consequently, the question "What's the matter" should somehow be reframed into expressions such as "that which matters" or "how it matters". Pain, anxiety, melancholy and fatigue *is*, or more accurate, *matters*, even before we try to grasp—or conceptualize these phenomena as being a collection of symptoms. They represent, and especially when referring and relating to the so called unexplained conditions, *appearances holding—and giving meaning. As human basic (ground) conditions, and as phenomena, they manifest or express life itself.*[8] To await a happening or an event wherein such expressions give themselves, calls for permission for an expression to make an impression.[9] Such awaiting concern, not a waiting for, as a waiting that awaits a certain result, but a waiting upon where we leave open what we are waiting for (Heidegger 1966: 68). By exceeding the automated (and over-focused) thinking concerning the expected medically (unexplained) symptom, one gives man a chance to dwell in the dynamic momentum wherein the voice of Leib expresses itself.

Indicative anxiety and multi-layered pain

One dimension of what we consider to be both a "körperliche" and "leibliche" appearance is *Anxiety*. It is furthermore considered to be an essential co-morbid symptom/condition associated with medically unexplained conditions (Schur et al. 2007). In other words, anxiety often accompanies unexplained health-imbalances. Exactly *how* it accompanies is still left as an unanswered question. There are basically three options for this involvement: (a) anxiety causes unexplained symptoms, (b) anxiety accompanies such symptoms or (c) anxiety is a consequence of unexplained health problems (e.g. persistent musculoskeletal pain). Even though one is able both to measure (through test batteries) and launch hypotheses regarding different causal pathways in anxiety, we argue that the fundamental challenge concerns understanding—not explanation. Anxiety is still a condition which is poorly *understood*. Accordingly, we suggest involving a contributor to a possible "pre-symptomatic" and "pre-disordered" understanding of

[8] Such an interpretation evidently rests on insights from phenomenology. In this way, it resonates with explications from phenomenologists such as Robert Mugerauer (2009). In an effort to describe the complex and inscrutable arrival of the phenomenon with the one who is gifted (the receiver), i.e. "the way phenomena make unpredictable landings in our lives" (s. 73), he continues: "Phenomena arrive so discontinuously, so unexpectedly, and so much by surprise that our contribution amounts to no more than being open to what hits us. Often we can only *await* and make ourselves ready to receive what might come, as would a good sentry at night, a first step towards which is giving up our attempts to control, much less produce what appears" (ibid).

[9] This is a phrase borrowed from the Norwegian philosopher Anders Lindseth.

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anxiety such as the Danish philosopher Søren Kierkegaard.[10] Through his work, first and foremost "Begrepet angst" (2005) (eng; "The Concept of Anxiety"), we were loudly reminded that this state called anxiety is a landmark of our humanity. Anxiety is like an adventure and "whoever has learned to be anxious in the right way has learned the ultimate" (s. 145). However, it is *not the "condition" in itself* which represents the momentum of his reflections. Essential for Kierkegaard is the "*pointing" or "indicating*" potential that anxiety holds. This "indicative" potential concerns the destiny of being human, that is, related to a "process" of *becoming*—the becoming of oneself. It is however difficult to accept that anxiety, besides arriving, influencing, frightening and disturbing—as its undertow drags us towards the abyss of nothingness—somehow could be related to a *possibility* such as becoming. In the midst of anxiety such a possibility is "not at hand" and the most obvious response would be to escape into distraction. Why should we then cling to remote potentialities in such a demanding and unpleasant state? Kierkegaard answers, "indicating", "pointing", "becoming". Thus, anxiety holds an *invoking* potential. Anxiety insists on a kind of responsiveness and sensitivity towards "that" which calls our attention (be it life processes or our finiteness). Anxiety *confronts* us with questions and wonderings concerning authenticity and inauthenticity (how we live and who we are). Anxiety could be seen as an *entry gate* to our emotional life. It is an "event" which reminds us of our freedom—our freedom to choose (Kierkegaard would add; *what* you choose is secondary to the fact *that* you choose). In harmony with such reasoning, a philosopher deeply inspired by Kierkegaard, Martin Heidegger (1996) calls attention to the following: "That about which one has Angst is being-in-the-world as such" (p. 186). Even more decisively he states that Angst is a mood or an attunement which *discloses*. It discloses the world, as world. It discloses human existence. Consequently, it also reveals our "potentiality-for-being-in-the-world" (p. 187). Anxiety, or angst, understood as "existential predicament", "human condition" or "ontological characteristic" is related to these dimensions of possibility. It is however a paradox that such assumed possibilities resist what Heidegger would describe as calculative thinking. The existence of such possibilities cannot be proved. They can only be experienced or lived through. As such, their existence—as possibilities, calls for thinking and rests on faith and trust.[11]

Let us then turn to the phenomenon and symptom named *pain.* "Living involves being exposed to pain every second—not necessarily as an insistent reality, but always as a possibility". These opening words are included in the introductory lines of the book "A philosophy of pain" by the Norwegian philosopher Vetlesen (2004). Together with publications provided by writers and scholars such as Lewis (2002) "The problem of pain", Brand and Yancey (1993) "The gift of pain", Scarry (1985) "The body in pain" and Wall (2000) "Pain: the science of suffering", he calls our attention to an extended view of pain. Both the manifestation of bodily and sensory pain and our exposure to (possible future) pain represent a fundamental dimension inextricably linked with being a living human. Although the pain is unambiguously painful, obvious and specific when the hammer hits your thumb, this is obviously not the case for those conditions we refer to as unexplained. The symptom of pain appears in an undefined, complex and possibly indirect manner in conditions such as low back pain (LBP) and irritable bowel syndrome (IBS). Expressions such as "my back hurts" or "I have a stomach ache" represent, to the doctor, initial and fuzzy descriptions. Accordingly, a condition like LBP is accurately referred to as "*non-specific* low back pain" (Salathe 2012: 273). The challenge is of course that man, in an effort to articulate such painful conditions, is dependent on language. Confronted by such a challenge, Scarry (1985) reminds us that pain is for the most part characterized by *unsharability.* It resists language. Even more intricately, she states that "Physical pain does not simply resist language but actively destroys it, bringing about an immediate reversion to a state anterior to language, to the sounds and cries a human being makes before language is learned" (p. 4). Consequently, what remains as essential in the human experience of the world of pain is pain understood as a *phenomenon*. Pain is lived experience. Pain itself does not distinguish between what is "physical" (somatic) and psychological (psyche). The pain takes control of our lives. It permeates our life-world.

Furthermore, Strang et al. (2004) with an article titled "Existential Pain, An Entity, a Provocation, or a Challenge?" hit the target quite accurately in terms of articulating the difficulties we face. Accordingly, the vocabulary in the foregoing paragraphs naturally appears challenging

[10] The term pre-symptomatic is among other used by Kellerman (2008). Her refers to Engel And Schmale (1967), "who point to what they call a "giving-up/given-up" complex. This is a nonspecific *pre-symptomatic state*. It contains a cluster of tendencies and characteristics including: a lessening of control and a lessening of a sense of security, helplessness and hopelessness, less certainty of one's perceptions of the environment and of past experience, and a clouding of differentiation between past and future (s. 7).

[11] We repeat that this explication altogether do not hold a normative decree. It is an *invitation*. An invitation to reflect on the *phenomenon* named anxiety. Consequently, we agree with Prasad (Prasad 2009) which notes that: "The worry, if one takes Heidegger's perspective, is not that health is an outcome to be optimized by cost-effective, evidence-based medicine, but that this might become *the only* way of thinking about health—that no alternative exists". (p. 17).

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to the medical professional. It leads us beyond a world of defined concepts, theoretical models, diagnostic classifications and objects for measurement. This highly compacted presentation does not of course do justice to the diverse literature on the topic of pain. However, such an explication is defensible, given that our intention has been to *indicate how pain, as a co-constitutive element or aspect of most medically unexplained condition, exceeds its well-defined symptomatic character*. As such, it withdraws from scientific attempts to grasp it. It dodges attempts to explain scientifically the possible mechanisms and causal pathways.[12]

Sensations

Furthermore, we find that certain *socio-cultural* approaches include ideas and perspectives that potentially supplement and liberate us from the medical concept called symptom. In what follows we will explicate a socio-cultural or anthropological dimension of humanness which to a degree is consistent with the previous preparation of the conceptual elements 'Körper und Leib'. The starting point could be a sentence like 'I am a bundle of nerves'. This sentence is an interpretation of maybe a whole series of different sensations and it denotes a certain experience of illness, an explanatory model for the concept of illness, and calls for a study of the setting and context of the expression (Martìnez-Hernáez 2000). The understanding of symptoms is thus closely related to cultural and biographical contexts, and based on this presumption Martìnez-Hernáez takes us through different varieties of analytical approaches within social sciences that develop the understanding further.[13] Consequently, if we focus on descriptions of symptoms, of their definition and their *whatness*, they merely portray the map of the diseases and not the landscape. The landscape however, is *experienced, lived and felt* by the patients and what is experienced are *bodily sensations*, not symptoms, and *embodied reactions*, not criteria.[14] Bodily sensations and the importance of attending to those in studying the experience of illness has been brought forward by several researchers within anthropology (Hinton and Hinton 2002; Jenkins 1991; Kirmayer 1996, 2007; Kleinman and Kleinman 1994; Nichter and Nichter 2003) who state that the process of interpreting and organizing sensations into meaningful perceptions for both patient and healer are of particular relevance to the anthropology of medicine (Hinton et al. 2008). Examining sensations means exploring what is felt by the body, how the body reacts to sensations and how these are e.g. *developed into* specific signs of distress or symptoms or perhaps dismissed as non-worrying signs. Sensations in this sense are not only our *basic senses* but also multimodal senses like nausea, dizziness, pain, shortness of breath etc. With this approach the starting point is not taken from what a physician classifies as a 'symptom' but from the individual bodily experience of sensations, bringing the topic back once again to who 'owns' the symptom and how is it conveyed.[15] Consequently, we argue here that such pre-symptomatic dimensions should be the focus for the analysis of symptoms in order to address the procedural and phenomenological nature of symptom experience. The reason for this is that symptoms require that something is known and must be done by someone. What lies ahead, what precedes a symptom, what 'is' before 'it' is e.g. a sensation, is something else: "*A sensation is embodied; it is felt experience. By contrast, a symptom is a constructed and*

[12] More than a symptom carrying unambiguous misery, we are therefore confronted a Marcelian mystery. That is, we are confronted with what we are unable to treat as a problem—as an object for analytic investigation. In dealing with what is not a problem and which pervasively concerns our existence, a reflective exploration of such fundamental issues is not aimed at generating "solutions". At best one can initiate a process whereby the present phenomenon is received as giving pause for thought. Consequently, pain will remain such a fundamental human condition independent of future medical breakthroughs as regards both diagnosis and treatments (Marcel 2001).

[13] Symptoms may be symbols in a Peircean sense, signs in a Saussurian sense, dominant symbols following Good, expressions of distress following Kleinman, 'texts', narratives, metaphors, metonyms following others etc. Ethnography and anthropology must study the symptom as a symbol in some sense. This is notably a positive step ahead for studies of symptoms, but turning back to the entrapment by the notion, we argue that although symptoms are being elaborated, contextualized and differentiated as basic anthropology or social sciences do, the possibility of letting go of the word/notion and stepping back to have a look at the pre-symptomatic processes of bodily signs is lost.

[14] This line of reasoning is however not restricted to a specific socio-cultural approach. The concept of "primary" sensations and embodied reactions also resonates with how a philosopher such as Kay Toombs (1993), inspired by Sartre, explicates the process whereby illness and disease is "constituted". She heavily relies on Sartre's analysis of pain and illness where he distinguishes between (1) pre-reflective sensory experience, (2) "suffered illness", (3) "disease" and (4) the "disease state" (p. 230). We find that the first and second stage is of particular interest here. At the first stage (1) according to Toombs "one first becomes aware that all is not well in the felt experience of some alien *body sensation*" (ibid). At the second stage (2), "experience becomes one that must be given *a meaning*" (p. 233). Even at this second stage, she notes that "illness" at this point is *not constituted as a particular illness*—that comes at the next level of constitution"(ibid).

[15] Importantly, any sensation is never merely a question of physiology but the meaning of sensations is culturally embedded, and mediated by social practices and symbolic systems of meaning (Howes 2003, 2005). Further, sensations are enacted and embodied through relational processes and thus important to whatever takes place concerning healing and care-seeking. As suggested by Hinton et al (2008), sensations are key sites of embodying metaphor, of memory making and of self-fashioning (2008).

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socially informed cognitive interpretation that indexes but is not itself an embodied sensation". (Hay 2008)

Semiotic signs

The socio-cultural rudiments lead us further into a situation where a human being find himself "thrown" into an intricate web of *signs* in which the medical symptom holds a prominent position. The German poet Hoelderlin even suggest that "We are a sign that is not read…".[16] Man is himself a sign which forever leaves open the possibility and process of reading. However, it is not poetry, but the academic branch of *semiotics* that will follow our dealing with this subject. Recognizing how this discipline makes itself relevant in medical affairs have previously been manifested by medical professionals such as Nessa (1996), Burnum (1993) and Malterud (2000). They acknowledge, although their professional discipline quite simply differentiates between an (objective) medical sign and a (subjective) symptom, that *semiotic signs* are of special relevance for medicine. Consequently, signs are understood, as indicated by Malterud, as "something that means something to somebody" (p. 604).[17] It is however necessary, in addition to this acknowledgement of the semiotic sign in a medical setting, to expand our focus. Accordingly, we suggest that the *medical conception of a sign* does not constitute an obvious fulcrum. The medical sign belongs to a specialized, bounded and pre-defined space of professionalism. For this reason, we should turn to a basic understanding of signs which exceeds and envelops the medical interpretation of the same. Such a continued analysis would include a contribution from Kugelman (2003). In dealing with this topic, he addresses one of those aforementioned basic phenomena constituting medically unexplained conditions, pain. With the telling title "Pain as Symptom, Pain as Sign", he emphasized how semiotics "*directs inquiry to precisely those moments, events and places within human activity where meaning is made, communicated and enacted*. This semiotic approach undercuts reified dichotomies, showing instead their social co-constitution" (p. 31). Furthermore, he explicates the threefold dimensions of the sign as it both signifies, is interpreted and point beyond itself;

> For by considering the sign, we locate our studies not at the entities that are the residues as it were of semiotic action, but at the *site* where these entities, subject and object, mind and body, sickness and health, are constituted. Pain occurs in a complex semiotic web, takes place structurally as a situation and exists through the agents who embody it in a variety of ways. Pain may be 'my private, my unknown', but it is at the same time a medium within which we share a common life.

Thus, Kugelman describes how we are integrated in a *dynamic* exchange of signs.[18] The dynamic aspect corresponds with the etymological basis of the term symptom, whereby this expression was related to descriptions such as occurrence, a happening and the verb to befall. It is therefore a potential conflict between the undisputedly dynamic character of a sign, and the medical ambition concerning a defining insistence—a deciphering and "retention" of the symptom/sign. That, which one attempts to capture, is a sign in motion. It moves, and this moving could be, as is often the case with regard to those phenomena we have discussed earlier, part of a withdrawal, into silence and "unreadability".

Archaic signals

Finally, we will briefly refer to how a psychoanalyst and philosopher such as Julia Kristeva (1994) has tried to open a landscape wherein the fixed concept symptom do not represent the center of rotation. In a ground-breaking effort to decipher those enigmas we name melancholy and depression (which by the way represents cardinal co-morbid aspects of the unexplained conditions), she addresses the humor named *sadness*. Drawn into the kingdom of affects, we are here faced with a kind of psychic representation, relating to—or arising from energetic "displacements". What is essential to our errand is how Kristeva interprets this representation as being before signs and before language. "The "sad" humor is triggered by an energetic arousal, a tension or a conflict in a psychosomatic organism" (s. 35) (our translation). She adds the following "It is reason to believe that we are here confronted with an *archaic energetic signal*…" (ibid). Although this approach differs from phenomenological and Heideggerian perspectives, the psychoanalytic conceptual framework leads us from territorializing and absorbing conceptions of health and disease—wherein the symptom holds a prominent role, and back to revitalizing and thought-provoking interpretations of human life-issues.

We admit that we have so far tried to recall and restore some basic human phenomena without providing any kind

[16] This is an excerpt from his poem "Mnemosyne".

[17] She is here referring to the Americal philospher Peirce.

[18] This point is also made by Queiroz and Merrell (2006), suggesting that "In sum, according to Peirce's pragmatic model, *semiosis*, is a triadic, dynamic, context-dependent (situated), interpreter-dependent (dialogic), materially extended (embodied) *dynamic process*. It is a social-cognitive process, not merely a static, symbolic system. It emphasizes *process* rather than *product*, *development* rather than *finality*. Peirce's emphasis rests not on content, essence, or substance, but, more properly, on *dynamics inter-relations*".

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of conceptual clarity. That is, we have not presented any alternative and defined *concepts* which have the capacity to replace or restructure the medical components which together constitute what are called medically unexplained symptoms (conditions). More accurately, so far we have not been able to come up with a correspondingly alternative to the medical term *symptom*. We have chosen to let the symptom, for necessary reasons, remain a medical symptom or 'a thing' (which is in line with our expectations for the clinical encounter). Accordingly, our ambitions have pointed in another direction. Facing a challenge such as medically unexplained symptoms, we have tried to address the basic human phenomena which somehow exist relatively unaffected by advances in medicine. This has several implications. We claim that the continuous conceptual expansions in scientific medicine contribute to a gradual loosening of its grip on and notion about the possible phenomenon it is facing. This resonates with a recognized way of thinking in science, whereby it is assumed that *the relationship between the concept and the phenomenon is such that the concept constitutes the phenomenon*. All phenomena are attacked with advanced and highly specialized terminology wherein definitions and conceptual structures represent a reassuring and guiding clarification. Through this process we experience what the French philosopher Gabriel Marcel would describe as a successful and unfortunate transformation of a mystery into a graspable problem. We grasp it 'as something' opposed to everything else. If we can't find the words for it, it does not exist. The epistemic constitutes the character of reality. The ontological is secondary to a product of and only conditional to the epistemic–linguistic, interpreted as a continuous collective practice. The 'grasping' overshadows a possible receiving. With reference to the phenomenon(a) called "medically unexplained conditions", the phenomenon has a head start, the concept strives to catch up; we are groping in the dark (Eriksen et al. 2013).

Archaism and romanticism?

At this late stage in our exposition we must however be responsive to possible doubts concerning this described returning back to the origins –to archaic moods and states. Accordingly, a crucial question arises in the aftermath of such reasoning; are we emphasizing a potentially reactionary or archaic attitude, given the unpleasant, disturbing and painful character of symptoms and the fact that we have access to presumed effective and evidence-based treatments (c.f. cognitive behavioral therapy)? We will briefly address this question in the following. First of all, we certainly do not dismiss developments in a branch such as neuroscience. We welcome all those initiatives which could provide relief for people who suffer from diverse unexplained conditions. However, we maintain what is crucial for our approach; a phenomenon such as anxiety is, and will remain, despite neuroscientific progress, an *indelible part of our humanness.*[19] Reducing anxiety to a neuromechanical matter locates this psychiatric disorder on the outskirts of human being. This is true also for the matter of pain and fatigue.

In extension of the preceding passage we choose to continue an addressing of the term *origin*, in this context, based on a possible issue such as *romanticizing*. That is, romanticizing interpreted as an elevation of potentially life-giving and health-promoting "states" such as fatigue, anxiety and melancholy (related to founding terms such as arché and ground). Assigning those mentioned "states" certain qualities, just as Maisel (2002) does in his book "the Van Gogh blues. The Creative Person's Path through depression", may possibly be correct. It is however not included in our errand to promote "positive self-development" as regards these matters. Our approach to this matter is more closely in resonance with the line of reasoning presented by a philosopher such as Alina Feld in her book "Melancholy and the otherness of God" (Feld 2011). We believe that her main message is to be found in the following passage; "A melancholy-less world is no longer a human world" (s. 194).[20]

Thus, we do not advocate that people should suffer through presumed "pioneering and progressive anxiety or melancholy". Neither do we consider people to be better off if they refrain from the benefits of scientific and technological breakthroughs in medicine. Consequently, a movement towards the "pre-disorder" foundations of appearances such as anxiety, unease, melancholy, grief, fatigue and pain holds no imperative. Instead, one should receive this whole exposition as an invitation: an invitation to the perhaps inviting nature of such human ontological conditions. Furthermore, this invitation does not reside in the competitive landscape of different interventions aimed at solving such "disorders/illnesses". It is not an alternative cure. As human ontological conditions they are inevitable, indispensable and ineradicable.

[19] A familiar line is presented by Damasio (2001) in his book "Descartes feiltakelse" (eng: Decartes' error). He emphasizes that a scientific breakthrough whereby one discover how a distinct feeling is a product of an interacting between the brain-system and body organs, *do not reduce or weaken this feelings status as a human phenomenon*. The phenomenon named love is not devaluated due to an increased understanding of the complex biological process that contributes to it (p. 15).

[20] In addition to this she emphasizes that "… melancholy is not reducible to contingent socio-cultural or psychological factors but rather is a *human ontological condition* par excellence…." (s. 192).

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Conclusion

Symptoms *constitute* the diagnostic actuality we name unexplained conditions. By the act of counting, measuring and classifying, these seemingly scattered and incomprehensible appearances are assigned character as real. Furthermore, by creating a complicated structure of primary diagnosis and unifying meta-diagnosis, one creates a world of acronyms wherein both doctors and patients can trace a possible clarifying and confident entity. We maintain and repeat that the creation of such a structure is the result of anticipated action. Medical professionals and patients need and long for such clarity. Medical researchers respond by delivering a diagnostic web that renders possible a name-giving. However, this does not imply that such a creative activity is exempted from criticism. We believe these diagnostic endeavors indicate that medical reasoning (and methodology) is facing a limit. Consequently, the medically unexplained conditions represent limit-cases, but they are handled as not-yet-resolved and obvious medical affairs. If the medical research community in the future refrains from reflecting thoroughly on the possible borders of medical reason, one will continue the producing of new artifacts and acronyms resulting in an advanced and prolonged confusion for both patients and doctors.

We suggest that one crucial element in a possible reflection regarding such a challenge, would be to return to the possible origins of symptoms. The centre of rotation in such an exploration are the following basic and self-evident facts (a) a patient is always, before he becomes a patient, a human being and (b) a symptom is always, before it becomes a symptom, an event or an experience that belongs to our humanity—our way of being-in-the-world. Man is a cultural, existential and social being before he becomes casuistry. He is thrown into a world of appearances, sensations and signs. The medical-scientific world of acronyms represented by CSS, PDD, BDD and MCS necessarily fails to accommodate the linguistic and pre-linguistic experienced world of humans. The landscape of archaic energetic signals, bodily sensations and meaningful experiences, is however not a landscape one should explore searching for ultimate answers. Consequently, these ideas represent nothing but a rich source for the birth of new questions. As such, they should be of importance to the medical professional or researcher. More decisive, they could certainly be of relevance for "common people" struggling with their daily torments and plagues. Where medicine, through advanced vocabulary, methodology and technology, lose sight of our humanness and human-like basic conditions (ontological conditions), "man" somehow forget and represses the same. This is however not an accusation. It is an invitation. To re-think and re-call that which we currently must designate *ground*. We are hereby thrown back to a possible baseline, i.e. the actual listing of symptoms usually related to unexplained conditions. Among these we find symptoms such as: loneliness, sadness/melancholy/depression, tiredness/fatigue, anxiety/dread/worry, diffuse or evident musculoskeletal pain, pessimism, lack of energy, dizziness, stomach pain, irritability, emptiness, hopelessness, difficulty concentrating and sleep problems/insomnia. Our goal has been to bring out how the aforementioned list of "events" or "states" concerns *basic human conditions – or ground conditions*. They give voice to and carry our humanness. Consequently, before such "states" are transformed into symptoms, they are encumbrances that follow with our vulnerability as human beings. The medical symptom is only a derivative of such, and this is something we tend to forget. The moods of sadness, melancholy and tristesse appear and mark the human being, before they are deciphered and labeled with the diagnosis we determine as depression. Consequently, the concept named symptom are hereby not replaced by other concepts, but are fundamentally led back and reduced to the basis/ground from whence humaneness arise.

Left with a possible opening and an invitation we could certainly refrain from any dealing with the practical medical reality—the clinic. However, we find it opportune to bring this symptomatic journey to a close with a brief comment on this issue. The previous chapters and paragraphs seemingly address the doctor as he is helpless and confused facing those mentioned unexplained challenges. Hampered by deficient communication skills, the lack of moral attitude and a decisive absence of adequate conceptual- or measuring tools, the doctor is convicted guilty. Even though we could seek support in empirical evidence for such claims, this description misses the target for several reasons. Mainly because such labels both generalizes and at the same time disregards the struggling efforts of those GPs dealing with such issues in their daily practices. Although some doctors for sure faces challenges in some of these areas, we are in doubt that the *art* of performing medicine—according to which the credible and empathetic fellow human being doctor is expected to practice, is the *only* place we should look for a necessary and renewed approach to the problem which here is named medically unexplained conditions. If the medical professional at all represents an adressee, we should first and foremost request these professionals to reflect on their *limitations*. That is, faced with unexplained "conditions" and incomprehensible symptoms, the doctor's main mandate is to apply his extensive *medical knowledge* aimed at detecting symptomatic "red flags" and take initiative to possible interventions aimed at reducing the patients discomfort and pain. Although the doctor, faced with experiences saturated with meaning and bodily sensations beyond measurement, could function as a counselor and clergyman, this is perhaps not his main obligation.

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Where this leaves future medical professionals is a question that calls upon further exploration.

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