The Place Where the Ground Gives Way:
Somatoform Disorders and the (Im)Possibility of Medical Uncertainty

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ABSTRACT

How do patient and clinician relationships with uncertainty shape the conditions of possibility in the clinic? Somatoform disorders are the phenomena in which someone is seriously ill – e.g. seizures, complex pain, paralysis – but no pathophysiological cause can be found. A multitude of competing explanations for these phenomena exist – emotional distress somatically manifested, disturbances in nervous system connectivity, etc. – and yet profound uncertainties remain. Research has historically focused on the therapeutic benefits of certainty, however, this thesis approaches uncertainty not as a cipher for ignorance, but as a flicker, a simultaneous polyphony. Based on two months of ethnographic fieldwork with clinicians and somatoform patients in a Canadian neuropsychiatric hospital, I argue that while both parties were avowedly conscious of the fundamental uncertainty of medicine, in clinical encounters they continuously enacted medicine as a regime of certainty – a term I offer to describe the social imaginary of medicine as a system that can and should provide access to certain, objective truth, making uncertainty an unacceptable clinical mode. I explore multiple potential reasons for the persistence of this regime, from patients' need to have their suffering legitimized and clinicians' anxieties about authority and efficacy to the affective associations of uncertainty. Turning to the implications, I argue that while certainty is often therapeutic in the moment, in the long-term, it may fail to hold the strange, dynamic experiences of somatoform symptoms, trapping patients and clinicians in a cycle of failure and participating in the marginalization of suffering that does not neatly correspond to organic pathology. In doing so, I ask what a medicine beyond certainty could look like and what therapeutic possibilities it might offer.

Comment les relations des patients et des clinicien.ne.s avec l'incertitude façonnent-elles les conditions de possibilité dans la clinique ? Les troubles somatoformes désignent le phénomène selon lequel une personne est gravement malade - par exemple, crises d'épilepsie, douleurs complexes, paralysie - sans qu'aucune cause physiopathologique ne puisse être identifiée. Il existe une multitude d'explications concurrentes pour ce phénomène et pourtant de profondes incertitudes subsistent. La recherche s'est historiquement concentrée sur les avantages thérapeutiques de la certitude, mais cette thèse aborde l'incertitude non pas comme un code d'ignorance, mais comme un scintillement, une polyphonie simultanée. En me basant sur deux mois de travail ethnographique sur le terrain avec des clinicien.ne.s et des patient.e.s somatoformes dans un hôpital neuropsychiatrique canadien, je soutiens que, bien que les patients et les clinicien.ne.s soient ouvertement conscients de l'incertitude fondamentale de la médecine, dans les rencontres cliniques, les deux parties ne cessent d'incarner la médecine comme un régime de certitude - un terme que je propose pour décrire un imaginaire culturel de la médecine comme un système qui peut et doit donner accès à une vérité certaine et objective, faisant de l'incertitude un mode inacceptable à habiter. J'explore les multiples raisons potentielles de la persistance de ce régime, allant du besoin des patient.e.s de voir leur souffrance légitimée jusqu'aux associations affectives de l'incertitude, en passant par les angoisses des clinicien.ne.s face à l'autorité. Je soutiens que si la certitude peut être thérapeutique à l'instant présent, à long terme, elle peut ne pas tenir compte des expériences étranges et dynamiques des symptômes somatoformes, enfermant les patient.e.s et les clinicien.ne.s dans un cycle d'échec et participant à la marginalisation d'une souffrance qui ne correspond pas exactement à une pathologie. Ce faisant, je me demande à quoi pourrait ressembler une médecine au-delà de la certitude et quelles possibilités thérapeutiques elle pourrait offrir.

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This work was completed in Tiohtiá:ke/Montreal on Kanien'kehá:ka territory and I conducted my fieldwork on other stolen lands in what is now known as Canada. As a settler scholar, I am an uninvited guest on these territories and owe my life and work to these lands.

My greatest gratitude to the patients and clinicians at 1 North, both those who feature as characters in this work and those who appear only as traces in the background thrum of thought and setting. They allowed a young ethnographer into their lives and work and without all of them this thesis would not exist; they shared their time and stories and pain with me so generously and taught me so well. Thank you.

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INTRODUCTION

Questions and answers

"My memory is getting worse. My stomach and throat are always burning. And this tremor… I gotta figure out how to get my body back. I need answers." The woman's voice is quiet and tentative, but her gaze is insistent as she turns to look at each of us in the room.

It's late afternoon, May, and I'm sitting in a cramped, sunny office, books piled on the grey carpeted floor beside the full bookcases, anatomy posters hung high on the walls. There's not enough space for the five of us – myself; the woman; a medical student; a neurology resident; and Dr. K., the psychiatrist[1] – and so I'm perched on the dark green vinyl examining table, the sun warming my back through the window as I listen intently, notebook in hand. Emma, the resident, has just spent the last three hours assessing the woman. I watched as she conducted an in-depth neurological exam, watched as the woman couldn't name the month or the prime minister; as she weakly pushed her wrists against Emma's firm hands, trying to resist, before slumping in defeat; watched her struggle to name line drawings of common objects: clock, barrel, giraffe. Now, after so many hours, we've joined K. in his office next door. With Emma's notes in his hands, he is here to give the woman her answers.

K. is leaning back in his chair, casual but confident, his attention entirely focused on the woman, seemingly oblivious to his spectators. "This has to be your nervous system," he tells her, eyes sharp. "Your brain. There's no other part of your body that this can exist in."

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[1] All names (of people and places) appearing in this thesis are pseudonyms in order to protect confidentiality – a practice that is standard in much medical anthropology writing as well as often required by ethics boards; however, it is also one that has increasingly been challenged in recent years, see Weiss and McGranahan (2021), Throop (2014). To be explicit about my own choices, I use initials, rather than the fictive first names I use for other interlocutors, to refer to the psychiatrists in order to indicate that they were the only people who went by their last names (which carry more biographical information) in the clinic. Additionally, some people, most often patients, asked me not to use any name for them at all in my writing and, as such, they appear through descriptors.

The woman looks down, adjusting her round wire-rimmed glasses, her tremor suddenly evident in the motion. She has come to K., to the clinic, because of persistent memory troubles, burning in her esophagus, and a tremor in one arm. She's desperately afraid she might have dementia or Parkinson's or ALS, but no doctor has been able to find any explanatory pathology, anything wrong at all. Every test – the MRIs, the PET scans, the ultrasounds – has come back clean and unremarkable. She has been ill for eleven years.

"Your nervous system is overreacting to threats," K. continues, gesturing with his notes, as if he wants to hand the evidence to her. "We need to calm it. Like with antihistamines. But you need psychological therapy to properly calm it down." He smiles kindly at her. "No one has tried to help you. We are here to address it. If you address it, these problems will correct."

The woman seems satisfied by K.'s explanation, by his solid gaze. With promises of follow-up, she gathers her bag and leaves. Turning to the remaining three of us, K. thanks Emma for conducting the assessment. The med student, troubled ever since Emma told her that she suspected this was a somatoform disorder, pipes up, protesting once more about the possibility of dementia. K. shakes his head, "Alzheimer's patients look to their caretakers. Functional patients will give you an answer." He sighs and looks at me, "We may only have gotten a murky picture," he gestures at the notes now spread across his desk, "but some things fit." The med student nods unhappily and follows Emma out of the room; I can hear them already debriefing the afternoon in the hall as the heavy wooden door swings slowly closed. I move to follow them, but linger for a moment against the doorframe. K., packing his briefcase, pauses and turns to me, raincoat in hand. "What did you think of your first somatoform patient?" He sounds pleased.

"How…" I hesitate. I'm not sure how to ask what I want to know. "How did you know she was a somatoform case?" *How did you turn the tangles that emerged from the interview and* *neurological exam into a cohesive story? How did you follow these symptoms, this suffering, back to her emotions instead of her myelin? Are you sure? How are you sure?*

He nods, pleased to teach. “So, for those of us that believe that the pathogen in somatoform disorders is a lack of recognition of an emotional state or an involuntary need to avoid an emotional state, by definition the patient…” he stops. “I mean you know our approach here.” His gaze drifts past me, clear eyes staring at something far away. He clears his throat. Back to me. “But I understand what you’re asking. There’s no objective means of *definitively* being correct about these conditions, right? We’re always struggling with– is this entirely voluntary? Or is it truly psychosomatic?”

“Is that difficult?”

“I think if you asked anyone, any clinician in any area, they’d say it’s anxiety provoking to not know what’s happening. And on the patient’s side there’s just this thirst to be found. I wish that we could objectively determine voluntariness…” he’s thoughtful, thinking in his pauses. “But also, I think it’s important that we sit with that uncertainty. Both for us and for them. It’s unavoidable, we have to tolerate it. And sometimes uncertainty can hold options open. That can be valuable. Like take neuropathic pain for example,” (the vague explanation he’d given the woman for the burning in her esophagus), “neuropathic pain leaves room for possibility. Maybe the hair dye did burn her all those years ago. Maybe it’s how the stress of her mother dying emerged. Or maybe she does have some chronic gastric problem. I can’t prove any of that, but we don’t need to foreclose all of those possibilities, in fact it might be better not to.”

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This thesis is an exploration of the threat and possibility of uncertainty in the clinic. It asks about how we relate to uncertainty in medicine; about what these relationships to uncertainty reveal about social imaginaries of medicine in North America; about uncertainty's potential therapeutics; and about how our relationships to uncertainty afford different possibilities for suffering, care, and recovery. It is an exploration of how relationships to uncertainty demarcate, inflect, or crack open the conditions of possibility within the clinic.

As such, this is a thesis of many questions and few answers – and the answers that I do offer tend to be hesitant, precarious, or contingent; I speculate, I wonder, I suggest. I do not aim to capture or contain the experiences I write about, but rather to step into the unsteady, uncertain currents of them. I have chosen this mode intentionally. The central object of this project is uncertainty in the clinic; I went to the field not to collect stable facts, but rather to attend to "the moments when the facts falter" (Stevenson 2014, 2), to doubt and the precarity of knowledge. As such, I am not interested in a totalizing analytic mode; I never intended to resolve uncertainty – what are somatoform disorders *really*? How should, how *must* patients and clinicians respond to uncertainty? These are not the questions I came to answer. Rather, throughout this work, I have tried to pause, to hesitate, to linger in moments of uncertainty, for it is these moments that are my object of interest, the moments where so much and so little seems possible all at once. And yet, of course, to write about uncertainty inevitably requires the writer to consider her own uncertainty – how does one write about something uncertain, something shifting and slippery with any kind of clarity? Does clarity betray the uncertainty of the object? As the historian of science Michelle Murphy writes in a reflection on her own work on uncertainty: "There is a contradiction buried deep in my methods: I [am] trying to explain a tangle clearly. In trying to be clear, I fear my narratives are too rigid and simple, leaving out much of the messiness" (2006, 15). There is an aporia[2] here. I am writing about uncertainty and, as will quickly become evident, am stubbornly curious about the (precarious, perilous) possibilities of uncertainty in medicine. However, the academic project, as it is traditionally understood, is one of understanding[3] – in these introductory paragraphs have I already betrayed my attempt to stay with uncertainty? I have endeavored to be as clear as possible in this thesis, to lay out my arguments and offerings carefully and persuasively. However, I have also attempted to render the uncertainties I encountered without resolving them. The clinic was often unsteady and confusing, beliefs and actions conflicting and colliding, stories spinning in circles. As an ethnographer I was not, am still not, outside the uncertainties that my interlocutors live and work within. And yet, an anthropologist in the clinic inevitably becomes a kind of diagnostician – this is what I witnessed, let me tell you what happened here. As such, there is a paradox in the method of this thesis – I am trying to write uncertainly about uncertainty, but in doing so, I will inexorably advance some certainties. However, while this may be a source of tension, I do not see it as one that precludes the work of this project. To attend to the possibilities of uncertainty requires one to cultivate a closeness with the contradictory. In this thesis, I explore both the threats and possibilities of uncertainty and ask how our relationships with uncertainty shape the conditions of (im)possibility in the clinic.

Between May and July of 2022, I conducted an ethnographic study of medical uncertainty in the context of somatoform disorders at a Canadian neuropsychiatric clinic – a

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[2] I choose this word carefully with an eye to both its definition as a fundamental impasse or contradiction and its meaning as a rhetorical expression of doubt. While I use it primarily for its first definition, I am very aware that I am simultaneously demonstrating its second one.

[3] This ethos, of course, has and continues to be challenged and, in the following pages, I question the correlation of certainty with knowledge; however, I believe it is important to acknowledge the motivations that brought me (and likely many others) to graduate school, to the clinic. I came to these places because I was curious; I wanted to understand a complex thing, I wanted the warm satisfaction of knowing.

place I call 1 North. Somatoform disorders are a psychiatric term for the phenomenon in which someone is seriously ill – seizures, paralysis, complex pain, blindness, tremors, cognitive problems, etc. – and yet, upon medical investigation, no pathophysiological cause can be found. No neurodegeneration, no lesion, no tumour, no virus or bacteria. There are many, often colliding, explanations for what is happening in these cases – perhaps the nervous system is miscommunicating with the body, perhaps an unidentified autoimmune disease is flaring up, perhaps trauma or psychic distress is manifesting physically. 'Somatoform disorder,' is the term favored by those who endorse the latter explanation – psychic distress appearing in the form of the body. However, there are many other terms and explanations that circulate in clinical spaces at this moment in time. Furthermore, even within theoretical paradigms, diagnosis, prognosis, and treatment remain deeply uncertain.[4] These disorders are fascinating, baffling, and contentious. A renowned patient advocate in this area has described somatoform disorders as situated at "the very place where the ground now gives way: at the collapsing scientific border between brain and mind" (FND Portal 2022). This metaphor refers to dualism, the problem so central to these disorders; however, it also aptly captures the, often terrifying and frustrating, experience of uncertainty.[5] As such, I argue that somatoform disorders are a particularly vivid context for considering medical uncertainty – it is palpably present whenever they appear. However, it is important to note that while somatoform disorders (and the patients and clinicians whose lives are structured by them) are dear to me, they are not the central object of study in this thesis. The object of this thesis is medical uncertainty – its threats and possibilities, its place in the clinic, and our relationships with it. Somatoform disorders are the strange, fertile, fraught

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[4] See chapter one for an in-depth discussion of somatoform disorders, their entangled histories and presents, and the fundamental presence of uncertainty.

[5] Ludwig Binswanger, whose writing I cite throughout this thesis, uses an almost identical metaphor to express the existential suffering of uncertainty – "or the giving way of ground beneath our feet" (1986, 82).

context for my thinking. My object and context are deeply entwined – this work would be radically different if it was situated in a different place and the few times I do offer (tentative) suggestions as to what might be done, what a more productive path may be, these are firmly grounded in the context of somatoform disorders. I care, deeply, about somatoform disorders and the particular challenges and snarls they present, about the work and stakes at 1 North; however, I do not offer any argument as to what somatoform disorders *really* are, the place they have in our culture, nor how we should understand them more broadly. I do not have any answers that would be satisfying to these questions. Rather, I use the ethnographic work I did at 1 North, the time and stories that patients and clinicians generously and continuously gave to me, to think about medical uncertainty. This work is about those patients and clinicians, about their relationships with uncertainty – but it is that uncertainty, not the disorder, that this thesis follows. As such, this thesis proceeds less like an ethnography of a particular disorder and more as an extended consideration of how relationships with medical uncertainty shape the conditions of possibility within the clinic in North America.

Thinking uncertainty

Uncertainty is a popular object of study, particularly in the twenty-first century. While I offer an in-depth discussion of scholarly approaches to medical uncertainty in chapter two, here I include a brief overview of anthropological engagements with uncertainty in order to situate my own approach – where this thesis builds on, diverges from, and conjoins with previous scholarship. While many contemporary anthropologists who study uncertainty[6] link their work back to E.E. Evans-Pritchard's work on misfortune (1976) or Mary Douglas' work on danger and

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[6] See for example Steffen, Jessen, and Jenkins (2005) or Keck (2015).

risk (Douglas 1966, Douglas 1994, Douglas and Wildavsky 1982), others have argued that the twenty-first century provides a unique context for thinking with uncertainty. For instance, in the introduction to an edited volume on anthropological studies of uncertainty that highlights the contexts of global economics, the climate crisis, and humanitarianism, Paul Rabinow and Limor Samimian-Darash argue that uncertainty is “a central problem in contemporary anthropological thought and practice” (2015, 1) and call for us to better “conceptualize uncertainty” in order to confront modern problems (2015, 4). While others have argued against the characterization of our contemporary moment as uniquely uncertain (see Di Nunzio 2015, Reynolds-Whyte 2002), anthropological work on uncertainty has flourished in the past 20 years. This work is diverse and spans a variety of subfields[7] within anthropology; however, it tends to cluster around a few themes: the ways in which new biological, technological, or social developments have produced novel uncertainties (Petryna 2015, Dumit 2000); state management of uncertainty through technology, governance, or policy (Kidron 2015, Samimian-Darash and Rabinow 2015, Stalcup 2015); and subjective or social responses to uncertainty (Petryna 2002, Dumit 2006, Reynolds-Whyte 2005, Dow Schull 2015). A well-known example that cuts across these approaches is Adriana Petryna’s *Life Exposed: Biological Citizens After Chernobyl*. In her book, Petryna asks what biomedical practices emerge in response to “novel social, economic, and somatic indeterminacies?” (2002, 6), considers how “uncertainty in scientific spheres can produce a social and political unraveling” (2002, 21), and argues that “biological citizenship,” – lay people’s mobilization of scientific and medical categories in order to gain state benefits – is a response to this context of uncertainty. Across this range of recent anthropological work,

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[7] There is a particularly strong tradition of anthropological work on uncertainty from Africanists – a tradition simultaneously critiqued as stemming from colonial imaginations of the continent and reaffirmed as a generative analytic in Cooper and Pratten’s edited volume *Ethnographies of Uncertainty in Africa* (2015).

uncertainty is generally positioned as the context for a scholarly focus on emergent technologies, subjectivities, forms of governance, or mobilizations of social resources. While this scholarship is fascinating and has helped me develop my thinking about uncertainty, my work diverges slightly from these traditional approaches. I am not writing about strategies for managing uncertainty nor subjectivities or technologies that emerge in response to it; I am interested in uncertainty itself, how patient and clinician relationships with it shape conditions of possibility within the clinic and act as a window into social imaginaries of medicine in North America.

Many studies of uncertainty either explicitly or implicitly link it with risk. This is an obvious leap in many ways; being unsure about the future seems to imply the possibility of disastrous outcomes.[8] As such, work on uncertainty, particularly responses to it, tends to focus on control and risk management. For instance, Steffen, Jessen, and Jenkins in their edited volume on uncertainty argue that "in the face of indeterminacy, people everywhere struggle to influence, even if they cannot completely control, their present and future situations" (2015, 11) and present a range of ethnographic examples of "the micro-politics of negotiation" of uncertainty. Similarly, Susan Reynolds Whyte, who has written extensively on uncertainty in healthcare contexts in Uganda, highlights "the sociality of uncertainty and control… the means of dealing with uncertainty are accessible through social relations" (2005, 247). Due to this close conflation with risk, uncertainty often becomes a corollary for crisis, for a threatening, negative state that must be urgently controlled and eliminated – or at the very least 'coped with.' This negative valence of uncertainty is both vivid and logical in Gaymon Bennett's work on engineered viruses and pandemic planning. Bennett describes the stakes of the uncertainty that his interlocutors are

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[8] Work in this tradition tends to draw on Ulrich Beck's work on risk and culture (1986) and John Dewey's work on social action as fundamentally a pragmatic means to control uncertainty (1929).

responding to as such: “What can we know about possible future pandemics by understanding the present biological conditions that might (or might not) contribute to their emergence? And assuming that we probably cannot know enough to prevent new outbreaks, can we at least learn enough to make decisions about which sequences to watch for?” (2015, 124). The stakes of uncertainty can be significant; from breast cancer prognoses (Greco 2021) to seismic planning (Zeiderman 2015), uncertainty is often a question of life or death. As such, the characterization of uncertainty as a crisis is deeply understandable – there is something terrifying about it. In this vein, I provide a comprehensive discussion of the threats of medical uncertainty to both patients and clinicians in chapter two. However, in this thesis, I do not read uncertainty as a solely negative state. A risk approach to uncertainty is a narrow one, continuously refocusing on the possibility of negative outcomes – a logical leap that seems to equate lack of control with disaster. In contrast, the approach I take to uncertainty has no automatic moral valence; uncertainty fundamentally implies that there is not a set outcome, that multiple paths, multiple realities and futures are possible. Some of these possibilities may be unwelcome, but others may be neutral or even positive. Uncertainty belongs to “a family of concepts that also includes insecurity, indeterminacy, risk, ambiguity, ambivalence, obscurity, opaqueness, invisibility, mystery, confusion, doubtfulness, skepticism, chance, possibility, subjunctivity, and hope” (Cooper and Pratten 2015, 1). Uncertainty may be threatening, but an approach that sees only its negatives obscures its foundational implication of multiplicity.

In line with this, some recent anthropological work has begun to call for productive readings of uncertainty. For instance, Cooper and Pratten’s edited volume on ethnographies of uncertainty in Africa opens by stating their approach to uncertainty: “We see uncertainty in a positive, fruitful, and productive framing. Uncertainty is not always and exclusively a problem to be faced and solved. Uncertainty is a social resource and can be used to negotiate insecurity, conduct and create relationships, and act as a source for imagining the future" (2015, 2). With this view, anthropologists have highlighted how people productively exploit uncertainty in order to escape tracking technology (Dow Schull 2015), to maintain hope of a better future even in systemically marginalized circumstances (Di Nunzio 2015), or successfully traverse the differing requirements of legal and medical systems (Dumit 2006). As Petryna argues, examining workers' responses to life after Chernobyl, "where ignorance once amounted to a form of repression... it is now used as a resource in the personal art of biosocial inclusion. Nimenko… politicized what-he-can-never-know [sic] as a means of securing his place as a scientific subject and, by extension, as an object in an official exchange relation with the state" (2002, 31). Uncertainty implies many options at once and it is possible to exploit that openness. However, it is important to note that while we may praise subaltern exploitations of uncertainty, uncertainty can also be exploited in profoundly negative ways. Scholarship, particularly in the social studies of science, has demonstrated the long history of corporations, especially tobacco and oil companies, using uncertainty in order to escape regulation, deny insurance coverage, or avoid liability (Oreskes and Conway 2011, Ceccarelli 2011, Murphy 2005, Dumit 2000). Uncertainty can be a resource that is exploited for a variety of social ends – some positive, some harmful. To use Petryna's words, uncertainty is both "a curse and a point of leverage" (2002, 28). As such, even in scholarship that focuses on the productivity of uncertainty, the generativity appears in how people choose to respond to it, in the techniques they employ and the social ties that are created in the face of it. Scholarship with this ethos has significantly influenced my thinking in regard to the dual threat and possibility of uncertainty; however, it again is not the exact approach I follow in this thesis. My focus is not on productive techniques, strategies, or responses, but on uncertainty itself.

Why am I interested in uncertainty? Why do I focus on it, on relationships with it, rather than on responses or management strategies? There are a few reasons. First, as I discuss closely in chapters one and two, uncertainty is a fundamental and unavoidable feature of medicine and especially of somatoform disorders; it structures experience, thought, and action in these contexts. As such, it deserves ethnographic attention. I expect that efforts to navigate and eliminate medical uncertainty will continue; however, in this thesis I pause and attend to uncertainty, to relationships with it. To be clear, I distinguish between ‘relationships with’ and ‘responses to’ uncertainty not because I position them as fully discrete, – in fact I argue that they are often intimately entangled; you have a negative relationship with uncertainty and so you attempt to eliminate it – but rather to indicate that I am not focusing on institutional guidelines that coach patients and clinicians on how to ‘approach’ or ‘respond to’ medical uncertainty (see Han et al. 2021 or O’Riordan et al. 2011 for examples of these). Second, I argue that uncertainty can be a generative state that offers new ways into thinking about medicine and therapeutics. I approach uncertainty not as a cipher for ignorance, but rather as a moment in which multiple possibilities simultaneously exist. I do not deny that this unstable simultaneity can be terrifying. The existential psychiatrist Ludwig Binswanger vividly describes the suffering that uncertainty can cause, writing, “in such a moment our existence actually suffers, is torn from its position in the ‘World’... Until we can again find a new firm, standing position in the world our whole Dasein moves within the meaning matrix of stumbling, sinking and falling” (1986, 81-82). However, I argue that the phenomenological difficulty of uncertainty does not foreclose its generative possibilities within medicine. As Annemarie Mol argues in her work on the multiplicity of atherosclerosis, “though nothing is sure or certain, the permanent possibility of doubt does not lead to an equally permanent threat of chaos” (2002, 181). My interest in the potential therapeutics of uncertainty directly follows scholars in both medicine and the social sciences who have argued for the benefits of ‘subjunctive medicine’ or ‘a medicine of the imagination.’ These scholars argue that ambiguity and uncertainty are essential processes for healing; they assert that healing (in any form) is fundamentally a modification of experience and thus requires an openness to possibility in order to be transformed (Hardman and Ongaro 2020, Dauphin et al. 2019, Kirmayer 2006, DelVecchio Good and Good 1994). Embracing uncertainty can thus perhaps be a therapeutic process itself or, at the very least, a part of responding to therapy. As Hardman and Ongaro argue in their manifesto for subjunctive medicine, “many aspects of the experience of illness and healing are not reducible to bodily dysfunction and its restoration: medically unexplained symptoms abound; chronic comorbidities with social determinants are common; recovery can often be achieved without physiological intervention” (2020, 1). In this context, they call for a subjunctive medicine, whose potential therapeutics they describe as such: “The subjunctive is primarily a realm of possibility… a realm in which novel configurations of ideas and relations, unentertained in ordinary indicative life, are explored and enacted” (Hardman & Ongaro 2020, 3). While uncertainty and the subjunctive are not exactly equivalent, I see an echo of the possibilities of uncertainty here. Furthermore, I am particularly interested in the possibilities of uncertainty in the context of somatoform disorders. Somatoform disorders are beset by a dualistic binary between the psychogenic and the organic – is this ‘real,’ in your body, or is it ‘fake,’ in your mind? Even the most thoughtful care that rejects dualism (as 1 North attempted to) often becomes stuck in these binary registers and the constricting moral possibilities they imply. In this thesis, I suggest that the need for a stable answer, for certainty, perpetuates the trap of this dichotomy. Uncertainty implies the simultaneous existence of multiple possibilities at once – maybe the burning in your stomach was caused by a chemical burn; maybe it is your body communicating your furious, lonely, heartbreak at the loss of your mother when language cannot; maybe, through epigenetics, your diet and stressful lifestyle has interacted with your genes and your gastric lining is perpetually inflamed through an autoimmune response. With uncertainty, all of these possibilities exist at once. As such, uncertainty may provide pragmatic therapeutic possibilities both by avoiding the constricting implications of a need for certainty and as an open, transformative, therapeutic mode in itself. K. demonstrates this therapeutic value of uncertainty in the opening scene of this chapter,[9] by focusing on neuropathic pain, he sidesteps the etiological question (is the origin of your suffering physiological or psychic), avoiding the moral implications and leaving multiple paths for recovery open (psychotropic medication, diet change, psychotherapy). Uncertainty may be threatening, but, by rejecting the need for a solid, stable explanation to proceed therapeutic endeavours and allowing healing to occur in mysterious or ambiguous ways (as it so often does), it also may offer possibilities within medicine. As such, in this thesis I attend to both the threats and possibilities of uncertainty within the clinic.

Key to this approach is my conceptualization of uncertainty. I approach uncertainty not as solely the absence of knowledge; it is not only a *not,* it is a *maybe* – multiple possibilities (both negative and positive) entwining and entangling, moving into sight and then out of view. I conceptualize uncertainty as a *flicker*, a simultaneous, if precarious, polyphony. My use of the

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[9] Although, it's important to note that, while he is explicit about this with me, he emphasizes certainty with the woman: "This has to be your nervous system, Your brain. There's no other part of your body that this can exist in." This disjunction will be essential to my thinking in this thesis – see chapter two in particular.

term *flicker* is an instance of convergent evolution, developed independently and then encouraged and elaborated through the ways in which João Biehl utilizes the term in his work on insurgent archiving. Biehl's use of the term comes via Walter Benjamin and Georges Didi-Hubermann; utilizing the image of fireflies, he argues that "oikography (home imprinting)," a type of archiving he is interested in, "promises us a *flickering* that sustains the possibility of both familiar and alien ventures, a dialectic proper to healing itself" (2022, S6, emphasis added). Biehl describes these insurgent archiving practices, including modes of healing, as engendering a particular type of openness, a "fragile multiplicity resisting foreclosures" (2022, S15), a movement that acts as "a means of imagining through and beyond the specter of extinction" (2022, S5). This is what I see in uncertainty. I do not read uncertainty as an antithesis to knowledge, curiosity, or understanding, only to the rigidness, the *only this* of certainty. I am not naive to the comforts of certainty and the stability it provides; however, I argue that, particularly in the context of medicine, the simultaneity of uncertainty can be vital and valuable. As such, in this work I conceptualize uncertainty as a *flicker* in order to highlight the multiplicity, the quick movement between possibilities, the precarious and yet stubborn openness that it offers.

While my thinking has been significantly shaped by the traditions of anthropological work on uncertainty I have outlined above, the scholars who have most profoundly influenced this work, who I am trying to be in conversation with, do not necessarily classify themselves as studying uncertainty. Rather, they work on a variety of topics from relations with the dead (Despret 2021) and hesitation (Al-Saji 2014) to spectres of violence (Desjarlais and Habrih 2021), archiving practices (Biehl 2022), and ontology and multiplicity within the clinic (Mol 2002). What connects these scholars, what has led me to them, is their interest (indexed through a variety of terms) in the uncertain and ephemeral. Desjarlais and Habrih, in their work on traces of violence in Paris, argue that rather than trying to stabilize, trying to know fixedly, “perhaps one needs to endure the aporias without trying to solve or banish them, or extinguish or efface the paradoxes and paroxyms involved, even if one comes out haunted by them… Can one cultivate a certain passion for the impossible, for hesitation and uncertainty?” (2022, 57). It is this passion that draws my work here forward. In my fascination with somatoform disorders, with the twisted strands that are so often polarized (this is entirely psychological, this is entirely physiological) or regarded as an interminable blockage (this is too difficult to engage with), I became less convinced that uncertainty was the aporia that so much research positions it as. I came to think of uncertainty less as a crisis of ignorance and more in line with how the philosopher Alia Al-Saji approaches hesitation – “A search without finality or teleology, an experimentation that does not dictate the future it will find” (2014, 143). To Al-Saji, hesitation is a powerful technique in interrupting racialized ways of seeing for it requires us to pause, to suspend judgment and “be open to a futurity that escapes prediction” (2014, 148). Similarly, I have come to see uncertainty as a radical response to the drive towards objectivity and control.

In this vein, these scholars’ interest in the spectral; in the play between visibility and invisibility; in the ways moving, slippery things can have force has been instructive for me. For instance, in Desjarlais and Habrih’s work on the entwined aftermaths of terrorist, colonial, and police violence, they oscillate back and forth between presence and absence, highlighting the ways traces “shimmer like mirages within the fissures of Paris, a place where present, past, and future waver” (2022, xxi). This approach reflects what I find so entrancing, fascinating, and maddening about uncertainty – it is in motion, flickering back and forth between possibilities that appear then disappear. I am continuously drawn back to this simultaneity even, perhaps especially, when it implies “the coexistence of the two contradictory versions” (Despret 2020, 26). Uncertainty is motion trapped in a moment, it does not settle into a set, clearly defined path. Uncertainty makes for unstable ground and yet, in this flicker, it refuses to become a terministic screen[10] – it opens a less stable, less secure world but also a less rigid and reductive one. This flickering simultaneity is aptly captured by Vinciane Despret in her work on relationships with the dead. Considering how people talk about experiences with the dead, – "it was as if [my aunt] was sending me a message of calm" (2020, 120) – Despret argues that this hedging, hesitating, uncertain language is not a weakness, but rather indicates a remarkable simultaneity: "this would be one of the roles of the 'as if,' one particular mode of operation: to keep the vacillating space open and to protect the enigma. So 'as if' is a lever that opens possibilities. It doesn't step back to interpret… it is a semantic device that makes it possible to affirm and actively maintain several possibilities; 'it could be; it may not be'" (2020, 124). Despret argues that these subjunctive linguistic markers allow people to act in contexts that they intellectually believe are impossible (a dead aunt speaking to you) and that they do so by injecting motion, "inflections, vacillations, flips, restarts" (2020 120), a motion that rejects the need for singular answers, "[as if] keeps the enigma open. It is its caretaker" (2020, 123). Despret's argument about the value of resisting closure and the role of motion in sustaining coexisting, even conflicting, possibilities has been instrumental to my thinking. There is a vitality, a multiplicity in uncertainty that is threatening and frightening but also unfurling.

With these scholars in mind, my interest in the possibilities of uncertainty is two-fold. I am curious about the possibilities of uncertainty because I suspect that simultaneity and

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[10] This concept comes from rhetorical theory, specifically the twentieth-century rhetorical theorist Kenneth Burke who argues, in words that any student of rhetoric can recite on demand, "even if any given terminology is a reflection of reality, by its very nature as a terminology it must be a selection of reality; and to this extent it must function also as a deflection of reality" (1966, 45).

multiplicity can be pragmatically therapeutic in the context of somatoform disorders.[11] The postcolonial philosopher Édouard Glissant, in his work on the right to opacity, argues that the Western need for 'transparency' is inevitably a reductive one, "a gesture of enclosure" (192). Similarly, I am suspicious that certainty as a therapeutic ethos reduces possibilities and, in doing so, can marginalize any suffering that does not neatly correspond to visible, organic pathophysiology. As such, following scholars working on subjunctive medicine, I am curious about the therapeutics of uncertainty. Additionally, turning from the therapeutic to the theoretical, I also suggest that the flickering nature of uncertainty can challenge hegemonic, totalizing, analytical impulses within medicine and scholarship on it. I approach the flicker of uncertainty as a place, a moment, that resists the overwhelming analytical gravity of definite, settled explanation in science and medicine. I suggest that treating uncertainty as a legitimate ethnographic object can productively unsteady our fierce fidelity to objectivity and open space for the unfinished, the interstitial, and the opaque.

Being at 1 North

While my object of study is uncertainty, the context is essential. These thoughts come from places. I conducted the fieldwork that this thesis is based upon at a neuropsychiatric clinic I call 1 North. The program is a tertiary adult unit; their mandate is to diagnose and treat adults with "brain illnesses" from classic psychiatric disorders such as depression, schizophrenia, and bipolar disorder to traumatic brain injuries, strokes, and diseases such as Parkinson's, Huntington's, or Tourette's. They also specialize in somatoform disorders.[12] The clinic is situated within a larger university hospital in a major Canadian city and includes both in-patient

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[11] See chapter two for an in-depth discussion of these potential therapeutics.

[12] See chapter one for a detailed discussion of 1 North's understanding of and approach to somatoform disorders.

– the program has a 10-bed ward that provides assessment and treatment for complex patients – and out-patient services. The program is staffed by a small group of neuropsychiatrists who take turns rotating through the in-patient program – rotations last two months long. As such, while all the psychiatrists work with out-patients year-round, only two at a time are ever present on the in-patient ward. Other staff members at the program include an occupational therapist, a social worker, a neuropsychologist, and many nurses – all of whom work the in-patient unit year-round.

In terms of my own daily activities, I came to the program attached primarily to one neuropsychiatrist, a clinician I call Dr. B. B. is soft-spoken, but sharp and curious. Unfailingly polite and calm, he is a practiced and attentive teacher and was an intensely generous guide throughout my time at 1 North. Shadowing B. was the primary basis of my fieldwork; each morning I accompanied him on his in-patient rounds, meetings with the clinical team, and out-patient appointments (if they were somatoform in nature). I shadowed him throughout his entire in-patient rotation, beginning on his first day on the ward and ending on his last. For much of this time, I was not the only person accompanying him; a variety of residents and fellows continuously cycle through the program, generally on one-month rotations. As such, while there were some weeks that I accompanied B. by myself, there were often one or two residents or fellows as well – the small group of us entering rooms after him and standing against the wall as he chatted with patients. Due to our similar level of status, I spent significant amounts of time with these residents and fellows – during quiet moments in the break room or shadowing them as they conducted solo assessments or evaluations. Additionally, I also spent time shadowing Dr. K., the other neuropsychiatrist on rotation during the first half of my fieldwork (neuropsychiatrist rotation schedules are staggered for continuity of care). K. is tall and gregarious, a demanding and active teacher to whom the residents flock easily. With a particular interest in somatoform disorders, he welcomed me warmly, inviting me to observe assessments and answering my questions thoughtfully. I spent many afternoons shadowing his residents as they conducted three to four hour long assessments of suspected somatoform patients – a process that generally included taking a personal history, a history of the present illness, and conducting a neurological exam, – followed by a formulation meeting where K. would review the findings and offer an explanation and plan of action to the patient.[13] K. and B. were the two clinicians I spent the most sustained time with and, as such, they repeatedly appear as characters throughout this thesis. However, there were many other clinicians – residents, staff, neuropsychiatrists not working the in-patient ward – who offered their time to me as I shadowed them for an afternoon, interviewed them, or followed them down the hall asking questions. Over the two months I spent at 1 North, I observed team meetings, weekly radiology and neuropsychiatry rounds, assessments, formulation meetings with patients, daily meetings with in-patients during rounds, and follow-up meetings with out-patients. In addition, I also conducted seven interviews – four with clinicians and three with suspected somatoform patients. While many of the figures central to my thinking are traditional ethnographic subjects (I spent days or weeks with them, participating in their work and lives in the clinic), others are flashes, people who appeared for an hour or an afternoon and then disappeared again. While this briefness contradicts the length and depth of the ethnographic ethos, I include them as legitimate and essential sources of ethnographic knowledge for they reflect the rhythms and practices of Western allopathic medicine; occasionally patients and clinicians spend sustained time together, but much more often they intersect for just a moment. Furthermore, despite the fleeting shared time, these encounters have profound effects on both parties as diagnosis, treatment, and prognosis are elicited, offered, and navigated.

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[13] The scene that this introduction opens with is an example of a formulation meeting following an assessment.

1 North is not a standard psychiatric setting. It is a tertiary program that deals with complex cases and thus requires a referral to be accepted as either an in-patient or an out-patient. Patients often wait for months, if not years, to see clinicians at the program and, therefore, are generally very eager to be there. Some in-patients I met were ‘certified,’ they could not choose to leave; however, this was a minority of patients and even then the clinicians were eager to get them functioning well enough to move to community mental health teams. The majority of in-patients could come and go as they pleased and were generally encouraged to leave on the weekends, to return to their homes or visit family and friends. Patients’ rooms often seemed more like small, worn hotel rooms (large windows, no medical equipment in sight) and the atmosphere of the ward was calm and friendly. The staff tended to be warm to each other, supportive of their colleagues’ endeavors and familiar with the details of each other’s lives. The wood-paneled hallways were quiet and clean; laminated posters, pamphlets, and tips pinned at regular bulletin boards – “how to get walking!” “Stress management strategies,” puns with clip art – and the classic cheerful and technically competent hospital art arranged in seemingly random configuration on the walls (flowers, landscapes, abstracts all sharing space). However, this is not to say that 1 North was a universally pleasant and easy place. Despite the collegiality, there were consistent, if quiet, undercurrents of tension between the psychiatrists who cycled through the in-patient unit for two months at a time, working Monday-Friday, 9AM-5PM, and the chronically understaffed nurses who worked 12-hour shifts. There was always something to do and rarely enough people to do it – I often watched as the floors were mopped[14] while people stood on them; all of us in the room moving a step to the left and then a step to the right.

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[14] Generally, by racialized workers who had even less autonomy in their work than the nurses did.

Furthermore, while most encounters I witnessed between patients and psychiatrists were thoughtful and calm – the clinicians cared deeply about their patients and wanted to help them recover even when they clashed with them personally – there were spectres of violence that appeared at the corners of my vision. The first day, as B. shook my hand and walked me down the hall to his office, he told me how the building used to be part of the asylum system. I remembered this history as, throughout my fieldwork, "code whites" (indicate a violent patient who needs to be subdued) echoed over the intercom from other programs in the same building. Furthermore, one day I arrived at the nurses' station and was unpleasantly surprised to see the screens which usually showed CCTV footage of the atrium displaying a small bare room with a young man curled up asleep on a mat on the floor. From the nurses' talk, I realized this was a patient from another ward who had been put in confinement. Despite the generally warm atmosphere, 1 North was not as separate from traditional psychiatric settings, with all of the violence and confinement they often imply, as it seemed.

Furthermore, while 1 North has porous borders compared to many psychiatric settings, it often felt like cut-off from the rest of the world. My focus was on the clinic, on how relationships with uncertainty shaped the conditions of possibility in that space, and as such I did not follow my interlocutors outside of that context. Additionally, despite the personal challenges that patients brought in, the stories they told me – of wandering up and down a highway in the middle of the night, trying to escape a buzzing noise; of disbelieving partners and estranged children; of falling headfirst into a glass display case at work and the disappearance of vision that followed – I found it strangely difficult to remember that this clinical world was a part of the wider one. For instance, the Dobbs v. Jackson[15] decision arrived during my fieldwork and, while

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[15] The U.S. supreme court decision that struck down Roe v. Wade and has widely imperiled abortion rights.

I had been miserably reading news coverage on the bus that morning, I was momentarily startled and confused when a patient and psychiatrist discussed it during rounds – it was as if, when I crossed the atrium (full of plants and fake brick), I was crossing a threshold into another world.

An ethnographer in the clinic

I was nervous about my presence in the clinic. Perhaps these are the nerves of every new ethnographer, but it often felt like so much to ask to be a part of such vulnerable moments. To echo Annemarie Mol's words about being in the clinic, "I found these observations rather intimate. Patients tell about so much and undress so often" (2002, 2). However, just as many clinical ethnographers before me have discovered, it is not an unusual thing to be an observer in a hospital. Rooms are generally filled with people – at least one, if not multiple, senior doctors; residents; fellows; med students; nurses. There's always someone who needs to learn, who has an additional perspective to offer. As such, patients tended to be curious but welcoming when a clinician introduced me as an anthropologist and they often asked me about my research while we waited for a chart or person to arrive. I am endlessly grateful for their generosity in this regard. The only two times patients were uncomfortable with my presence was due not to my role as anthropologist, but rather my identity as a young woman. In both cases, they were middle aged men who were uncomfortable discussing sexual matters in front of me and I left the room. In contrast, the clinicians, particularly the nurses, were often more suspicious of my presence – unsure whether I was evaluating them or what I was allowed to have access to. However, after explanations from the neuropsychiatrists and my continued presence, they tolerated me and treated me as one of the many students cycling through the program. The psychiatrists, perhaps due to the advantage of having read a proposal of my work, tended to be more open (although a few declined to speak with me for various reasons). I initially worried about how to explain clinical ethnography to them, how to account for myself; however, on my first day I noticed that both B. and K. had copies of Tanya Luhrmann's ethnography of psychiatrists, *Of Two Minds,* in their offices. Anthropology and psychiatry were not as strange to each other as I had worried.

Rather than standing out, I eventually came to be concerned about my ability to blend in. After the first week, staff often confused me for a resident or a med student – understandably, given that I traveled with them and was vaguely the right age and appearance (no one except the nurses at 1 North wore scrubs and so jeans and sweaters placed me within the class of clinical trainee). This was not a dire issue; I always reiterated my role when I observed or interviewed a clinician and I was fine to let most of them view me as an unusually quiet and inept resident. However, despite clinicians always initially introducing me as a medical anthropologist doing a research project, I noticed how I slowly became a member of the clinical team to patients. The somatoform patients, the ones I knew best, I think understood me to be separate from 1 North; I spent time with them one on one and asked very different questions than their doctors did. However, one day as I was walking down the hall to meet a resident, a patient who I had seen on rounds for multiple weeks stopped me and asked a question about his medication. When I reminded him I was an anthropologist not a resident, he laughed and said that that sounded vaguely familiar. Furthermore, despite my efforts to distinguish myself from the clinicians, my affiliation with 1 North facilitated my access to patients. While I did not confirm if I had interviewed a patient, their clinicians often knew if I had asked someone to participate as they were the ones who had introduced me. Despite these moments of discomfort, patients and clinicians were generally exceedingly generous with their time and I came to know and like them to an extent that often surprised me. Patients repeatedly thanked me (for what I was never sure) when they left the hospital and wished me luck with my work. Both patients and clinicians were not only generous, even when I'm sure my presence added work to their days, but also kind to me. I was very aware throughout my time at 1 North that I was generally the least experienced person in the room. Somatoform patients are long-term patients and thus were far more familiar with the rhythms and languages of the clinic than I was and even the medical students who accompanied us occasionally were at least in their second or third year. Despite the theory and reading I brought with me, and the time I had spent working in psychiatric contexts in the past, I was generally the newest newcomer in a strange place.

Map

In this thesis, I attend to medical uncertainty in the context of somatoform disorders, to patient and clinician relationships with it, in order to explore how this shapes the conditions of possibility within the clinic. Throughout, I remain attentive to both the threats and possibilities of medical uncertainty – the stress it causes and the openings it offers, both therapeutically and theoretically. Chapter one dives into somatoform disorders, tracing their diverging and converging histories. I do not offer my own analysis of their ontological basis, but rather argue that, across interpretations, they are characterized by a persistent uncertainty that is fundamental to the clinical experience for both patients and clinicians. Thus, I argue that they are a generative context in which to study medical uncertainty. In this chapter, I also include an in-depth discussion of how somatoform disorders are experienced at 1 North, focusing on how uncertainties in diagnosis, prognosis, and treatment persist despite the declared theoretical solidity of the program's model. Chapter two moves into the clinical encounter, considering scholarship on medical uncertainty specifically as I explore two central ethnographic scenes between a somatoform patient I call Charlie and the neuropsychiatrist B. I argue that while patients and clinicians are both avowedly conscious of the fundamental presence and even utility of uncertainty within medicine, in the clinical encounter, both parties tend to enact medicine as a *regime of certainty* – a term I offer to describe a social imaginary of medicine as a system that can and should provide access to stable, objective truth. I explore the roots and implications of this insistence on certainty and suggest that while certainty may be therapeutic in the short term, over time it may not be able to hold the strange experiences of somatoform disorders, thus trapping patients and clinicians in a cycle of failure as they continuously strive for an impossible certainty. In this chapter, I also explore the potential therapeutics of uncertainty – drawing on my ethnography at 1 North as well as movements elsewhere. In chapter three, I turn my attention to the disjunction between patients' and clinicians' acknowledged acceptance of uncertainty with me and their refusal to tolerate it with each other. I linger with one scene between myself and a somatoform patient I call David, drawing on affect theory to examine certainty and uncertainty as objects that travel with culturally mediated affective associations. I argue that, in North America, certainty functions as a happy object, promising a path to the clinical good life and thus uncertainty is viewed as a fundamental source of unhappiness. I end this chapter by considering how affect shapes the conditions of possibility within the clinic and how we can engage with its, often naturalized, structuring effects. Finally, I conclude with a consideration of what a medicine not structured by certainty, might look like, the places and moments it already exists, and what it might offer. Uncertainty is a shifting, slippery, moving thing. And yet, it is in this movement, in this flicker, that both its threats and its possibilities lay. Why does uncertainty feel so threatening in the clinic? What does it make possible? How are orientations to uncertainty in medicine sustained and replicated? And what happens in the breaches where uncertainty surges through?

CHAPTER 1 – The Debris Field

What is this thing we call a somatoform disorder?

The exam room is small and sweltering. I am tucked between the end of the papered examining table and the door, my knees aching from sitting on a stool, unmoving, for the past three and a half hours, but I'm not tired – I'm watching. There's a man sitting in front of the room's one window and Liam – a neurology resident at 1 North, curly-haired and boyish yet quietly authoritative – questions him intently. The man's back is to the window, silhouetting him even though I'm no more than three feet away in this clean, cramped room. Despite the shadows, I can see him, see his body. He's middle-aged with spiky hair and a loud voice; his answers to questions often seem like angry shouts and as he speaks he twitches, his upper body spasming every few minutes. The man tells us that he has been having uncontrollable muscle spasms, hand tremors, non-epileptic seizures, and terrible, chronic, "rotting," back pain for the past 10 years. He's in pain. While Liam stares down at the paper he is taking notes on, only occasionally looking at the patient, I linger on the man, loathe to look away. From the corner, I watch as he winces, grabbing his knee or elbow roughly, over and over again; pain seemingly appearing and disappearing like waves breaking and ebbing across his body. No doctor has been able to find any reason for why his muscles are spasming and nothing has lessened his pain – not medication, not 12 nerve blocks, not physiotherapy. Eventually, as out the window the sun begins to drift downward, smudged amongst thin clouds, Liam looks up and, rolling his chair closer to the man, begins a neurological exam – "I'm going to run my fingers down the sides of your face… does it feel the same on both sides?"; "If you have $10 and buy an apple for $2.75, how much is left?"; "Can you walk, heel to toe, across the room for me?"; "Okay, I'm going to try and pull your arm down – resist me." I watch as the man struggles to comply, trembling as Liam manipulates his body in different ways. Finally, after these long afternoon hours of verbal and bodily information, we are done and the man leaves the room. The door clicks shut and there is a moment of still, warm silence. Then Liam swivels in his chair to look at me, inviting my presence to return to the relational, "So, Dr. K. was right. No one's found anything over the years, those deficits don't follow the patterns of the body, and that tremor was distractible. Looks like we've got a somatoform disorder."

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This object of this thesis is medical uncertainty, however, it is fundamentally grounded in the context of somatoform disorders. As such, it is important to begin on shared ground. This chapter attempts to answer the questions: what does the terminology 'somatoform disorder' refer to? What other histories and contemporary conundrums are these disorders linked to? And why are they relevant to a study of medical uncertainty? These questions are simultaneously simpler and more complex than one might expect. While few people recognize the term 'somatoform disorder,' most are familiar with the concept – someone is seriously ill and yet, upon medical investigation, no pathophysiological cause can be found. This definition I've offered is fairly straightforward; however, throughout the chapter I have made decisions – about terminology, about gathering together certain stories, about causality or lack thereof – that others studying these phenomena would vehemently disagree with.[16] Furthermore, in this chapter I mobilize a descriptive, rather than interpretive, mode. This thesis does not proceed under "the shadow of discursive certainties—ways of knowing and acting in the world that keep doubt or uncertainty

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[16] The fact that I am intentionally broad, theorizing across a variety of terminology, each with their own historical and moral connotations, is particularly contentious and I doubt this chapter will please clinicians or patients who have dedicated themselves to any one of these specific disorders (chronic Lyme disease, FND, CFS/ME, etc.) or scholars who have been raised in a tradition of psychoanalysis and thus tend to approach the body as a site of social inscription and a communicative tool that exceeds itself.

from emerging" (Stevenson 2014, 2) nor is it trying to establish them. Rather, in this chapter, I argue that these phenomena, which I refer to as somatoform disorders, are a generative site in which to think with medical uncertainty because they, historically and contemporarily, are structured (or perhaps unstructured) by uncertainty.

It is important to be clear about my objectives in this chapter. I hope to provide a necessary and helpful grounding for my work, to situate the uncertain snarl I am interested in within its relevant histories and persuade the reader about the appropriateness of this context (somatoform disorders) for my object of study (relationships with uncertainty in the clinic). I am not making any argument about what somatoform disorders 'really' are. Despite its centrality in so much scholarship, I, in many ways, find the least interesting question about these disorders to be the ontological one. Rather, following Michelle Murphy's work on multiple chemical sensitivity, I proceed with the approach that circumstances surrounding these disorders "cannot be adequately understood by answering the question, 'Is it real or not?'" (Murphy 2006, 18). As such, I am not attempting to present a unified theory of these phenomena; rather, in this chapter, I walk through the historical, nosological, and political *debris field* that the entity I call somatoform disorders exists within – a field littered with differing terminology, explanatory theories, and taxonomies – in order to attend to the pervasive presence of uncertainty. I am interested in patient and clinician relationships with uncertainty, relationships that become vivid as they encounter these fraught, contested disorders. This is not a story about what somatoform disorders *really* are, whether they are caused by psychic distress, complex neuronal patterns, or political unrest; it is a story about what happens in small white rooms, in wood paneled corridors, between tables and counters, when people are not sure. It is a story about the simultaneous threat and possibility of uncertainty in the clinic. As such, this chapter is not a Rosetta stone, but a map – a place to go forward from.

In this chapter, I situate the arguments and observations that will follow, outlining the context and history necessary to accompany the theoretical and ethnographic work that this thesis does. I begin with a brief history of somatoform disorders, linking the term to the others it has evolved from, diverged from, and is entangled with. This history is intentionally shallow, attempting to highlight the multiplicity of heterogenous positions, rather than elucidate the complexities and implications of each individual one. I mobilize this historical record in order to orient a reader and attend to the stakes of my context. With these fracturing and diverging histories in mind, I then explore how uncertainty is inherent across interpretations of these disorders before briefly outlining anthropological engagements with this topic. Shifting from the general to the specific, I then conduct an in-depth examination of 1 North's understanding and approach to somatoform disorders (the ideology that unites the clinicians' approaches as well as the many multiplicities and contradictions that exist within it), including an exploration of how uncertainty appears in practice in the clinic. This chapter thus introduces the context of my thesis, first broadly and then specifically in the place and time that my research was conducted.

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A quick note on terminology. Throughout the chapter there is a proliferation of language for these phenomena – hysteria, conversion disorder, psychogenic, psychosomatic, medically unexplained symptoms (MUS), somatization, somatic symptom disorders, functional illnesses. Whether these terms can be used interchangeably is hotly contested – each tends to be associated with variations in technical, metaphorical, and rhetorical meaning – and I do not present them together in order to argue that they all refer to the exact same underlying illness entity; I present them because I hope to illustrate the uncertainty foundational in the plural, unsettled histories of these phenomena. As for my own terminology, I use ‘somatoform disorders’ (a rare and unpopular choice) not because I believe it is the most elegant, but rather because it is the language that my field site uses and is professionally committed to. I use the term because it is accurate to the experiences I am trying to think with.

Histories

‘Somatoform’ is a Frankenstein term, an etymological conjoining of Latin and Greek that literally means ‘in the shape of the body’ (Scamvougeras & Howard 2020). While I begin with somatoform disorders, a strict history of the term is not particularly revealing – its temporal range has been brief. First appearing officially in 1980 in DSM-III (Diagnostic and Statistical Manual of Mental Disorders, third edition) as part of a general effort to phase out psychoanalytic concepts and move towards syndromes whose biological basis would, assumingly, eventually be discovered, the category of somatoform disorders was defined as: “Physical symptoms suggesting physical disorder… for which there are no demonstrable organic findings or known physiological mechanisms and for which there is positive evidence, or a strong presumption, that the symptoms are linked to psychological factors or conflicts” (American Psychiatric Association 1980, 241). At this time, the category was then subdivided into somatization disorder, conversion disorder, psychogenic pain disorder, and hypochondriasis, each referencing specific variants of the concept. While the sub-categories shifted, ‘somatoform disorders’ was preserved as a category in DSM-IV (1994) and its revisions; however, by 2013 and DSM-5 it was gone, replaced with ‘somatic symptom disorder’ (American Psychiatric Association, 2013). DSM editions are an easy way to mark history, but they offer a limited picture. To understand the stakes of somatoform disorders, one must look farther back for, as the architects of the diagnosis in DSM-III clearly state, “traditionally, these disorders have been lumped as ‘hysteria’” (Hyler & Sussman 1984, 469).

Hysteria, first defined as mysterious symptoms etiologically linked to the uterus, is traditionally traced back first to ancient Egypt and then ancient Greece where it was formally recorded in Hippocrates’ writing (Veith 1965, Porter 1993, Scamvougeras & Howard 2020). However, others, most prominently the medical historian Helen King, have argued that this historiography is in actuality based upon mistranslation and no individual term for a variety of vague and mysterious illnesses connected to the uterus exists in the Hippocratic corpus (King 1993). To this end, King has argued that the classical view of hysteria is in fact an invention of nineteenth century doctors, translators, and texts in conversation with one another (1993). This contested beginning is not unusual for hysteria nor for the entities that have evolved from it; historians of medicine have written multiple comprehensive and yet profoundly divergent histories of hysteria – see Szasz (1961), Veith (1965), Shorter (1992), Showalter (1997), or Micale (2019). Roy Porter, the eminent medical historian, summarizes the situation as such: “We should expect not a single, unbroken narrative but scatters of occurrences: histories of hysterias” (1993, 226). This plurality makes any synthesis troublesome; however, my goal here is not to provide a unified history, but rather attend to the divergences, for I argue that it is here that the persistent and pervasive uncertainty of these phenomena becomes visible.

Let us return to these multiple, fractured histories. While English physician-scholars such as Thomas Willis and Thomas Sydenham theorized that hysteria might be neurological as early as the 1600s, its conception as a gynecological condition persisted for the next two hundred years. As such, the primary source of the nervous, neurological, and psychic associations of hysteria come from Europe in the nineteenth century, the “epicenter of the history of hysteria” (Porter 1993). Over the course of the nineteenth century, a series of figures transformed hysteria. The first was Jean Martin Charcot (1825-1893), the renowned French neurologist who both popularized the idea of hysteria as a unified organic condition – he famously declared “‘l’hystérie a toujours existé, en tous lieux et en tous temps’” (Porter 1993, 231) – and made the condition far more visible than it ever had been before. Charcot transformed hysteria from a gynecological condition into a neurological illness resulting from “a hereditary defect or traumatic wound in the central nervous system” (Showalter 1997, 30). Charcot, an “ardent neurologist” driven by his “urge to reduce neurological chaos,” was committed to an anatomical model of hysteria and yet he remains most well-known for his (perhaps collaborative, perhaps exploitative) performances of hysteria (Porter 1993, 257). In his clinic at the Salpêtrière in Paris, Charcot put on spectacular and sensational performances with female hysteric patients, publicly hypnotizing them and causing them to have hysterical attacks. In his study of the reciprocal entanglements of hysteria and images, Georges Didi-Hubermann describes these ‘Tuesday lectures,’ as such: “Three or four choreatic or hysterical women would be brought into the amphitheater, bedecked despite themselves in feathered hats, the discussions and measurements thus following a colorful shudder… a ‘queen of the hysterics’ swooning—no, in contortions, her neck bared to the staring assistants” (2003, 238). Charcot redefined hysteria, but also made it a spectacle. He proposed stages of hysteria, attempted to link specific symptoms to different bodily regions, and left a legacy of case reports, photographs, and theories. As such, Charcot is often considered to be the beginning of modern medicine’s fascination with hysteria. However, while his neurological model is once again becoming popular (see the end of this section), it was his student, Freud, who most profoundly shaped our contemporary conceptions of hysteria.

Sigmund Freud (1856-1939) was briefly a student at the Salpêtrière; however, while he took with him a profound and lasting interest in hysteria, for him hysteria was fundamentally psychological, caused by repression rather than organic lesions in the nervous system. Freud was inspired by the theory of hysteria that Pierre Janet (1859-1947), another of Charcot's students, proposed which centered the roles of suggestion and dissociation. Building on this psychological pivot and in collaboration with Joseph Breuer – see *Studies on Hysteria* (1895) – Freud proposed that hysteria was caused by trauma, particularly "disturbing sexual experiences patients had repressed, thus creating symptoms through a process of symbolization… The memories were then banned from consciousness and converted into bodily symptoms that were 'mnemonic symbols' or physical metaphors of the suppressed trauma" (Showalter 1997, 38). For instance, for Freud, a paralyzed leg was not an indication of a hidden brain lesion, but rather the symbolic somatic manifestation of the psychic trauma of a beloved father's death from an infected abscess in his leg. While Freud cycled through a variety of specific etiological theories of hysteria over the course of his career (childhood sexual abuse, oedipal conflicts, etc.), his psychological paradigm spread widely through popular case studies of hysteric women such as Anna O. and Dora. Key to Freud's model was 'conversion,' the process by which psychic distress becomes physical symptoms. While Freud was classically vague about conversion – "the leap from a mental process to a somatic innervation… which can never be fully comprehensible to us" (Freud 1909, 157) – the concept flourished and the diagnosis 'conversion disorder,' as well as the term 'somatization' (tendency to express mental states as physical symptoms) remain in use today. Due to Freud, strange physical symptoms with no clear cause became intimately linked with psychic distress. As such, Freud’s theoretical empire birthed the conception of hysteria that still haunts and guides contemporary clinical practice and scholarly thought.

While both Freud and Charcot acknowledged that men could have hysteria, they never made them their star patients and thus did little to disabuse the public conception of hysteria as a women’s disease.[17] As such, feminist critiques of hysteria have been long-standing; first beginning in the 1880s, these critiques generally argue that hysteria is simply a way to pathologize and control women’s legitimate anger and distress at living within patriarchal systems (Wood 1973, Showalter 1997). Although others, particularly French feminists in the 1970s such as Luce Irigaray or Hélène Cixous, have attempted to reclaim hysteria as a language intimately connected with the body and thus a resistance to masculine forms of communication (Evans 1991). Throughout medicine’s fascination with hysteria – and its many evolutions, see below – women have consistently been diagnosed more than men, generally at a ratio of 3:1 (Hatcher & Arroll 2008). However, this story becomes quickly complicated when one considers war. Mysterious symptoms connected with physical violence, especially formal warfare, have gone under many names from ‘shell shock’ and ‘railway spine’ to ‘Gulf War Syndrome’ and ‘PTSD’ and many argue that, despite the disconnected language, these conditions are all fundamentally forms of ‘hysteria’ (Showalter 1997, Young 2000, Dumit 2000, Micale 2008, Dumes 2019). As Siri Hustvedt has argued, “hysteria and war go together. The problem is one of vocabulary and the magic of naming. If you give it another name, it appears to be another *thing*” (2009, 75). This is all to say that if one attends to the relationship between gender, illness, and

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[17] The metaphoric extension of mind as masculine and the body as feminine has, and continues to, underlay much psychosomatic thinking (Kirmayer 1988).

culture, the story of these phenomena splits and tangles even further. Are all of these syndromes of violence the same underlying illness entity as Charcot's epileptiform women? Maybe. Maybe not. In my own fieldwork, the majority of somatoform patients I met were women (two men out of 11) – a statistic that many of the clinicians at 1 North referred to as "unfortunate," – however, a proper gender analysis is beyond the scope of this thesis; I include it briefly here in order to indicate how a supposedly certain aspect of these disorders (the gendered prevalence) becomes unsteady and uncertain under even slight theoretical attention.

For much of the 20th century, scholars declared that hysteria (as it appeared in Freud and Charcot's work) had disappeared (Veith 1965); however, this story is now largely rejected in favour of one of widespread proliferation in presentation and categorization. The classic cases of blindness and paralysis shrunk and were replaced with complex pain, syndromes involving many bodily systems, and disturbances in cognitive functioning – although epileptiform seizures, today known as psychogenic non-epileptic seizures (PNES), pseudoseizures, or non-epileptic attack disorder (NEAD), remain some of the most common symptoms. Furthermore, while hysteria remained a common analytic (particularly in scholarly contexts) throughout the century, official diagnoses splintered. As the medical sociologist Monica Greco argues about the current clinical landscape of these phenomena, "people with unexplained symptoms are seen and managed in contexts that vary from primary care settings to the whole range of medical specialties, where they may receive different diagnoses" (2012, 2362). These diagnoses include (with varying levels of controversy regarding their inclusion on this list): irritable bowel syndrome (IBS), chronic pelvic pain, fibromyalgia, non-cardiac chest pain, hyperventilation syndrome, chronic fatigue syndrome/myalgic encephalomyelitis (CFS/ME), multiple chemical sensitivity (MCS), temporomandibular joint dysfunction (TMJD), and somatoform disorders (Johnson 2008). While each of these diagnoses has their own specific context (and degree of legitimacy within medicine), what unites them is an absence of sufficient pathophysiological explanation and, often, conflict between patients and clinicians as different forms of knowledge (experiential versus professional) clash. It is common these days to see scholarship focusing on one of these specific diagnoses – fibromyalgia and CFS/ME are particularly popular within the social sciences. However, when scholars do theorize across these diagnoses, a variety of terms tend to be used – e.g. psychogenic, psychosomatic, or contested illnesses. At this moment in time, the two most prominent terminological choices are: 'functional illnesses,' and 'medically unexplained symptoms/illnesses' (MUS/MUI). These two terms are generally used in order to loosen the grip of psychoanalysis on these conditions, embrace an etiological neutrality in order to protect patients from stigma, and reject dualism. 'Functional' (as opposed to 'organic') is an old term (appearing in both Willis and Charcot's writing on hysteria) used to refer to illness arising from disturbances in the functioning, rather than the structure, of the body – i.e. there is no visible lesion or degeneration to the nervous system, but it seems, for some reason, to be functioning incorrectly. 'Functional' is generally understood to be an acceptable, non-stigmatizing label for patients (Stone et al. 2002); however, others argue it is not nearly as neutral as it seems and in fact perpetuates the dualistic psyche/soma divide it claims to reject (Hustvedt 2013). As for 'medically unexplained symptoms' (MUS), currently the preferred scholarly choice, this terminology attempts to take a neutral stance, focusing not on etiology, but rather on patient and clinician experiences – e.g. Ringberg & Krantz 2006, Dumes 2020, or O'Leary 2018. Laurence Kirmayer describes the work that the term 'MUS' does as such: "The term 'somatization' turns the ambiguity and uncertainty of [MUS] into the presumptive clarity of a distinct form of psychopathology. Any serious analysis of the problem should probably begin by reversing this rhetorical move and turning 'somatization' back into its 'raw observable': medically unexplained symptoms" (1999, 272). 'MUS' leaves the etiological question unresolved and focuses on the question of what follows from this predicament. However, despite the clustering around these two terms ('functional' and 'MUS'), they tend to be used differently by individual clinicians and clinics and thus carry different meanings depending on the context.

As for etiology, contemporary theories tend to highlight understudied physiological factors – e.g. reactivity, autoimmune disorders, pain perception thresholds, hypothalamic-pituitary-adrenal axis dysregulation, or genetics (Johnson 2008) – and some recent studies have argued for structural brain differences amongst patients with MUS (Burke 2019). Psychological distress is sometimes dismissed as a factor entirely or, more commonly, included as one of many factors in the development of these conditions. Despite these updated models and terminology, despite advances in technology and understanding of the body, the past 100 years have brought more, not less, uncertainty to these disorders. As Monica Greco argues, "even basic taxonomical questions such as 'are we dealing with one or many phenomena when it comes to describing medically unexplained symptoms?'... remain open to debate" (2012, 2362). While somatoform disorders are directly genealogically linked with hysteria, today they exist within, what I visualize as, a debris field.

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The conceptions I have outlined here oscillate between interpretations of these phenomena – neurological lesions, repression, trauma, social suffering. This hermeneutic plurality is not surprising; Laurence Kirmayer and Allan Young have charted the general interpretive approaches to these phenomena, arguing that there are seven common ones: "a) an index of disease or disorder; b) a symbolic expression of intrapsychic conflict; c) an indication of specific psychopathology; d) an idiomatic expression of distress; e) a metaphor for experience; f) an act of positioning with a local world; and g) a form of social commentary or protest" (1998, 423).[18] I have no desire to pin my research upon one of these interpretive approaches. However, across these conceptions, a profound uncertainty about what is happening (in the body? In the world?) and what should be done, tends to remain. When looking for answers in the historical record, the only stable referent amongst this debris field is uncertainty. While explanations for these disorders have risen, shifted, and disappeared throughout the years, from the beginning uncertainty has been a fundamental feature. Early gynecological and neurological explanations were far from comprehensive and doctors were aware of that, naming their own confusion – Thomas Willis, in his 1684 "Essay on the Pathology of the Brain," argues that hysteria is the term used for when "at any time a sickness happens in a Woman's Body, of an unusual manner, or more occult original, so that its causes He hid, and a Curatory indication is altogether uncertain" (69). 'Hysteria' was often used as a synonym for uncertain illness. Furthermore, even as models developed, such as Freud and Charcot's supposedly cohesive paradigms, significant ambiguities remained – how exactly does 'conversion' happen? What type of functional lesion will eventually become visible? As Pierre Janet, giving a lecture on hysteria to Harvard medical students in 1907, declared, "the description of such a disease is very difficult… because the disease is not clearly defined, because its limits, unfortunately, are very vague" (1907, 18). Roy Porter illustrates this fundamental uncertainty perhaps most clearly in his own history of hysteria, stating "for reasons clear to every reader of this book, 'hysteria' inevitably induces doubts" (1993, 226). These doubts, these flickering interpretations and understandings, remain today.

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[18] These approaches are not mutually exclusive; Young and Kirmayer argue that each have their own epistemic limits and power dynamics and as such can, and perhaps even should, co-exist.

Often the only thing that connects different medically unexplained illnesses is the fact that they are "characterized by inherent uncertainty" (Greco 2017, 111). Treatments may have evolved – across contemporary explanations, even those that centre potential pathophysiological causes, it is generally acknowledged that psychosocial interventions tend to be most effective (Johnson 2008), although physical therapy and biofeedback techniques are also common – but the predicament remains the same. In a study of neurologists' understanding of these phenomena, Kanaan et al. note that "there was often a statement of uncertainty at the core of the neurologists' response: 'I don't understand it. I imagine...here we're just going into speculation . . . I don't know...it's at an unconscious level…' [and] 'Well, I don't really know...I can't say...I suppose it's...well I suppose it's maybe their way of dealing with problems they can't solve'" (2009, 2892). A patient is seriously ill, perhaps they are twitching or seizing, perhaps they are blind or paralyzed, perhaps they are in terrible pain, but no blood test, no physical exam, no ultrasound or MRI, can find anything wrong. Something strange is happening, something that challenges our understanding of the body and mind, but we are not sure what exactly it is. The writer Siri Hustvedt, in her auto-theory *The Shaking Woman: Or a History of My Nerves* (2009), in which she searches for what is causing her own full-body shuddering (traversing hysteria, conversion disorder, pseudoseizures and more), concludes her account as such:

> Ambiguity is not quite one thing, not quite the other. It won't fit into the pigeonhole, the neat box, the window frame, the encyclopedia. It is a formless object or feeling that can't be placed… I can't tell what it is or if it is anything at all. I chase it with words even though it won't be captured and, every once in a while, I imagine I have come close to it. In May of 2006, I stood outside under a cloudless blue sky and started to speak about my father, who had been dead for over two years. As soon as I opened my mouth, I began to shake violently. I shook that day and then I shook again on other days. (198-199).

These phenomena, whatever they may be, whether they are unified or many, all share an inherent, fundamental uncertainty – for patients, clinicians, and observers.

Anthropological engagements

It is important to briefly note how my work builds on and diverges from other anthropological engagements with this topic for there are many that have been guides or foils to my thinking throughout this project. There is a tradition of work on these phenomena within anthropology – often appearing as work on hysteria or ‘culture-bound syndromes’ that focus on trying to discover what exactly is causing these strange symptoms. The vast majority of these engagements have focused on the Global South – although see Susan Greenhalgh’s work on fibromyalgia and the medicalization of social problems (Hadler & Greenhalgh 2005) for an exception – and approach these phenomena as a cultural idiom of distress, a culturally-patterned form of suffering. For instance, Arthur Kleinman’s work on neurasthenia in China argues that neurasthenia can be read as depression in a different cultural context (Kleinman 1977) and, as such, somatization should be understood as a “bioculturally patterned illness experience” (Kleinman 1982). Similarly, Devon Hinton, in his work with Cambodian refugees, has argued that *khyaˆl* attacks, surprising episodes of dizziness and weakness, are culturally specific manifestation of panic attacks and trauma disorders (Hinton et al. 2010). Other scholars have approached these phenomena as having specific social or communicative functions. Allan Young, in his work linking hysteria and PTSD, argues that hysteria is a “protolanguage” that serves to “transmute knowledge and feelings – anger, pain, fear, resentment, self-loathing – into imitations of true disease and, ipso facto, into states of suffering and absolution” (2000, 135). Similarly, Robert Winzeler in his work on *latah*, a hyper startle response common in Southeast Asia, has argued that it has such specific social functions that it in fact should not be regarded as an illness (Winzeler 1995). Along these lines, Andrew Willford argues that conversion disorder in southern India is a result of social violence, specifically the forceful flattening of modernity, and thus should be understood as a “political symptom” (Willford 2022, 167). While these approaches are logical for a discipline focused on culture, some have critiqued the approach to these phenomena as cultural idioms of distress. Aidan Seale-Feldman, in her work on conversion disorder in Nepal, argues that the tendency to assume that anything that looks like hysteria must be a culturally specific form of expressing psychic distress universalizes Western psychiatric categories, neglecting local contexts and the plurality of phenomenological experiences of illness (Seale-Feldman 2022). Similarly, Horacio Fabrega has argued that even the concept of somatization, the process which so much scholarship on these phenomena hangs off of, is a Western concept and thus is only relevant within the modern Western ontological view of disease (Fabrega 1990). While much of this work has been useful to understand what approaches have been taken, my research diverges from these traditional approaches; I am not asking what these phenomena ‘really’ are nor what function or meaning they have in a particular context.

Rather, my work more closely builds on that of medical anthropologists working in North America who have focused on issues of care and epistemology in these disorders. For instance, Abigail Dumes’ work on Chronic Lyme Disease in which she argues that medically unexplained symptoms are in fact an essential part of modern medicine, defining its limits and thus included through exclusion, has been helpful in thinking through the relationship between these fraught phenomena and the medical system (Dumes 2019). Others who have focused on things such as the intersubjectivity of pain in chronic regional pain syndrome (Buchbinder 2015) or chronic fatigue syndrome and the social suffering of delegitimation (Ware 1992) have drawn my attention to patients’ experiences. Similarly, Joe Dumit’s work on these disorders, which he terms “bio-mental” – “their nature and existence are contested as to whether they are primarily mental, psychiatric or biological” (Dumit 2000, 210), – highlights the importance of “suffering in code," or in institutionally recognized ways (Dumit 2006). My research builds on this work in that it is curious about what these disorders, through their fraught and heightened context, can tell us about the culture of medicine and scientific knowledge in North America. As such, this project owes many debts to excellent work on specific medically unexplained illnesses (most commonly MCS, CFS, and chronic Lyme). However, each of these contested illnesses have their own specific contexts, histories, and meanings and I do not mean to generalize across them, even though the clinicians at my fieldsite often did (see the next section). Instead, my research focuses on the people who did not get caught in the nets of meaning spun around any of these individual diagnoses, but rather fell through the cracks of specific contested illnesses and found themselves at the end of the line – somatoform disorders and psychiatry. While psychiatry may seem like a stable place for these phenomena, a place where there is a cohesive approach and school of thought, even it is not settled; rather, it remains unstable and shifting, uncertain and murky.

Somatoform disorders & 1 North

With this debris field in mind, let us now turn to 1 North. My thinking in this thesis is grounded, temporally and spatially, in my fieldwork. The context of this thesis is somatoform disorders, but specifically the somatoform disorders that exist within the walls and practices of 1 North.[19] As such, let us now examine these phenomena in practice. 1 North follows a specific and clearly defined model of somatoform disorders. However, this is not to say that there are not internal, theoretical contradictions in this model (there are), nor that there is not a multiplicity of thinking about these disorders that emerge in individual clinicians' practice (there is). 1 North is

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[19] I follow Annemarie Mol's assertion that disease (even a disease as seemingly simple as atherosclerosis in her case) becomes multiple through its enactments (Mol 2002). As such, in order to provide the meaningful context I hope to in this chapter, it is essential to explore the practices and understandings of somatoform disorders at 1 North.

a clinical community gathered around a shared understanding of somatoform disorders; however, even this declared theoretical solidity does not insulate clinicians or patients from the uncertainty of these phenomena. Uncertainty continuously slips into view through the contradictions and contested certainties inherent in the practice of these disorders. Multiple explanations, some dualistic, others non-dualistic, some psychoanalytic, some biological, exist within the program's model and practice. 1 North is a neuropsychiatric program and, as such, foregrounds the neural correlates of psychiatric illness[20] – "All aspects of somatoform conditions are products of complex brain function and dysfunction, we just don't understand the specific nature of them," one psychiatrist at the program once told me. However, they also define themselves as psychiatrically "orthodox" (they tend to strictly follow the DSM, although somatoform disorders are an exception) and many of the neuropsychiatrists are still very influenced by psychoanalytic thought.[21] 1 North's model for somatoform disorders, initially developed by the program's founding neuropsychiatrist and elaborated upon by the psychiatrists who joined him, brings all the clinicians at the program onto roughly the same playing field in terms of their understanding of the disorders, their origin, and their appropriate treatment, while also allowing for diversity in individual psychiatrists' practices. So, what is a somatoform disorder, according to 1 North? In their own documents, the program defines somatoform disorders as: "Any condition where physical symptoms and signs are judged, after thorough assessment, to be the result of underlying emotional distress rather than primary physical disease." They are committed to the terminology 'somatoform disorder' and believe it most accurately describes the condition, a stance they recognize as diverging from the clinical and research zeitgeist, but believe reflects

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[20] An approach they describe as rejecting dualism. However, I am still somewhat suspicious of whether embracing the material brain is truly an anti-dualistic approach. Does valorising the brain meld the categories of the physical and the psychic? Or does it further entrench the division by relegating the psychic to simply an epiphenomenon?

[21] Somewhat surprising given psychoanalysis' decreasing popularity within psychiatry since the 1980s.

the validity of their model. In their approach, the program foregrounds emotional distress and makes the somatic manifestations secondary. They do not believe that categorizing these disorders based on the presenting symptoms (as the DSM does with conversion disorder/functional neurological disorder) is meaningful and assert that underlying psychic distress does not neatly correspond to symptoms – i.e. two people with psychogenic non-epileptic seizures may have very different underlying psychic pathology. The clinicians at 1 North believe that emotional distress is the central problem of these phenomena and thus should be the primary focus. Furthermore, the program defines emotional distress as made up of two contributing factors: 1) psychiatric distress (e.g. as a result of a psychiatric disorder such as depression, anxiety, or a personality disorder) and/or 2) psychological distress (e.g. insufficient coping mechanisms, overwhelming life stressors, etc.). In any individual patient, the program expects the central, underlying distress to be caused by one, or a combination, of these factors. While this understanding is based in traditional psychiatric understandings, it is not strictly psychoanalytic; the clinicians at 1 North generally do not believe that specific somatic symptoms have any symbolic relevance, rather, when they were interested in symptoms (which they mostly were not), they investigated them as likely mirroring of someone in the patient's life or awareness – "Weird presentation." K. said to a resident after assessing a patient with memory problems, "has she ever been exposed to anyone with dementia?" Additionally, the program stresses the involuntariness of these conditions and (at least officially) sharply differentiates them from factitious disorders or malingering – "The patient suffering a somatoform symptom experiences it as entirely real," a clinician told me sternly early on. As such, while the program itself traces a smooth history from early Greek and Egyptian accounts of hysteria, through the DSM iterations to the present day, they have their own unique boundaries on the condition and combine elements from multiple theoretical approaches. This theoretical mixing, and sometimes contradiction, was visible in practice as well as definition. For instance, in conversations with patients, I watched clinicians call the program a “psychosomatic unit” while simultaneously stressing that the nervous system was the seat of the illness. Additionally, the program’s approach, both philosophically and diagnostically, is broadly inclusive. While individual clinicians’ comfort with including other well-known diagnoses under the somatoform umbrella varied – one listed the conditions he considered to be somatoform in an increasingly loud list, while others seemed troubled and hesitant about what should be included, – practically, the program understood (although did not always communicate to patients) somatoform disorders to encompass ME/CFS, fibromyalgia, IBS, MCS, and Chronic Lyme Disease.[22]

Beyond definition, 1 North’s model of somatoform disorders also comes with specific treatment approaches. Most centrally, they argue for long-term follow-up as key to success. Treatment, in their view, is always based on addressing the underlying emotional distress and thus can involve psychological and behavioral interventions (psychosomatic counseling primarily), pharmacological treatment (generally antidepressants), and occasionally physical therapy if the specific symptoms have led to physiological changes – such as muscle shortening, or weakness or strain from not using a particular limb. However, in practice, the team mostly focuses on diagnosis and assessment rather than treatment. As multiple clinicians told me, somatoform patients are long-term commitments and they do not have the capacity to treat them all. Additionally, while most of the team defined themselves as “mental health clinicians,” many did not feel qualified to do the type of psychosomatic counseling that they often directed patients

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[22] And even perhaps long COVID (under active discussion while I was there).

towards. As such, after a diagnosis, patients were most often referred to their psychiatrist in the community and offered (limited) help to find a qualified counselor.

Of course, 1 North is not a monolith. Individual clinicians spoke very differently to me – in terms of sympathy for patients, central problems, and conceptual frameworks – in response to my questions. Additionally, the many residents who cycled through the program during my fieldwork (and who did much of the clinical work assessing and speaking to patients) often had very different attitudes and beliefs about the entity they were attempting to diagnose and treat. When I asked one young resident how her time at the program had been, she endorsed the program's model telling me, "I've enjoyed the somatoform disorders. Those patients are rare, and they have a pretty unique lens here, how they understand it. And you know it's wild that you could be depressed enough you couldn't walk." However, others seemed to be conflicted, struggling with the extent to which they bought into the model. For instance, in the break room with two residents one day following an assessment one had done on a suspected somatoform patient, I witnessed the following conversation:

> "Dr. X. says migraine, IBS, it's all functional. He sees pain, everything as functional. Even psychosis! It's ridiculous."
>
> "I know. And migraine is complicated. Sure, everything's functional then. There's always a psychological component. But…"
>
> "We're lumping it all in as this functional thing."
>
> "We can't totally separate the functional from the medical. But I don't know how to write that nuance."
>
> "I mean most somatoform disorders have a medical component. Like people with PNES also usually have epilepsy."
>
> "I'm not going to put IBS in her psychiatric history. I'd be laughed at."

1 North has a shared theoretical model of somatoform disorders that guides their assessment, diagnostic, and treatment approaches, and yet, 1 North's model is continuously unsettled by contested certainties; multiple, sometimes conflicting, understandings of the relevant theoretical factors; and persistent uncertainties. Furthermore, despite the declared theoretical solidity – one

of the first clinicians I spoke to interrupted me as I asked him about uncertainty declaring, "There's nothing uncertain about these conditions! We know exactly what's going on," – even fidelity to a specific school of thought does not isolate clinicians from uncertainty.

Uncertainty in practice

Uncertainty is an unavoidable aspect of somatoform disorders at 1 North. The first day I arrived, just minutes after explaining the program's model, B. told me, "Somatoform disorder is a controversial diagnosis. Or at least one we don't know much about, it's a big mystery." The clinicians at 1 North believe, firmly, that these disorders are caused by underlying emotional distress, but uncertainties remain at every step of the process – from assessment and diagnosis to formulation and prognosis. While patients appearing at 1 North were generally already assumed to be psychiatric (it took months if not years of referrals in order to be accepted to the program), test results were rarely definitive and sometimes the suspected underlying emotional distress was not clear – I once watched a frustrated K. tell a patient as, together, they struggled to identify what his psychic distress was, "Okay, we don't want to be making this up. I don't want 'probably.' I want 'this happened.'" Furthermore, more often than not, there were overlapping cases where it was difficult to determine whether symptoms were the result of the suspected somatoform disorder or one of the patient's other organic diseases. As an older clinician said to me once, "The patient has MS, so it could be that? But maybe it's also a pseudo flare? That makes it more complicated. There's always cases in everybody's practice where we don't know what the fuck is going on." For clinicians at 1 North, much of the uncertainty of somatoform disorders comes not from a dualistic gulf between mind and body, but rather from a sense of entangled psychic and somatic intimacies. However, the biggest concern with somatoform patients was always misdiagnosis. Misdiagnosis was a constant anxiety for clinicians, haunting their every decision and never fully being banished. B. told me early on that when he first sees a patient he has two jobs, “1) To clarify that it is somatoform in nature – don’t want to miss an organic pathology and 2) engage with the psychology.” The residents were especially anxious about this possibility, often expressing their doubts to me about whether the patient we were seeing was truly somatoform and continuously asking the psychiatrists whether it could be an organic disease – Parkinson’s? Alzheimer’s? A rare autoimmune disorder? A resident once frantically told me, teaching as though I was his medical student, “Somatoform is always the last diagnosis on your list. Wanna make sure there’s no organic pathology you’re missing. Always wanna make sure you’re not missing anything. And sometimes you’re wrong. You know just because I’m seeing something that’s functional doesn’t mean there’s not anything else.” Or, as a senior psychiatrist said to me:

> There’s no physiological test, no test, that will say this is *absolutely* psychogenic versus non-psychogenic. And movement disorders can be extremely bizarre and even amongst movement disorder specialists you won’t find a lot of inter-rater agreement that what you’re seeing is definitely psychological as opposed to organic… or we take *pain*, *fatigue*, it’s much harder to localize and then [the patient] says, ‘I’m hypersensitive everywhere,’ so a lot of it is subjective account… there is no way of saying it’s not that.

From residents to clinicians practicing for over 40 years, uncertainty is an inherent aspect of the care and experience of somatoform disorders.

Furthermore, this uncertainty did not diminish once a diagnosis was made. Even if a clinician felt certain they were dealing with a somatoform disorder, prognoses still remained largely mysterious. While the clinicians I worked with were committed to their patients and clearly told them that a somatoform diagnosis meant that they could get better, when I asked if a specific treatment (medication, counseling, physio, etc.) would resolve symptoms, the clinicians were generally ambivalent; common answers included: "that's the hope," or "what've they got to lose?" Furthermore, when treatments failed the clinicians often started to question whether their diagnosis had been correct, whether this was truly involuntary or if there was some level of malingering, some type of secondary gain – disability benefits, employment insurance, etc. – that was interfering with a patient's desire to recover. I often felt uncomfortable in these instances, when doubt and suspicion came explicitly to the fore, but it was a lingering uncertainty for the clinicians. As one once told me, "The problem is we can never prove malingerers. But probably 20% or a quarter of these patients are malingering… As much as you want to care for people you also need not to be fooled." Others were softer about this conundrum. After I asked about malingering, B. thought carefully then said, "What is the line between conscious and unconscious? I don't know where you can draw that line. I don't know if we can know." Finally, there was always the risk that even if the program was fairly certain that a patient was somatoform, an organic, potentially fatal, illness might develop along the way. As one of the neuropsychiatrists told me when I interviewed him,

> While you're watching them, some of them are gonna get brain tumors, cause that's happened to me, you find them and they've got psychosomatic disturbances and one day these psychosomatic symptoms are identical and then they have a seizure, they've got a huge brain tumor and they're dead within two years. So, a person who has that diagnosis… you're always on the guard for, you can't stop thinking, [stammers], they're *treacherous*.

At every stage, somatoform disorders are accompanied by a constant, persistent uncertainty.

Beyond the clinic, the clinicians at 1 North were also very aware of the controversial and uncertain landscape that they practiced within and were often bewildered and enraged by the tangles they found themselves in. The team was largely dismissive of emerging attempts to redefine somatoform disorders as disorders of functional nervous system connectivity, telling me this "flight from the psychological" was stigmatizing – refusing to engage with the psychological as a legitimate mode of suffering and instead trying to find an organic basis. They saw these professional differences as uncertainty about the central conception of somatoform disorders – a clinician once rhetorically asked me, ranting about neurologists, "What is a somatoform disorder from a neurological perspective if disinhibition works?"[23] Furthermore, they often told me about the sorrow and anger they felt when seeing other doctors under psychologize (taking patients down expensive and invasive treatment options). This frustration and doubt also applied to research. A clinician, lecturing me about why you shouldn't take what somatoform patients said at face value – because, according to him, by definition they don't have insight – quickly turned his ire on researchers, "This is why I can't trust the literature on somatic symptom disorder because these [researchers] trusted what [the patients] said. What am I reading? How can I contextualize this?" They often got heated telling me these things, voices harsh in small spaces; however, occasionally even in these rants a vein of doubt slipped in. One afternoon in the nurses' station, B. told me about a doctor in the region who supported the idea of Chronic Lyme Disease (a 'Lyme literate physician,' see Dumes 2020). B., telling me that the doctor would put patients on years-long courses of antibiotics, huffed and threw up his hands, "I mean, what's that going to do?" But then, in the middle of his indignation, he paused, "...Maybe it might help. Some patients said it helped them." These phenomena are tangled in uncertainty at almost every angle.

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[23] Disinhibition, traditionally with hypnosis or drugs like sodium amytal, was a common diagnostic technique for these disorders in the 20th century. Clinicians would bring patients into a state of disinhibition and then video tape them to show them how their paralysis/tremor/blindness etc. would disappear. While this technique has evolved into distraction during a neurological exam (the symptom disappearing when a patient is asked to do a cognitively difficult task like reciting the alphabet backwards), the 'trick' approach has fallen out of favour. When I asked B. about this change, he told me it was partially due to symptoms being more complex these days and thus not being as affected by disinhibition as well as a contemporary emphasis on building trust with the patient rather than using a forceful short-cut – "Sure, they'll get disinhibited and tell you their dad was a bastard" he said, "but so what? Everyone's was. How does that help us?"

Onwards

In this chapter, I have attempted to illustrate the diverging, contested, plural histories of the phenomena which I refer to as somatoform disorders. I have mapped where this thesis stands in relation to other work (anthropological, medical, historical) on these disorders and, most importantly, introduced the entity of somatoform disorders as it exists within the walls of 1 North. While I am agnostic regarding the etiological ontology of these disorders, I assert that a feature, across its many lives, is uncertainty – both theoretical and practical. The debris field that somatoform disorders exist within is an unstable one, beset by lingering questions, by fog. As such, it is often a difficult place to find oneself – clinician, patient, or anthropologist alike. These strange phenomena are fascinating, alluring, obsessively interesting and yet the stakes, the politics of suffering and authority and reality, are significant; to paraphrase the senior neuropsychiatrist, this debris field is *treacherous*. However, it is this unstable, shifting field, this persistent uncertainty, that makes somatoform disorders a particularly generative site in which to consider both the threats and possibilities of uncertainty in the clinic. While uncertainty is a constant companion throughout most medical practice, rarely is its precarious undertow as strong as it is in the treatment and experience of somatoform disorders. From diagnosis and prognosis to treatment choice, follow-up, and recovery there is almost nothing about these disorders that is certain, even after all this time. As such, the questions that my thesis pursues are particularly vivid – how do patients and clinicians relate to uncertainty in the clinic? What does medical uncertainty threaten? Is there a potential therapeutics of uncertainty? I went to 1 North, went looking for somatoform disorders, to try and understand how relationships with uncertainty break open or foreclose different possibilities, and it is from this debris field that I proceed.

CHAPTER 2 – A Regime of Certainty

The Aneurysm

Despite it being almost June, the clouds are thick and low today. Rushing down the hall to meet B. in the nurses' station, my breath makes my mask stick to my face uncomfortably. The station, open on two sides to the ward which encircles it, is quiet but busy and I have to squeeze past rolly chairs as the nurses sit and chart at the central table. Flipping open my small notebook, I lean against the counter at the back of the room, trying to stay out of the way. It is results day for Charlie.

Charlie is in her 60s and, while she's had a variety of medical problems throughout her life – Ehlers-Danlos syndrome, hyperthyroidism, and breast cancer to name just a few, – her current suffering emerged in 2017 when, after going to Oregon to watch the solar eclipse with her wife, her world began to shake. She first thought this was an external event (an earthquake? Nearby construction? The air conditioner? Power lines?) but the tactile and auditory vibrations follow her wherever she goes and no one else can feel or hear them. While she now mostly accepts that this is something within herself, no doctor has found any kind of explanatory pathology – no vestibular dysfunction, no neurodegeneration, no vascular problems. A few years ago she was told she had psychosis, but antipsychotic medications have had no effect. She is deeply afraid that her "earthquake attacks" are something that will kill her. While B. has been operating under the assumption that Charlie's symptoms are the result of a somatoform disorder since she became his patient last month, she has been in hospital for the past two weeks on an investigative admission. During this time, B. has ordered new MRI scans, an ambulatory EEG (electrodes that measured her brain waves for 72 hours), as well as neuropsychological testing, and an array of blood tests – all to try and avoid misdiagnosis.

B. strides into the nurses' station, his hair neat as always, his huge cell phone clipped onto the outside of his dark dress pants. A nurse at the table looks up and congratulates him on a recent talk he gave on the program's experimental use of ketamine as a treatment for refractory depression. The unit secretary, leaning against the doorframe, cheerily agrees. B. smiles and thanks them, bashful but pleased. He greets me and beckons me over to the computer in the corner. Charlie's bloodwork and imaging has come back. I hover by his elbow, notebook in hand, as he opens the report, narrating for me: "HIV negative, Lyme negative. Beautiful. No autoimmune. So, overall, we're not seeing anything dangerous." He nods approvingly. He then pulls up the radiologist's report. Scrolling through the different MRI images, B. hmms, "That's quite atrophied there." He points at the cerebellum and the anterior temporal lobe, glancing back at the report, "but I suppose it could be incidental. We'll keep an eye on it." The report also identifies a small aneurysm. B. frowns, switching over to the MRA[24] images that isolate the blood vessels. He stares for a long moment at the screen then clicks, rotating the 3D grey-scale scan. He squints and leans closer, "Where is this aneurysm?" He frowns. "Maybe that enlarged bit there?" He huffs, frustrated. "I don't know. They say it's there, but I can't see it."

Visuality is a primary evidentiary truth for reality in medicine (Foucault 1973, Buchbinder 2015) and without it, even with a report from his colleague, B. doubts the aneurysm's presence; as Kelly Joyce has argued, "the claim of truth is staked partially on the terrain of the visual: For something to be true, it must be seen" (2008, 10). I ask if the aneurysm could be causing Charlie's symptoms and B. sighs, "Every time you do a brain scan or something with such resolution you'll find something. *I don't think it's related*." He stares blankly at the screen. "But I'm not sure." He closes the report and turns around, crossing his legs

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[24] Magnetic Resonance Angiography, a type of MRI image that shows the brain's vasculature.

as he leans back and braces himself against the desk. “Sometimes you get clear results. But the vast majority of time you don’t. Science gives us biological abnormalities. This is where the art of somatoform diagnoses comes in.”

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In this chapter, I turn my attention to medical uncertainty in the clinical encounter. Following the wakes of two central scenes between the psychiatrist B. and a suspected somatoform patient named Charlie, I explore how patient and clinician relationships with uncertainty shape the conditions of (im)possibility within the clinical encounter. Specifically, I argue that while patients and clinicians at 1 North were avowedly conscious of the fundamentally uncertain nature of medicine, and especially somatoform disorders, in the clinical encounter both parties continuously insisted upon and performed certainty. I suggest that in these instances patients and clinicians are enacting medicine as a *regime of certainty* – a term I offer to describe a social imaginary of medicine as a system that can, and should, provide access to a stable, objective truth. Within this regime, uncertainty becomes an unacceptable clinical mode to inhabit, viewed as an error that must be corrected rather than a legitimate clinical state that therapeutic endeavors can proceed from.

I begin by reviewing how scholarship has historically approached medical uncertainty, including its simultaneous ubiquity and problematic status as well as recent moves to accept and utilize uncertainty in the clinic. I then return to my central scenes, examining how B. approached a situation of uncertainty during Charlie’s admission – specifically how he performed a certainty he did not have. Next, I turn to Charlie, exploring how she insisted upon certainty even when B. tried to allow room for uncertainty in the explanation and treatment of her suffering. With these two scenes, I delve into the specific threats medical uncertainty poses to both patients and clinicians – from social suffering to challenges to professional identity. I then mobilize an ecological approach to the clinical encounter – attending not just to the psychology and motivations of individual actors but also to the dynamic relations between parties – and ask how patients and clinicians jointly create and shape conditions of (im)possibility. With this framework, I argue that what emerges across these scenes is an enactment of medicine as a regime of certainty. I then question whether this will to certainty should be understood as a failure, an act of care, or both; suggesting that, while certainty is soothing in the moment, it may fail therapeutically in the long-term, trapping patients and clinicians in a loop of failure as they continuously strive for a certainty that is impossible in this context. Furthermore, I argue that, due to a regime of certainty's requirement of clear logics of etiology and recovery, it contributes to the marginalization of suffering that does not neatly correspond to organic pathology. Finally, exploring what other orientations to medicine, beyond a regime of certainty, might look like, I examine the peculiar cases of two religious patients at 1 North.

Scholarly approaches to medical uncertainty

Uncertainty has long been a central focus of both medical scholarship and social scientific scholarship on medicine (Fox 1957, Katz 1984, Atkinson 1984, Mackintosh and Armstrong 2020, Whooley and Barker 2021). While sociological work on medical uncertainty is generally cited as beginning with Talcott Parsons (1951), the most substantive work has come from the sociologist Renee Fox who once, reflecting on her career, described medical uncertainty as the central theme of her research (Fox 1980). Early in her career, Fox famously argued that medical school is a process of "training for uncertainty" and classified three central sources of uncertainty for doctors: "incomplete or imperfect mastery of available knowledge," "limitations in current medical knowledge," and the difficulty of distinguishing between the two (Fox 1957, 208-209). Following Fox, scholarship on medical uncertainty has tended to cluster around three themes: typologies of medical uncertainty (Davis 1960, Bosk 1979, Light 1979, Beresford 1991, Han 2021), strategies for managing uncertainty (May et al. 2000, Littlejohn and Kimport 2017, Mackintosh and Armstrong 2020, Greco 2021), and illuminating the stress that uncertainty causes clinicians (Katz 1984, Adamson 1997) and patients (Clarke and James 2003; Cohn 1999; Nettleton 2006; Dumit 2006; Stenner, Dancey, and Watts, 2000; Stenner et al., 2015).

While evidence of a tradition of scholarly interest, this work also points to the ubiquity of medical uncertainty. From diagnosis to treatment, the work of medicine is fundamentally entangled with uncertainty; as bioethicist Abraham Schwab has argued, "judgments in medical practice are always accompanied by uncertainty, and this uncertainty is a fickle companion – constant in its presence but inconstant in its expression" (2012, 28). Uncertainty is such a pervasive figure in medicine that declarations of its presence generally go uncited – of course medicine is an uncertain practice, everyone knows that.[25] While there has been a recent flood of work on medical uncertainty due to its visibility throughout the COVID-19 pandemic (Whooley and Barker 2021, Han 2021), asserting its ubiquity is not a new nor radical declaration. Sir William Osler, regarded as one of the founders of modern medicine,[26] famously described medicine as "a science of uncertainty and an art of probability" (quoted in Mackintosh and Armstrong 2020, 1714). Clinicians must continuously make decisions that they cannot know the exact outcome of. While in some cases, such as somatoform disorders, they may be genuinely at sea, even in the most straightforward of situations (for example, the realignment and casting of a

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[25] I, of course, am a student and so do not have the pleasure of making broad, generalizing statements without offering evidence.

[26] A history recently confronted given his pervasive and committed racism both within and outside of medicine, shocking even for his era (Persaud, Butts, and Bergere 2020).

broken limb) the results (functionality after healing) are often not certain. Across specialties and illnesses, there are “inherent limitations to medical explanation” (Kirmayer et al. 2004, 664). As an older psychiatrist at 1 North once told me, “You’re never quite sure; the body doesn’t read the textbook.” Clinicians, speaking outside of the clinic or to each other, have long been clear that uncertainty is an unavoidable aspect of their work (Katz 1984). They may not admit it to patients – and may be criticized for refusing to do so (O’Leary 2018) – but uncertainty is, and has historically been understood by clinicians to be, the norm in medicine.

While uncertainty is a fundamental feature of medicine, it is, of course, especially heightened in the diagnosis and treatment of somatoform disorders (see the previous chapter). Despite the clarity supposedly imposed by terminology, – a somatoform disorder is a case of somatization, the body manifesting emotional distress – in practice, uncertainty is present in almost every aspect of the disorders. What is the trigger in this particular patient? Why these specific symptoms? What treatment will be effective? How much recovery is reasonable to expect? Are you sure this isn’t a rare manifestation of a fatal disease? The disorders are ambiguous and thus explanation, treatment, and recovery remain stubbornly uncertain (Kirmayer 1999). My first day of fieldwork, sitting in B.’s dark office, straight-backed in a painfully carefully chosen turtleneck sweater, I listened intently as B. told me, “Somatoform disorders are the myths we believe and tell each other.” Passionate and speaking quickly up until that moment he then paused and laughed, “Sometimes we have no idea what we’re doing.” He told me things like this often as we walked briskly between patients or lingered in a corner of a wood paneled hallway waiting for someone. B. is quick to admit what he often calls the “art” or “spirituality” of psychiatry and happy to claim it; more than once he referred to himself and other psychiatrists as the “priests of modern medicine.” While it may not be immediately obvious to a lay person, for clinicians, medicine, and especially somatoform disorders, are nothing if not uncertain. However, as we'll see, acknowledging uncertainty is very different than accepting it in practice.

Furthermore, despite its ubiquity, medical uncertainty is almost always referred to as 'the problem of uncertainty' (see Greco 2004, Murphy 2006, or Fjelland 2002) and theorists have driven their careers by developing frameworks and strategies to manage the 'issue.' For instance, Paul K.J. Han's *Uncertainty in Medicine* describes medical uncertainty as an "illness" that must be diagnosed and treated (2022, 9) and develops a conceptual paradigm that outlines strategies for how doctors can tolerate it. Critiques of medical uncertainty generally come from two sources: 1) Within medicine where medical uncertainty is seen as stressful for clinicians and interfering with clinical decision-making and thus urgently requires a solution (Han 2021, Fox 1980) and 2) From the social sciences where three critiques are generally highlighted: medical uncertainty as causing patients stress and social harm and, therefore, must be eliminated (Hinton & Armstrong 2020, Lane 2020); medical uncertainty as allowing room for bias (such as racism or misogyny) to enter the clinic and as such must be controlled for (Rouse 2009); and/or clinicians' denial of uncertainty as evidence of biomedicine's oppressive authoritarian objectivity which should be rectified through clinicians' humble acknowledgement of their limitations (Brinkman 2016, O'Leary 2018). While the specific critiques of and responses to medical uncertainty vary across these approaches, what is common to them all is the general view of uncertainty as a threat that causes a wide variety of problems within medicine. Whatever the exact harm we might understand medical uncertainty to do, it makes everyone – clinicians, patients, and scholars – uneasy.

While this orientation to medical uncertainty remains the norm, in recent years approaches that emphasize the necessity and value of accepting medical uncertainty and using it creatively have become popular (within both medicine and popular discourse). The most widespread of these efforts, coming from the philosophy of science, is the concept of epistemic humility. Broadly, epistemic humility refers to acknowledging the quality (or lack thereof) of evidence for a truth claim (Schwab 2012). In practice, it is often claimed as a virtue clinicians should embrace in the process of giving up their position as the ultimate source of authority (O'Leary 2018, Simpkin & Schwartzstein 2016). In the context of somatoform disorders, I find two interventions in this vein to be particularly relevant. The first is Laurence Kirmayer's, developed in a 1994 article on psychosomatic diagnoses and improvisation of meaning in which he argues that diagnostic and therapeutic goals are different and thus "the strategies appropriate in one context become problematic, strange and deforming in the other… Authority is concerned with legitimation and hence with truth, while the therapeutic enterprise is fundamentally concerned with how to continue and hence with the improvisation of meaning" (184). An ultimate, certain truth need not be the goal in psychosomatic therapeutics Kirmayer argues, rather, a more effective clinical enterprise will focus on explanations that have meaning for patients and help control the chaos of a psychosomatic condition. For instance, in Charlie's case, this could (rhetorically) look like B. understanding that a pathophysiological explanation would be meaningful to Charlie and suggesting that 'perhaps these symptoms are caused in part by your body's response to this aneurysm, it was trying to tell you that something was wrong.' Importantly, according to Kirmayer, explanations may, and even should, shift overtime continuously attempting to provide a meaningful framework for understanding. Similarly, Monica Greco, drawing on William James, calls for clinicians to adopt a mode of "speculative pragmatism" in response to medically unexplained symptoms, relinquishing objective accuracy in favour of explanations that "lure events – and the embodied experience of the patient, in this case – in the direction of new possibilities" (Greco 2017, 122). This approach is specifically focused on trying to alter symptoms, and in Charlie's case could look like trying to shift her towards what could be changed – for instance, suggesting that her shaking is not likely a side effect of the aneurysm but rather one of the many other health conditions she lives with and thus they should pivot from diagnosis to management strategies. The focus shifts from clarity of knowledge to explanation that is flexible and reparative. Of course, neither of these approaches explicitly call for clinicians to embrace uncertainty or communicate it to patients, rather they shift away from the problem of uncertainty towards a more practical, therapeutic endeavor in which questions of etiology, diagnosis, and prognosis can remain in flux, responsive to patient needs. With these approaches in mind, and my overarching curiosity about the possibilities of uncertainty, I approached the clinical encounters I witnessed at 1 North with an eye not just to the threats but also the possibilities of uncertainty.

The certain doctor

Let us return to Charlie and B., a week after we left them – B. standing next to me, frustrated and trying to see the aneurysm, and Charlie, present in her test results and brain scans. Today, we are in B.'s office on the other side of the unit with Charlie and a student nurse. His office is typically messy, books and papers stacked in uneven piles on the grey-carpeted floor, bookshelf stuffed tightly. The blinds are open for once and I can see the sunken delivery area outside from my perch on a stool by the door. Charlie seems more anxious than usual; her grey hoodie is wrapped tightly around her and her hands flutter a bit as she smooths her white blond hair and the edge of her light blue medical mask. B. turns to his computer and opens the MRI scans, "I wanted to show you your brain." Charlie becomes excited and animated, oohing as we all lean forward to watch the flair sequence,[27] the glowing ring of her skull blooming and shrinking on the screen as we move up and down through the cross-sections. B. and Charlie review the scans, dancing back and forth as she questions him about things she sees, small white spots, differences between each side, struggling between normality and abnormality, worry and reassurance. B. then moves to show her the MRA scans of the blood vessels in her brain; "And here you'll see the small aneurysm that we found last week" B. says, voice calm. Charlie's hands go to her temples as she stares at the 3D ghostly outline of her head turning slowly on the screen, the blood vessels glowing in opaque tangles.

"Where?" she asks, her voice small but steady. Her posture at this moment, hands to her head, gaze to the screen, reminds me of Anne Boyer's *imagelings*. In her raging breast cancer memoir, Boyer writes of the sudden transformation of herself into a data subject, "radiology turns a person made of feelings and flesh into a patient made of light and shadows" (2020, 15). Charlie was ill before this, gravely ill, but the aneurysm was unknown. With these images, the shifting tides of her suffering, the many meanings it could have, have momentarily crystallized and she is something, someone different in this moment – she is coming to know, to use Joe Dumit's term, her "objective-self," the sense of self constructed by knowledge we consider to be objective and extrinsic; a form of life lived with and through scientific fact (Dumit 2004).

B. uses two fingers to point at the screen, "Deep in the brain, on the right side." He says this confidently, smiling and leaning back as he points. "We'll keep an eye on it, but it isn't involved in your symptoms." He is clear and firm. Gone is his baffled irritation as he strained to

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[27] The flair (Fluid Attenuated Inversion Recovery) sequence is a common MRI technique in which the images produced show cerebrospinal fluid as dark and tissue, bone, and pathology as bright. The sequence is very sensitive to abnormalities and is commonly used to search for central nervous system pathology. It is also often referred to as the MRI technique that produces the most 'beautiful' images – for more about the aesthetics and wonder of MRI images see Joyce (2008). In this moment, we are watching as B. quickly scrolls through a series of MRI cross-sections, ascending and descending through Charlie's head which makes it look like we are watching a video of a rapidly shifting brain.

even see the aneurysm, stuck in a tangle of pathology, abnormality, and normality. B. is presenting the aneurysm, it's exact location in fact, with a certainty I know he doesn't have. He is putting on a beautiful performance of certainty for Charlie. He is the doctor and he is sure. Leading with the scans, B. is also taking advantage of the significant evidentiary truth of vision. By showing Charlie images of her brain, even if she needs to ask where the aneurysm is, he is entering into a firm realm of certain evidence. Kelly Joyce, in her writing about MRI, has argued it is a cultural icon that functions as a "technology of truth" and "offers a promise of certainty" (2008, 161) – alluring interpretations that efface the uncertain snarls involved in constructing and interpreting brain scans. A machine-generated image, presented by a doctor, shuts the door on doubt – even though it is there. With his words, his kinetic gesture of pointing at the screen, and the MRA images, B. creates an architecture of certainty that structures the encounter.

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Despite B.'s backstage confession of uncertainty to me, – a type of nuance he often described as enjoyable, "That's the fun part of this job; we wrestle with uncertainty" – in this encounter with Charlie he is all certainty. I was unsteadied by this turn from confusion and uncertainty with me to absolute certainty with Charlie (B.'s easy locating of the aneurysm, his definite statement of its irrelevancy), but the move is not necessarily surprising. Clinicians' professional identities are constructed on the basis of their mastery of specialized knowledge and, therefore, uncertainty threatens their self-concept (Whooley & Barker 2020); clinicians' ability to control their own uncertainty has been described as "the mark of the true professional" (Light 1979). This has often been cited as a central reason for clinicians' dislike of somatoform patients and others with contested or uncertain illnesses such as fibromyalgia or ME/CFS – the uncertainty inherent in these disorders elides the ideal of the clinical encounter in which the doctor can present a certain answer and a successful treatment; as a result, these patients threaten clinicians' sense of their own abilities (Kirmayer et al. 2004, Barker 2005). While this authoritarian professional identity and "aura of infallibility" (Katz 1984) seems to evoke a past, particularly masculine and paternalistic, image of the clinician, contemporary developments have not entirely banished this persona. As a resident at 1 North, an exceedingly bright and kind young woman, once told me about working with somatoform patients, "It's really difficult. Everyone hates functional disorders. It elicits a very strong response. You feel like you're not going to be able to help them." The ability to offer an answer is central to clinicians' identities and thus uncertainty seems like a direct threat to not just their work but also themselves. Beyond their professional identities, doctors are also urged towards certainty because of the nature of their work. Jay Katz, in his oft-cited article "Why Doctors Don't Disclose Uncertainty," argues that doctors exhibit a persistent "disregard for uncertainty" that is the result of psychological discomfort, professional authority, and the specific requirements of their work, "there are limits to living with uncertainty. It can paralyze action. This is particularly true… in practical affairs, as in the practice of medicine, where decisions must be made" (1984, 38). Theoretical uncertainty is one thing, but doctors, by professional mandate, are called to make decisions, to *do* something. Offering certainty is often seen to be a part of providing care. A medical anthropologist interested in the possibilities of uncertainty can value it all she wants, but a clinician face to face with a patient who is seriously ill is under significant pressures that should not be thoughtlessly disregarded. As Vincent Laliberté, a friend and psychiatrist-anthropologist, said to me after I presented some of this work, "It's easy for you to grapple with uncertainty, but I could lose my job if I wasn't certain." I was, and remain, sympathetic to his concerns (and his pushback on the type of theoretical joy an anthropologist has the privilege of playing with). However, I am an anthropologist. I am also very curious about the imagined community he feels would punish him so severely for uncertainty – who would fire him and for what? A patient complaint? The pressure he feels (whether imagined or material) is in itself revealing as to why doctors' so often hide the uncertainty they cannot escape. In this context, B.'s behaviour with the aneurysm fits neatly into scholarly findings on medical uncertainty going back at least 70 years; however, it is also not the whole story. Yes, B. did perform a certainty that he did not believe, but he was not the only one who centred certainty. Patients, as I turn to now, are also active participants in the clinical encounter with their own relationships to uncertainty.

I want an answer

We return to Charlie and B., five days from when we last left them. It's the end of the week and B. and I are with Charlie again, this time in the small, windowless interview room on the ward. She's being discharged tomorrow morning. B. and Charlie sit on the small brightly coloured vinyl loveseats facing each other and I perch on the ottoman next to B. – present, but adjacent to the encounter between them. Charlie seems to be struggling. She has a grey blanket wrapped around her shoulders and isn't wearing a mask. Her usual easy cheer and sharp wit are absent. Her eyes are wide and round and her hands grasp each other tightly, fingers twisting. She tells us she's feeling the shaking sensations strongly today. B. begins to review the work that's been done in the past few weeks and what the next steps will be in terms of treatment (medication and therapy), but before he can fully outline his plan Charlie interrupts him,

"I'm feeling like I want a diagnosis. I want the system to tell me what's wrong." I'm surprised; I know that this is what she wants, she said it outright to me when I interviewed her, but this is the most assertive she's been since coming to 1 North.

B. responds immediately, “You’ve got a somatic symptom disorder.” He told her this on Monday and has been clear throughout her admission that this is what he suspected.

“Isn’t that quite general?”

“It’s all general, welcome to mental health. No matter how much anyone wishes this was concrete, it’ll never be, that’s just the way it is. Sometimes we gotta figure it out ourselves.” In sharp contrast to his earlier behaviour, B. is sidestepping authoritative certainty and inviting something else in, an openness to a range of possibilities in terms of her symptoms, their meaning, and their resolution.

Charlie looks deeply sad. In a tiny voice she asks, “What should I tell my friends, when they ask me what’s wrong with me? What does somatic symptom disorder mean?”

B. looks kindly at her, “It means your mind’s software is not functioning to the full capacity and it could be due to all kinds of things.” He lists some of the stressors she’s gone through in recent years, “They made your world and your body less sure of itself.” Charlie nods and looks down. B. leans back, “We’re getting to the end of what science can tell us. Science is a blunt instrument. *Maybe* a tiny blood vessel has gone awry near your ear and is causing these vibrations, or *maybe* a small stroke in a vessel to your legs?” He’s trying to share an orientation to medicine with her that is inherently ambiguous, contingent, and limited. “Science goes dark with sensory issues. Sometimes what we want, what we need, is to make friends with the grey areas, the uncertainties. Science rarely rescues a person with this type of disorder.”

She raises her head and makes steady, unafraid eye contact with him, “You think I’ll get better.” It could be a question, but it’s not. It’s a statement, a command, a demand for a promise. “You think a lot of talk therapy will work. I’m looking for assurance that if I do everything and work hard, I’ll get better.”

B. looks back at her thoughtfully, “That’s where faith and hope come in.”

She is unblinking, voice hard, “I had that when I came in, but now I’m not so sure.” They stare at each other for a long moment.

Then B. sighs and rubs his eye, breaking their eye contact, “I am 99 per cent certain you are not going to die with something horrible in your brain.” Charlie’s mouth is tight, but she nods. Despite this seeming resolution, it feels like something has been lost. The fluorescents feel dimmer, the walls closer. B., for a moment, put aside his authoritative certainty and tried to move to somewhere beyond rigid objectivity, somewhere where Charlie could participate in the meaning of her symptoms, of their hopeful end. Somewhere beyond the binary registers of psychogenic versus organic pathology and the constricting moral and therapeutic opportunities they imply. B.’s “maybe a tiny blood vessel…” is characteristic of the possibilities of uncertainty as I understand them; *maybe your earthquake attacks are due to psychic distress, to trauma, but maybe they are also due to something in your blood vessels, maybe both*. Multiple meanings can simultaneously exist at once in the place that “maybe” conjures, flickering in and out of view. We could interpret B.’s “maybe” as a kind of clinical tact, a softening of the stigmatized psychic nature of a somatoform diagnosis by allowing doubt in, but it seems like more than that to me. B.’s “maybe” creates a space in which somatoform disorders need not be “ontological refugees” (Despret 2020) existing in the fraught purgatory between psychic and somatic existence, rather they become, for a moment, both. Following Isabelle Stengers use of Deleuze and Guattari’s *lines of flight*, B.’s “maybe” offers the possibility for adaptation, a new path that retains multiplicity. His uncertainty in this moment, “betrays” medicine “bringing into disclosure an ingredient [uncertainty] that both belongs to the territory [medicine] and connects with an outside against which this territory protects itself” (Stengers 2008, 42). However, this uncertain "maybe," B.'s attempt at a line of flight, fails. Charlie refuses it. She does not want something beyond the salvation of science. She ties B. to her with her eye contact, forcing him to stay with her, in this linoleum floored room, in a neuropsychiatric hospital, under the fluorescents, where she is suffering. She demands certainty and B. relents, falling back from his therapeutic uncertainty ("maybe," "maybe," "maybe") and restricting himself to the certainty he feels he can offer (there is not something lurking in your brain that will kill you).

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Across the months I spent at 1 North, patients were consistent in demanding certainty during clinical encounters. While they were often measured and nuanced with me – Charlie once told me that she was fine "If this thing is unexplainable. I know that they can't know everything" – they were exacting with clinicians. It was common practice, especially with the younger residents, to begin or end an encounter by asking "Why have you come to 1 North?" and the answers were always uniform: "To get some answers," "to figure out what's going on." Uncertainty is threatening to patients because of the assumption that certainty leads directly to treatment, if not cure. As Chloe Atkins writes in her illness memoir of myasthenia gravis (which for almost 20 years was presumed to be a somatoform disorder), "[my physicians] were obviously confounded. As the object of their bewilderment, I grew afraid. Not only was I utterly dismayed to be paralyzed again, but I also felt imminently threatened by the mysteriousness of my affliction. If no one knew what was wrong with me, no one could prevent it from happening again" (2010 33). However, the threat of uncertainty for patients also goes beyond practical concerns with prognosis. One day as I was chatting casually to K., he told me that patients often came in not just hoping for, but needing him to have a certain explanation. "In fact," he said, towering above me as we lingered in the doorway of his office, "I remember one case where an individual could not wait for the formulation, she was so uncomfortable not knowing that she was pressuring me to tell her what I thought before I really understood. Literally she couldn't wait until the end, she just *needed* to know. So yeah that pressure to give an answer is there." Scholarship on social suffering helps situate the motive behind this need for certainty. As many scholars have persuasively argued, a significant source of suffering in contested illnesses is the social suffering of uncertainty (Clarke & James 2003; Cohn 1999; Nettleton 2006; Dumit 2006; Stenner, Dancey, & Watts 2000; Stenner et al. 2015). These scholars demonstrate that uncertainty in illness is often read less as genuine uncertainty and more as suspicion, specifically a paranoia (from clinicians and social networks) around the reality of patients' suffering. Writing about Chronic Fatigue Syndrome, Norma Ware points to how uncertainty inevitably leads to stigma (how can you be 'really' suffering if they don't know what's wrong with you?) which then results in social isolation and further suffering, "the psychological paralysis induced by the ambiguities of the illness, and the shame of being wrong about 'really' being sick all contribute to psychic suffering" (1992, 355). The state of social suffering that an uncertain diagnosis results in has been described as one of "embodied doubt" (Frank 1995) and "narrative chaos" (Nettleton 2006). Uncertainty leaves patients in a social predicament where, in addition to the bodily and mental suffering they are experiencing, they are also seen as suspicious clinical and moral actors by nearly everyone around them – clinicians, family, and friends alike. Why don't they know what's happening to you? Are you not in control of yourself? Are you faking? As Charlie told me once, her greatest fear was: "My friends' fear of the unknown. If I go out to my friends and say 'oh, they don't know what it is,' well that's going to be problematic." Medical uncertainty is a palpable social threat to patients.

The social suffering of uncertainty is especially relevant in somatoform disorders as suspicion is continuously foregrounded in medically unexplained symptoms – malingering always haunts the margins. Kirmayer has argued that “the ambiguity and ambivalence of the clinical response to medically unexplained symptoms creates a crisis of legitimation for patients” (1999, 274). Furthermore, contested illnesses with uncertain etiologies generally do not lead to increased care, rather, through a combination of negative interactions with providers and lack of resources, patients with uncertain diagnoses are often systematically forced outside of the medical system (Dumit 2006, Murphy 2006, Dumes 2020). If no one’s sure what’s wrong with you, no one wants to deal with you. To access care, disability benefits, or accommodations one needs to “suffer in code,” in institutionally recognized ways (Dumit 2006). To have an uncertain illness often means patients are abandoned to bureaucratic indeterminacy where they are denied access to care and support. As such, for somatoform patients, uncertainty is both anxiety inducing in itself and can have material effects on the ability to access care. As Monica Greco succinctly argues, somatoform disorders “involve an additional burden of suffering (second-order phenomenon) that stems from profound uncertainty, from social stigma, from the potential denial of access to benefits and services” (2017, 113). Patients are acutely aware of this “second-order” suffering. All the somatoform patients I met at 1 North had spent at least five years trying to get a diagnosis (many had spent more than 10) and were familiar with being dismissed by or shunted between practitioners. It was difficult to be accepted into 1 North (many had had referrals denied over the years) and patients were often desperate not to lose their chance at diagnosis and treatment. As Charlie said to me right before her discharge, in her darkened corner room, “I’m an old woman. I’m afraid of slipping through the cracks. Out of sight, out of mind and all that.” Patients at 1 North wanted the clinicians to find a cause for their symptoms, ideally an organic one (an encephalopathy everyone had missed for some reason), but by this time they generally would accept anything, any diagnosis that could be put on their chart and make them legibly ill to the medical system and their social networks, even one as uncertain as a somatoform disorder. In this context, Charlie's refusal of B.'s uncertainty can be read as a protective act of self-advocacy. Certainty is not just a semantic matter for patients, it directly affects both their social status and ability to access care. Much of the recent work on medical uncertainty, and especially the calls to sit with or accept it, have focused on clinicians; however, this supposes that clinicians are the only ones *doing things* in a clinical encounter. As these scenes with Charlie and B. illustrate, both patients and clinicians actively shape what becomes possible in this space.

A regime of certainty

Why does B. perform a certainty he does not have? Why does Charlie demand it? We can analyze these scenes as emblematic of the psychological stresses of uncertainty – as I have just done above. However, I would like to focus not solely on individual psychological explanations, but rather on the clinical encounter as an ecological space. [28] A clinical encounter is a fundamentally relational system of responses and connections; two people (at least) are coming into contact. Specifically, I am inspired by Belgian philosopher of science Isabelle Stengers who has described an ecological approach as such: "Referring to an ecological question means referring to a question of encounters and connections, the connection between what has come

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[28] While there is currently multiple movements within medicine, and especially psychiatry, towards "eco-social" paradigms of illness that centre social systems as sites of pathology and intervention (Kirmayer 2019, Gómez-Carrillo and Kirmayer 2023) and/or conceptualize the brain to be part of a widely connected network of body and culture (Rose, Birk, and Manning 2021), here I specifically mobilize ecology in the sense that Isabelle Stengers does, in terms of a shifting methodological focus.

into existence and the many differences it can make to the many other existences with which it is connected" (Stengers 2008, 48). I take this as a methodological intervention and attempt to think with uncertainty not just as a psychological, epistemic state but to consider it as a structuring phenomenon within medicine itself. I am trying to understand these scenes not only in terms of individual motives – is B. claiming certainty about the aneurysm because he is anxious about his professional authority? Does Charlie insist on a certain diagnosis because she is terrified of what others will believe of her if she does not have one? – but focus on what is happening across these moments of contact; what comes into view if we attend to these many moving parts at once? How do both patient and clinician relationships to uncertainty – responsive, colliding, colluding relationships – shape the conditions of possibility within the clinical encounter?

With this framing, I argue that what emerges across these encounters is the enactment of medicine as a *regime of certainty*. I adapt this term from historian of science Michelle Murphy's concept of "regimes of perceptibility." Developed through her work on sick building syndrome, Murphy defines regimes of perceptibility as "the regular and sedimented contours of perception and imperception produced within a disciplinary or epistemological tradition" (2006, 24). Building off of Murphy's work, I offer a *regime of certainty* to mean a social imaginary of medicine that bounds the practices, perceptions, and responsibilities of the discipline by certainty; uncertainty thus exists outside of its purview, becoming not just undesirable but imperceptible as clinical work. While I understand a regime of certainty as a type of a regime of perceptibility, it is not wholly subsumed within Murphy's category. Murphy uses the concept to draw attention to how specific assemblages make chemical exposures alternatively real and unreal. However, my use of regime of certainty goes beyond just what is perceptible (what can be seen, what is recognized as real) and also applies to the methodological and ethical – under a regime of certainty a patient should not accept uncertainty as a legitimate response from medicine and a clinician should not admit to uncertainty nor attempt to use it as a therapeutic technique. It is not simply about what is visible, but about what actions are acceptable. A regime of certainty imagines medicine as a system that can, and therefore should, provide us with access to stable objective truths. Certainty becomes a central goal of medicine – the place therapeutic efforts must proceed from – and uncertainty is, in contrast, always an error that must be corrected. When a regime of certainty is the dominant social imaginary of medicine, the clinical encounter becomes a space for asking questions and receiving answers, a place of evidence and truth – not a place of improvisation, imagination, or accompaniment in the uncertainties of illness.[29] Medicine as a regime of certainty forces patients and clinicians to see uncertainty as an unavailable possibility – for a subject position, a diagnosis, or a prognosis. Thus, under a regime of certainty, B. admitting to Charlie that he is not sure if the aneurysm is related to her symptoms (or if it's even there) automatically becomes a failure – he is not skilled enough, has not run the appropriate tests. The legitimacy of his uncertainty about the aneurysm becomes imperceptible and unacceptable as a clinical mode. Certainty becomes the ideal that structures every action. It doesn't matter if doctors constantly face uncertainty in their everyday work; a regime of certainty defines the social imaginary of what medicine can, and should do, for both clinicians and patients.

A regime of certainty is perhaps the most dominant social imaginary of contemporary medicine;[30] however, it is also continuously enacted within the clinical encounter. In her work on MRI, Kelly Joyce identifies the hegemonic expectation of medical certainty as one of the factors

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[29] This imaginary likely appears to different extents across sub-specialties, for example ones in which long-term relationships between patients and clinicians are fostered such as family practice may be able to suspend the desire for certainty somewhat, however, in these particular specialist circumstances I am writing in, it is vivid.

[30] At least in North America, the setting of my research.

that leads to the scans being interpreted as physical reality; she cites a doctor who tells her, “the public expects 100 percent perfection. They don’t expect [a doctor] to give them anything but a 100 percent black-and-white answer” (2008, 161). We expect medicine to give us not just an informed opinion, but access to a stable, objective truth. One day in the conference room at 1 North, I watched as a patient solicited guidance on the latest COVID vaccine booster, saying to B. and a resident, “You guys can infer what’s true and what’s not true.” In line with this, Carolyn Rouse, writing on sickle cell, has argued that we consistently ignore medical uncertainty “because it contradicts our notion that medicine is a highly rational and exact science” (2009, 75). It doesn’t matter if medicine is a fundamentally uncertain practice, we imagine it to be certain. As such, I argue that a regime of certainty is perhaps our most dominant relationship to medicine in North America at this moment in time – further evidenced by the many terms used to describe the era of medicine we are living in: positivist, empirical, evidence-based, etc. (see Gillett 2004, Dumes 2020). However, this regime is not simply passively received as it is passed down through discourse, it is also enacted and rematerialized in clinical encounters; it both acts on clinicians and patients and is enacted by them. When B. shows Charlie her MRA scans, claiming confidently that he knows exactly where her aneurysm is and what effects it is having on her, he is rematerializing medicine as a regime of certainty, as a system that’s central purpose is to provide stable, objective answers. Similarly, when Charlie rejects B.’s offering of uncertainty as an intervention and demands he give her certainty, she is refusing to see his uncertain offering as legitimate clinical mode, a place therapy can proceed from. Every clinical encounter is influenced by this social imaginary of medicine, but also has the possibility to sustain or interrupt it. Both Charlie and B. are influenced by the tradition of medicine as a regime of certainty, but together they also rematerialize it in the moment and thus shape the conditions of possibility for themselves and each other. It is not enough to say they are each individually responding to the psychological pressures of uncertainty; they are also, together, acting within the dominant social imaginary of medicine and, in doing so, creating it anew – this is where and what your aneurysm is; tell me how I am ill and how I will stop being ill. The clinical encounter is not simply a static place governed primarily by unequal power dynamics, it is also an ecological, unfinished, dynamic space in which the conditions of possibility are actively being established and (re)negotiated by patients and clinicians – in this case, specifically both parties' relationships with uncertainty.

Therapeutics of (un)certainty

I suggest that these scenes between Charlie and B. reveal a regime of certainty; however, they also leave us with a lingering question – is sustaining medicine as a regime of certainty a failure? The scholarly and clinical record provide persuasive evidence that certainty is soothing for both patients and clinicians. As such, isn't fidelity to certainty a therapeutic act? Perhaps we should disregard concern about the boundaries of perceptibility and possibility that this social imaginary of medicine imposes and instead focus on the immediate therapeutic benefits that certainty provides. From one perspective, it is a deeply pragmatic and astute act of care to declare, without hesitation, to a patient who you suspect has a severe underlying anxiety disorder, that the aneurysm the radiologist claims to have found has nothing to do with her shaking – so much of effective care is often focused on calming the chaos and confusion of illness (Kirmayer 1994). From Charlie's perspective, certainty was a desired gift; she asserted, very clearly, what she needed from B. and he was responsive. I recognize certainty's gifts and I think what I witnessed when B. broke Charlie's eye contact was an act of care. And yet. I am also suspicious of the totalizing therapeutic benefits of a regime of certainty.

First, somatoform patients are infamous for needing chronic care. While some somatoform patients experience complete and spontaneous recoveries, stories that everyone loves to tell, success is generally defined by a decrease in symptoms. It is in this context, of a lifetime of strange, disturbing symptoms that are not limited by anatomy or physiology, that I am suspicious of the ability of certainty to hold these experiences. Near the end of my fieldwork, a woman who had been admitted to the clinic many years ago suddenly reappeared. In the past, she presented with tremors in her neck but was now experiencing full-body myoclonic jerks and refusing to eat. The staff were surprised, they hadn't heard from her in years and, last they had, she was steadily improving; why was she back in the clinic? The discharge manager, a friendly brusque woman, checked her notes and told the conference room (densely populated for the weekly team meeting), "Her psychiatrist is desperate for anyone who can remind her that it's a functional disorder." The certain explanation of a somatoform disorder that she had been given (this is emotional distress manifesting physically) seemingly could not hold. Over the years of her strange symptoms, doubt had crept in and eroded the therapeutic certainty she had been given, returning her to the place she had begun. If certainty is the goal of our dominant social imaginary of medicine, when it fails, patients and clinicians must return to where they began, searching, straining for certainty – which, at least in the case of somatoform disorders, may never be possible. I left 1 North only days after this woman arrived and she is, of course, just one case. However, my memory of the clinicians' confusion and the woman – furious, thin, shaking – lingers uneasily. Perhaps certainty, no matter how immediately therapeutic, cannot always hold the strange, stubborn experiences of a somatoform disorder. Certainty's soothing effects may unravel under the vicissitudes of life and time.

Second, considering scholarship on the constellation of ideologies – dualism, empiricism, evidence-based medicine – that participate in the marginalization of medically unexplained symptoms (Kirmayer and Gómez-Carillo 2019, Dumes 2020), medicine as a regime of certainty seems to become quickly complicit in discrediting any suffering that does not neatly correspond to organic pathology. As previously discussed, I understand uncertainty not as a cipher for ignorance, a lack of knowledge, but as a flicker, a precarious yet simultaneous multiplicity of possibilities, a "polyphony of variants" (Despret 2020, 62). In contrast to this, a regime of certainty demands a clear, logical, visible explanation – your arm is in pain because you have broken your radial bone. Certainty requires a fixity, a stability. Somatoform disorders cannot satisfy these criteria. Even within the certainty an orthodox psychiatric explanation supposedly offers there remains an etiological tangle – we believe your shaking is caused by childhood trauma, but we're not sure why it is being manifested as such; maybe because you had a friend who had epileptic seizures, but perhaps you also have some pathophysiological predilection for epilepsy. If medicine is a certain practice, then anything that cannot be adequately dealt with under these parameters does not belong, is not legitimate suffering. Adriana Petryna, writing about illnesses that were classified as psychological following Chernobyl, echoes this, reflecting on "the ways the scientific research process itself contributes to the spread of pain and suffering by searching for easy answers and simple closures." (2002, 12). By making etiological answers central to medical research and practice, Petryna argues that medicine reifies the categories of "authentic and inauthentic suffering" (ibid). A medicine not structured by a regime of certainty might not see somatoform disorders as so baffling, frustrating, or suspicious. As such, I suggest that continuous patient and clinician enactments of medicine as a regime of certainty in the context of somatoform disorders can be thought of as a relation of "cruel optimism," to use Lauren Berlant's concept. Berlant defines this term as such: "A relation of cruel optimism exists when something you desire is actually an obstacle to your flourishing… when the object that draws your attachment actively impedes the aim that brought you to it initially" (2011, 1). Certainty may be something that doctors and patients desire and yet, with its narrow standards that somatoform disorders cannot fulfill, I suggest it is likely an obstacle to any long-term therapeutic flourishing; under a regime of certainty, somatoform patients have always-already failed the ideal of the clinical encounter and standards for "correct" suffering. While patients and clinicians may wish for a certain future in which somatoform disorders can be diagnosed with an fMRI, where involuntariness can be measured with a test, at this moment that is an unachievable fantasy and operating as if it is true forces patients into a state of continuous failure in which they are not suffering correctly, not existing as good citizens of medicine, and thus are always suspicious and unwelcome. Despite both parties desiring certainty and believing that it will be therapeutic, in the long-term it traps patients and clinicians in a cycle of failure. Berlant argues that this looping cycle is a feature of relations of cruel optimism, describing the attachment as producing: "A sustaining inclination to return to the scene of fantasy that enables you to expect that this time, nearness to this thing will help you or a world to become different in just the right way" (2011, 2). We desire certainty in the clinic because we believe it will lead to recovery, that it is even required for it. However, certainty is a brittle stone, cracking and eroding and fading under years of doubt and pain; especially in somatoform disorders where the ground is always-already giving way. As such, despite the immediate therapeutics of certainty and its practice as an act of desired and offered care, I suggest that there is no reparative future or legitimate beginning for somatoform disorders under a regime of certainty.

It is in this context that I am curious about other possibilities, other imaginaries of medicine; I find the work of Katrin Solhdju and the Dingdingdong Collective to be compelling here. Working in the aftermath of positive Huntington's genetic tests, the Dingdingdong collective rejects medicine as "the provider of singular forms of truth, truth-which-cannot-lie, the specificity of which is to crush all others" (Solhdju & Rivières 2021, 29). When Alice Rivières (the founder of the collective) received the results of her genetic test, her doctor told her that the rest of her life would be "dreadful" and quickly outlined all the things she must get in order before her inevitable decline began (Solhdju & Rivières 2021, 27). Rivières describes how, in the face of this medical certainty, her life narrowed and collapsed until a neurologist friend helped her found the Dingdingdong Collective and, together, they developed an "antidote" to this crushing certainty. She describes this 'antidote' as such: "a slow and gradual reinjection of everything that had been eroded by the test: doubt, uncertainty, hesitation, the maybes, what-ifs, and feel-your-ways" (Solhdju & Rivières 2021, 35). While Huntington's disease is a specific, genetically deterministic, context, I find the Dingdingdong Collective's rejection of the therapeutic benefits of medical certainty and embrace of uncertainty as an essential mode of life with illness compelling. An orthodox somatoform explanation that relies on certainty, 'your body is manifesting your emotional distress,' allows for such a narrow range of possibilities – it obfuscates the many entangled psychic and somatic intimacies and unknowns which exist below this certainty and makes anything that doesn't quite fit in (a new symptom? Or symptoms in a new context?) liable to break the explanation. It is in this vein that I became fascinated with the surprising wellness of two religious patients I met during my time at 1 North.

Miracles

Bright and bubbly, Jenny worked as a teacher in a gifted children's program until, due to the predictable cycles of layoffs based on seniority, she was fired and harshly reprimanded for sharing her disappointment. She then began to experience jerks in her upper body. Over the next few years these intensified, becoming massive complex seizures; this then escalated to memory and breathing problems. With a team of 11 neurologists from around the province, it seemed like there was something seriously and fatally wrong. Finally, when she was having upwards of eight seizures a day, she was admitted to a seizure unit where she could be extensively monitored. Within six days, the team came to give her the good news, there was nothing wrong with her brain. A psychiatrist then told her words that she repeated to me reverently: "It's a severe psychiatric condition. It's a big deal. But there's hope and you can get better." From that exact moment on she never had another seizure. All of her symptoms vanished. Now a mental health advocate, she was charming and friendly when I interviewed her. The psychiatrist's words seemed like a successful example of therapeutic certainty; she was diagnosed and cured in one moment, one speech act. I assumed that it was the certainty of this explanation that cured her. However, as we chatted further, she shared that even her psychiatrist and neurologists told her that this immediate recovery was hard to explain; scientifically, it didn't fit with how somatoform disorders are understood. This didn't bother her; as she told me, "I feel like I was gifted a miracle when I needed it." She meant this literally. She described herself as a person of great faith, and when I pressed her on her "miraculous" recovery she shrugged and smiled, telling me she was sure there was some science involved, but it didn't matter to her exactly what had happened. I still wonder if religion was a source of explanatory certainty for her – was the uncertainty of her suffering contained within a greater certainty in God? – however, my impression of her was one of no attachment to certainty. She described her recovery as a miracle, but was also a passionate mental health advocate and described her seizures as being caused by "neural mixed messages" – mixing discourses of religion, psychiatry, and neuroscience. She didn't care if things couldn't be firmly or neatly explained.

Similarly, one warm afternoon I joined B. by Zoom for an outpatient appointment. He was eager for me to join because it was an unusual case. The patient was a woman who had been experiencing convulsions; however, while she had been given a diagnosis of a somatoform disorder, she was also devoutly Catholic and believed her convulsions were associated with demonic possession. Based on this information, I expected the call to go the way many others had gone – frustrating, sad, and draining. However, when she got on the call I was surprised. She was effusive and cheery, driving to school to pick up her child as she talked with us. She laughed easily and called B. "doc," as she updated us on her life. She barely seemed to be suffering – at least not in the way I'd learned to expect from somatoform patients. She talked casually about how she still had seizures while praying, but told us that they'd been getting much better and she was back to work. B. asked her how she was feeling about her symptoms receding, expecting I suspect, to have to offer her an explanation. However, she was unfazed. She didn't ask him once about how her symptoms could be explained or a prognosis. Rather she confirmed she could refill her antidepressants as usual, cheerily thanked him for his help and hung up. Afterward, I told B. I was surprised by how functional she was, given the condition of other patients we'd seen with almost identical symptoms. B. nodded and confessed he also found it unusual.

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I am still, in many ways, adrift with these two patients. While they both had faith in something outside of medicine, I am skeptical that it was an enduring, concrete certainty in God, an alternative explanatory model, that made them recover remarkably well. Jenny called her recovery a miracle and the Catholic woman believed her symptoms were caused by possession; and yet they also both happily embraced medical explanation and intervention – whether psychotropic medication or therapy. Tanya Luhrmann, in her work on how spirits become real, argues that faithful people do not simply believe in the reality of spiritual forces, but rather work hard to foster relationships with them – work that, centrally, includes an acceptance of the ambiguous (Luhrmann 2020). I initially, and perhaps naively, equated faith with certainty. However, it now seems to me that it was their comfort with uncertainty, with the ambiguous, that served these two women well. Neither Jenny, nor the Catholic woman, needed certainty to guide their experiences. They borrowed explanations and treatments from both biomedicine and religion, seeming to easily accept that there are things that cannot always be neatly explained. Uncertainty, in terms of etiology and recovery, wasn't a threatening abyss that they needed to protect themselves against, rather, they seemed to barely register it as a problem. I came into contact with each of these women so briefly, but they linger in my thinking for their experiences contrasted so vividly with the other patients I spent time with at 1 North. In these glimpses, I see both a potential therapeutic path for somatoform disorders[31] and that other imaginaries of medicine may be possible. Medicine can be other things beyond an unyielding search for a stable, certain truth. Neither woman required any certainty from B. and he seemed happy to let them be, focusing on treatment on going forward. Outside of a regime of certainty, the conditions of possibility – in terms of suffering, recovery, and care – may be transformed.

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[31] Acceptance of ambiguity, not religion, to be clear.

(Not) good enough?

Across these scenes, a regime of certainty that both shapes Charlie and B.'s actions and is sustained by them in return comes into view. However, the implications of such a regime are not easy to settle on. From the scholarly record, it seems clear that certainty can be a therapeutic act, one that can soothe patients and give them solid ground to stand upon as they navigate their symptoms, their social worlds, and access to treatment. However, it also seems that certainty cannot always hold the experiences of somatoform disorders and may even participate in their foundational marginalization. As such, while medicine as a regime of certainty may be therapeutic, it may also be insufficient, and marginalizing. The therapeutic and the violent are not mutually exclusive, even for the same person, even in the same moment. Under a regime of certainty, somatoform disorders are a puzzle to be solved, an unruly illness in need of categorization, rather than a phenomenon that unsettles our thinking about science and the body, about our commitment to objectivity. Medicine may always be a practice of the good enough, the for now, the stop-gap measures until we can do better, and I don't know if it is fair to ask more of it. However, as Annemarie Mol argues,

> Reality moves. It can no longer play the role philosophy cast for it a few centuries ago, the role of something to… be sure about… we confront another question: how to live with doubt? It isn't easy. But somehow we must come to terms with the fact that we live in an underdetermined world, where doubt can always be raised. Somehow we must learn to understand how it is that, given this possibility, we can still act. (2002, 165)

At the very least, we should be aware of the conditions of possibility, for ourselves and others, that our relationships with uncertainty in the clinic create and try to remember that other imaginaries of medicine are possible.

CHAPTER 3 – Affects of (Un)Certainty

Forces and impacts

I don’t want to be in this room. It’s a thought that is immediately followed by a rushing flood of guilt – I have, after all, gone to a great deal of trouble to get myself here and the young man lying across from me has offered his time and pain generously. And yet. There is something in the air, in between us, coming from him (?), that makes it hard to breathe – a heaviness. I lock one ankle behind the other and force myself to be still.

David is young, just a few years older than me, but his bearded face, gaunt with pain, makes him seem much older. He’s lying on top of the blankets in his hospital bed, but there is no comfort in his body. Back and neck rigid at awkward angles, his legs are drawn up into a half bend – over the past 12 years of back pain he has become increasingly immobile, the pain and fear freezing him so much that the muscles and tendons in his knees have shortened, making it impossible for him to fully straighten his legs. Here on the bed in this dark room, limbs at odd angles, pain visible in every shadow on his face and body, it looks as if he has fallen from a great height and been suspended in the moment of impact.

“...beyond the pain at my thoracic injury, the first pain that I got was in my rib cage. It felt like it was pulling apart and it was really strong, harsh pain when I was a teenager… so that’s kind of how things have arisen um… like I’ll get a lot of pain in a place and instead of feeling like it resolves, it feels like it… just the shape of my body has changed.” I force my attention away from his body, away from this current in the air, and back to his voice. He’s answering my question about what brought him to 1 North after so many years. His voice is slow and thin, but forceful. I nod, tell him that that all sounds awful (a terrible, insufficient, useless thing to say) and look down at my notes as if I’m trying to decide what to ask next – I need a moment to try and disperse this heaviness. I clear my throat and ask him about his experience at 1 North. This is what I am most interested in hearing about but, as soon as I ask, the force in the air gets tighter, spiking into something hot and live. A twisting precarity, like the sense of yawning, palpable emptiness when walking near a precipice in the dark. A charged abyss.

“My experience here…” David pauses and then his voice starts to rise, louder and faster, louder and faster, louder and faster, louder and faster, “it all feels *poisoned.* My low back is getting worse and I still can’t sleep with my legs down… I just don't understand, like why not fix this one spot in my back that’s been the cause of everything? I don't see how I’m not gonna become like a total hunchback in– I don't know how many years it will take and how much will I suffer?” His hands, previously drifting up and down his torso, touching his ribs lightly as we spoke, are now in fists, gripping the thin beige hospital blankets tightly. “I just *want to know.* Because… it just doesn't make any sense to me. None of this makes any sense.” The anger and pain and fear radiating off him, vibrating in the air, makes my chest feel tight and I look away, trying to hide how unable I feel to hold his pain, trying to figure out how to guide our conversation towards safer ground. This swarming, spiking, charged force in the room is crushing. “...And I don’t know, based on what the doctors say it seems to have zero… it means *nothing*.” Bang! My head snaps back. He has slammed his fist against the side of the bedside table, upending his keys and an opaque white plastic cup, beads of water skittering across the laminate surface. “Like if it means nothing then what is true?” He’s rubbing his fist, trembling. “If I hit myself with a hammer, is that not real? Is that… I can’t even trust, what can I trust? I’m sorry.” I’m trembling now too; the impact resonating in my body. There is something here that I don’t understand. Something rogue and shifting and overwhelming. This room is saturated with it.

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In this thesis, I have argued that patients and clinicians together enact a regime of certainty, materializing a social imaginary of medicine as a system that can and should provide access to a stable objective truth – even when both parties avow an acceptance of the presence and utility of uncertainty within medicine. In the previous chapter, I discussed contributing factors to this disjunction, including patient fears of delegitimation and clinician anxieties about authority. However, as I argue in this chapter, an additional and essential aspect of this discordance is affect. Thinking with affect helps us get closer to the simultaneous threat and possibility of uncertainty in the clinic, to the incongruous yet intimate slip between consciously acknowledging that uncertainty is an inherent aspect of medicine that can have therapeutic value and rejecting it as a clinical mode at every turn. I argue that the phenomenon of medicine as a regime of certainty is, at least partially, grounded in the affective system. As such, affect – the circling, swirling, currents of force and feeling that saturated the encounter between David and I, "the name we give to those forces – visceral forces beneath, alongside, or generally other than conscious knowing, vital forces insisting beyond emotion – that can serve to drive us toward movement, toward thought and extension, that can likewise suspend us… or that can even leave us overwhelmed by the world's apparent intractability" (Greigg and Seigworth 2010, 1), – is a vital part of this story of medical uncertainty.

In this chapter, I conceptualize certainty and uncertainty not just as psychological or epistemic states, but as objects that travel with culturally mediated affective associations. Specifically, drawing on the work of Sara Ahmed (2010), I suggest that, within the clinic, certainty is a 'happy object' and uncertainty an unhappy one. Ahmed describes 'happy objects' as objects that positively affect us and thus, as a result of that good feeling, we judge to be morally good. We orient ourselves towards objects that are imbued with positive affect for we believe that proximity to them will bring us further happiness and turn away from those that cause us unhappiness or interfere with our closeness to a happy object. Thinking with Ahmed, I argue that the affective associations of (un)certainty shape, inflect, and interrupt relationships with medical uncertainty in the clinic. Furthermore, I argue that while these affective associations are mediated by cultural and historical trends, their bodily immediacy makes them appear natural to us, reinforcing our judgements of these objects. Affect thus helps to shape the normative field in the clinic that prizes certainty and reviles uncertainty, making it difficult to approach medical uncertainty otherwise. Thinking with affect theorists such as Sara Ahmed, Teresa Brennan, and Alia Al-Saji, in this chapter I explore the affective undercurrents I encountered, witnessed and became caught[32] in during my time at 1 North. To be clear, I do not assert that affect is the sole, or perhaps even the primary, explanation for a regime of certainty; however, I argue that it is an essential factor and one that is often under-attended to in theorizations of the clinic. As such, this chapter approaches the phenomenon I have previously explored from the side, circling back and around to explore the texture of this regime's presence and persistence in the clinic.

I begin with a selective overview of contemporary affect theory, outlining its multiple definitions and uses in social theory and collecting the particular theorists and thoughts I am guided by in this chapter. I then move to an exploration of certainty and uncertainty as affective objects – the coupled pairing of the 'happy' object of certainty and the 'unhappy' object of uncertainty – and how the affective associations of each promise and/or threaten imaginaries of suffering and recovery in the clinic. This includes a brief detour into the source of these affective attachments. I then explore how somatoform patients' themselves become unhappy objects,

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[32] I am here, of course, referencing Jeanne Favret-Saada's work on fieldwork, writing, and affect (2015).

straining the relationship between patients and clinicians. Next, I investigate the play between culture and the body in the interpretation of these affective associations before closing with a discussion of how thinking with affect shapes our ability to engage with uncertainty in the clinic.

Affect theory

Affect is a notoriously slippery scholarly approach. Simultaneously beloved and loathed[33] across a variety of disciplines, the term points in multiple, entangled directions at once; oftentimes building on other affect scholars, but just as frequently contradicting them in the details. Many theorists trace the beginnings of affect theory to Dutch philosopher Baruch Spinoza's "*affectus*" and his argument that bodies have the ability to affect and be affected, to cause and respond to transitions in bodily states that are related to, but not synonymous with emotion (Spinoza 2006). Others choose to begin with Brian Massumi's succinct description of affect as the "felt reality of a relation" (Massumi 2002, 16) or ground their work in the psychologist Silvan Tomkins' conceptualization of affect as the biological portion of emotion and his assertion that it is the "the primary motivational system because without its amplification, nothing else matters—and with its amplification, anything else can matter" (Tomkins quoted in Frank and Wilson 2020, 14). Affect's multiplicity has led to a variety of conceptualizations across disciplines. In neuroscience or psychology, affect describes the subconscious automatic bodily reactions that undergird emotion – once the force rises to consciousness and is interpreted it will then, often clumsily, be assigned an emotion: shame, fear,

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[33] Affect theorists' tendency towards totalizing explanation, 'affect is at the heart of everything. By focusing on affect I have pulled back a veil from the world and now we can see it clearly,' is often grating to people – see Leys (2011) for more on this critique, amongst others, of affect theory. While I appreciate affect theorists' provocativeness in the strength of their theories, I am not drawing on affect theory as an exhaustive paradigm, rather I am using it to pull on one strand of the tangled story of medical uncertainty I am trying to tell in this thesis.

happiness, etc. Importantly, the same underlying affect can be assigned different emotions depending on the context and interpretation. However, in the social sciences and humanities affect tends to be less strictly defined. Melissa Greigg and Gregory Seigworth in their introduction to the *Affect Theory Reader*, describe the concept as such: "Affect arises in the midst of in-between-ness: in the capacities to act and be acted upon… found in those intensities that pass body to body… in those resonances that circulate about, between, and sometimes stick to bodies and worlds, and in the very passages or variations between these intensities and resonances" (2010, 1). Affect is related to emotion, but it is more nameless, more ambiguous, more forceful and moving. Furthermore, while affect is intimately connected to the body, it is not contained by it. Atmospheres can also be affective, holding and circulating forces of feeling (see Anderson 2009) and a key component of much contemporary affect theory is the understanding that bodies are porous, that affect jumps and moves between people (see Brennan 2004). Whether affect comes from outside or from within,[34] affect theory tends to reject a contained subject. To think with affect thus requires one to attend to the non-discursive, to the ephemeral and moving, to the intensities that linger in bodies but also flit between and across them. As Kathleen Stewart argues, "[affects] work not through 'meanings' per se, but rather in the ways they pick up density and texture as they move through bodies, dreams, dramas, and social worldings of all kinds" (2008, 3). Anthropologists in recent years have become increasingly drawn to affect as a way to share a "critical dimension of fieldwork (the state of being affected)" (Favret-Saada 2015, 97)[35] as well as a way to attend to the unspoken, the imaginal, and the subjective (see Stewart 2008, Collu 2019). Affect is a mobile description for a mobile target – a

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[34] An often contentious topic, see for instance Sara Ahmed (2010)'s discussion of Teresa Brennan (2004)'s theorization of these processes.

[35] See also Cristiano Giordano and Greg Pierotti's work on affect theatre (2020).

fact central both to its infuriating and adored status; as Greigg and Seigworth say, “there is no single, generalizable theory of affect: not yet, and (thankfully) there never will be” (2010, 3).

What do I mean by affect in this chapter? I never intended to write about affect. I went to 1 North looking for uncertainty, looking for orientations and fears and approaches to the precarity of knowledge, but in those rooms, in those hallways under the fluorescents, I stumbled across something moving and forceful that I didn’t have a name for. For a long time I ignored these moments. I didn’t understand them and so I left them in my notes, tucked away from my desire to clarify, to explain. As Samuele Collu has written in his work on affect in systemic couples therapy, “the evanescent and impersonal quality of affect challenges our hermeneutic tendencies as it asks the anthropologist to be attuned to often non-discursive aspects of the world” (2019, 291). Furthermore, in writing about affect, it is rarely possible to isolate it neatly. Affect resists clarity; it does not exist purely, but rather tends to be “refracted,” tangling and splitting as it moves – “while an affective intensity… circulates across bodies, every subject might be inhabiting a quite different temporal and imaginative fold… Even if shared at some level—we all felt something—affect can be refracted by different mediums that alter, redirect, and distribute their intensity” (Collu 2019, 307). I didn’t know what to do with these things I could barely articulate. But they lingered, haunting the margins of my computer screen, of my vision, as I wrote and talked and tried to wrestle my experiences at 1 North into thought. Affect, the parallel, underlying currents of force and feeling, is also a part of this story. For the purposes of this chapter, I use the term ‘affect’ to describe the forces that circulate, cresting and crashing and resonating within and between bodies, sometimes giving rise to conscious emotion, other times lingering quietly as an atmospheric mood. In this chapter I am trying to pay attention to “the forces that come into view as habit or shock, resonance or impact” (Stewart 2008, 1), to the "intensities they build and what thoughts and feelings they make possible" (Stewart 2008, 3). I am trying to understand what the force that I felt in that dusky room with David, the crushing breathlessness that passed between us and hung in the air, made possible or impossible in regard to thinking and acting with uncertainty.

While contemporary affect theory is most often mobilized by queer theorists, feminist scholars, and philosophers thinking with race, modernity, and capitalism, it is also at home in the clinic. Affect, although not always by that name, has been a central concept of theorization from psychoanalysis (see Klein 1980, Brennan 2004) to contemporary counselling and therapy (Fosha et al. 2009, Hill 2015, Kirmayer 2019, Collu 2019). It appears in concepts such as transference and countertransference, the therapeutic alliance, the talking cure, and placebo efficacy. As such, one could say that affect theory is particularly appropriate in the context of somatoform disorders. Teresa Brennan, building off of work by Julia Kristeva, has even argued that affect (particularly its transmission or lack thereof) is at the root of disorders like chronic fatigue syndrome and fibromyalgia (Brennan 2004). Furthermore, thinking back to chapter 1, the language 1 North uses to describe and theorize somatoform disorders – psychic distress, emotion stuck in the body – seems to echo off these walls. However, I am not laying out an affective theory of somatoform disorders; these strange, fascinating, infuriating disorders remain the context for considering the affective associations of certainty and uncertainty and their significance. This detour into the place of affect in the clinic is simply to note that while affect often remains under-attended to in clinical ethnographies, affect and the clinic have a long history together.

(Un)happy objects

I return now to David, to David and myself, in that darkened room on the edge of July. We're nearing the end of the interview, a sprawling hour and 45 minutes together – although looking back at the transcript now, it's sparse. He often answers in just a few words, or pauses, silence stretching out on the tape when I listen back.

In many ways I feel like I have a less clear picture of him and his pain now than I did before I walked in, knocking carefully on the open door and stepping around the dark curtain that blocked his bed from the sight of the hallway. His psychiatrist told me that as a teenager he had begun to have back pain which had increased exponentially over the years until he eventually became bed bound. The team told me that he had been eagerly embracing their suggestions, trying to practice sitting and beginning to attempt standing with an upright walker, his socked feet twisted, just barely brushing the ground. They said he was beginning to accept that his pain might be due to psychic distress. However, his story, the one that emerged in that dark room, was very different. He told me immediately of an injury, a moment in the past in which he ran with a friend on his back, jumped off the edge of a curb and felt a crunch in his spine. He tied everything back to this instant. He described his back's unnatural curve to me, the way his ribs *felt* wrong, the pain that was so bad he couldn't go for a bone scan. His ultimate goal, which he repeated to me over and over again, was surgery; he wanted a surgeon to fix his spine and return him to the life he had had 12 years prior.

The atmosphere in the room is still taut and heavy but has subsided from its earlier eruption into a low, thrumming buzz. Shuffling the papers in my lap, I ask him the question I always end with,

"Before we finish, was there anything you expected me to ask or say that I didn't?"

"Um…" David hesitates, hands twisting in his lap. "I guess I was expecting a bit more, like psychological type things. I guess I expected you to ask me about psychological 'factors' or whatever. To tell me that you believed me." His voice is flat; this line of explanation is both exactly what he should expect from the clinicians at 1 North and I know is often seen as a betrayal by many patients. He continues, "... I thought you might say that this was *maybe* psychological, *but maybe also* physical," I notice that his hands are fisting at his sides again, clutching the blankets so tightly that his pale knuckles blanch even further. Trying to resist the sucking pull of the current in this room? Or stoking it? "That maybe, *maybe*–" he spits out this final 'maybe' like it's a foul word; his voice catches and he grimaces, shaking his head. Something sharp and smoldering has once again surged up from the dense heaviness.

"Well, I'm not a doctor. I probably know even less than you," I mumble. "I'm not a medical doctor at all. I'm just an anthropologist. I'm sorry. I can't offer you any explanation."

He stares at me. Hard. Unflinching. Angry. I feel ashamed, like a poor ethnographer, an erring student, a flincher. *I need to get out of this room*.

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For a long time I didn't know what to do with David, with the day I spent with him in that room. I ignored the transcript and didn't mention it to anyone. His anger felt like an indictment; I could only see it as a failure. I came back again and again to that final question I asked. The things he said he'd expected of me were the things I saw the doctors say, the things that I associated with them being a 'good' doctor. Weren't you supposed to tell someone you believed them? That there were likely many factors? That you thought maybe multiple things could be true? I admired the clinicians I'd seen say such things. Why did the atmosphere become so sharp? Was it because I hadn't said those things? But that force didn't surge until he spoke the words he was expecting, ventriloquizing a parallel version of me. Now, from a distant temporal and geographical vantage point, I think that what appeared in that moment, in that 'good' doctor response, was uncertainty. It was this day with David, this suffocating, saturating intensity, that made me begin to consider uncertainty as an unhappy object.

This line of thought comes from the queer theorist Sara Ahmed, specifically her 2010 essay "Happy Objects." In this essay, Ahmed argues that affect shapes our evaluations of objects (broadly conceived) – we judge something to be good because it makes us *feel* good. Furthermore, this tangle of affect and judgement is not individually established; Ahmed argues that affect is "sticky" and thus objects accumulate shared affective values, circulating as social goods. It becomes socially 'correct' to value and seek to attain a happy object. Affect thus orients us toward some objects and away from others; an object imbued with positive affects becomes a means to happiness and any object that interferes with obtaining this happy object becomes identified as the cause of unhappiness. To be clearer, in Ahmed's work she specifically argues that the family is an archetypical happy object – we believe that family is a path to happiness; those who orient themselves around family are regarded as good, as having the correct values, and those who do not direct themselves toward it or even interfere with its reproduction (the queer child or feminist kill-joy in Ahmed's case) become sources of unhappiness. Affect is thus not just a private, phenomenological experience, but also an engaging, interactive one that links us with the world and with others. As Ahmed says, "objects are sticky because they are already attributed as being good or bad, as being the cause of happiness or unhappiness… Groups cohere around a shared orientation toward some things as being good, treating some things and not others as the cause of delight" (2010, 35). Affect is not simply a result of personal preference or response; many objects have deep culturally shared affective associations – either positive or negative. As such, when we encounter these objects – whether we've sought them out or endeavoured to avoid them – our affective responses are already primed. Affect thus drives intimacy with or distance from objects; and, in doing so, it shapes the possibilities for behaviour, thought, and judgement.

It is with this theoretical framing that I argue that certainty is a happy object in the clinic, and, as its paired inverse, uncertainty is seen as a significant source of unhappiness. Certainty is often cited as an uncomplicated good, a desired result – in that dark room David tells me "I just *want to know*;" Charlie insists that "the system," tell her what is wrong with her, assure her that she will get better, more confident than I had ever seen her; and B. is calm and pleased, leaning back in his chair, smiling with an easy air about him when he asserts that the aneurysm has nothing to do with Charlie's symptoms, as opposed to the troubled fog that swirled around him when he told me about the ambiguous results. Certainty makes both patients and clinicians feel good and so we judge it to be good. Due to this status, certainty also becomes positioned as necessary for future happiness. As Ahmed writes, "objects not only embody good feeling, but are perceived as necessary for a good life. How does the good life get imagined through the proximity of objects?" (2010, 34). There is a type of 'good life' in the clinic that often only seems possible through certainty. Certainty in medicine promises answers, soothing the chaos and fear that accompany suffering. It is calming; it can tell us what is happening to us, whether and how we can be healed, how we might recover, or if we won't – 'If I know why I am suffering, I can be healed, I can return to my life. Or, if I am going to die, at least I can expect it, I will know what is coming.' Certainty seems to promise happiness – perhaps the desired outcome of a full recovery ('you have an infection, take these antibiotics and everything will be okay'), but even when a simple recovery fails, it promises to soothe the chaos of unknown suffering, to chart a path forwards. Certainty is seen as so necessary for the clinical good life that it can become the primary desire. I once watched as a distraught suspected somatoform patient told the resident conducting an assessment, "Clearly there's something wrong with me. You need to tell me what it is. I need some clarity. *And then I'll be OK*." Certainty makes us feel good and so we believe it must be good, that it must be *necessary* for recovery or an ill existence. The desire for certainty becomes a pursuit of happiness. As Ahmed argues, "objects become 'happiness means.' Or we could say they become happiness pointers, as if to follow their point would be to find happiness. If objects provide a means for making us happy, then in directing ourselves toward this or that object we are aiming somewhere else: toward a happiness that is presumed to follow" (Ahmed 2010, 34). Certainty is a happy object in the clinic; it positively affects us and thus we continuously orient ourselves toward it, believing that it promises us happiness, promises us the clinical good life, if only we can reach it, hold it tight.

How has certainty become so linked with happiness? Affect theorists tend to point to the cultural milieu in order to explain the cause-and-effect of affect. Ahmed stresses how our affective reactions influence our evaluations (this object makes me feel good and so it is good), but also how these reactions are mediated by culture, by the "affective community" – "objects are attributed as the cause of happiness, which means they already circulate as social goods before we 'happen' upon them, which is why we might happen upon them in the first place" (2010, 41). Similarly, other scholars, such as Alia Al-Saji in her work on affect and racialized ways of seeing, highlight how our affective attachments do not simply appear, but rather are culturally produced. Our habits of feeling "owe to a social, cultural, and historical field" (Al-Saji

2014, 138). To follow Ahmed and Al-Saji would be to firmly argue that certainty's status as a happy object is a culturally mediated one – specifically, in my case, considering the location of my fieldsite, a Western one. This seems logical in many ways. Postcolonial philosopher and writer Édouard Glissant critiques the totalizing desire to "grasp" as a uniquely Western one and argues that "[Western thought]'s basis is this requirement for transparency. In order to understand and thus accept you, I have to measure your solidity" (1997, 190). I read 'transparency' here as akin to certainty. To be certain is to know beyond doubt. Through certainty we believe we can become the contained, knowing, thinking subject who can reason their way to truth and thus control their own life, and often others,' lives. However, others would contest that the desire for certainty is solely cultural. For instance, the existential psychiatrist Ludwig Binswanger, in his writing on the ontological suffering of uncertainty, describes the happiness of certainty as a "primal force [that] points to the desire for an objective grounding and stance" (1986, 91). The scope of this thesis does not allow me to make any claims about the presence or absence of a socially entrenched desire for certainty in other cultural contexts[36] – is it something we all, intrinsically, *a*culturally share[37] or is it a product of specifically Western cultural values? I'm not sure. However, I do argue that certainty's status as a happy object in the context of my fieldsite is, at the very least, magnified by the cultural milieu in the West – specifically our romance with biomedicine and its supposed objectivity, certainty, and truth. Steffen, Jessen, and Jenkins, in their volume on uncertainty in medicine argue that there has been a "long-term attempt in western industrialised states to create, through massive investment in

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[36] The work of the Africanists who I have cited throughout this thesis (see Di Nunzio 2015, Whyte 2005, Cooper and Pratten 2015, etc.) seems to indicate that the desire for certainty in medicine is present in many African contexts.

[37] I must confess that I am rarely persuaded by arguments of universal innateness; yet I acknowledge that this is a possibility.

biomedicine… a social environment of predictability” (2005, 15) and thus “institutionalised biomedicine can be understood as the state-sponsored and organised attempt to control uncertainty” (2005, 17). I contend that certainty’s status as a happy object can be linked to our contemporary fascination with biomedicine in the West, to our belief that the world and the body can become knowable and controllable through science, to “our romance with biomedicine [and] longing that this rational discourse can in Rousseauian fashion locate and unmake our suffering” (Rouse 2009, 5-6). For instance, even Teresa Brennan, the late affect theorist who writes so beautifully and provocatively about how transmission of affects challenges our modern Western ideas of subjectivity states, “nonetheless, it may be through biochemical and neurological research that we will locate mechanisms for the transmission of affect and understand more of the energetic force of attention” (2004, 42). The fundamentally uncertain and ambiguous reality of science is continuously ignored in favour of our romance with it as a source of the found. To use Raymond Williams’ concept (1977), certainty as a happy object can perhaps be understood as a contemporary ‘structure of feeling,’ a shared affective response that characterizes our historical, biomedical time. Charlie continuously talked about how we were “Doing the science” at 1 North and when B. asked her what she meant by that, she paused, stopped wringing her hands, and smiled, “It means picking up every single rock and looking under it, until we find what we’re looking for.” Certainty in medicine promises that we can act, that we do have power and agency over the body, over suffering. As a clinician at 1 North once told me, “We expect as a society for there to be clarity, especially in medical professions, we expect a clear diagnosis… and oftentimes people want that more than they even want the treatment, they just want to know what they have going on, they feel out of that period of limbo they’re fine.” We believe certainty can promise us the clinical version of the good life – recovery, the end of pain, or at the very least calming the chaos of suffering. Both patients and clinicians, consciously or unconsciously, orient themselves towards certainty because we imagine the clinical good life to follow. To use Lauren Berlant's framing, certainty "promises to guarantee the endurance of something, the survival of something, the flourishing of something" (2011, 48). As such, certainty's status as an entrenched happy object within the clinic is mediated, or at the very least magnified, by our contemporary cultural milieu – specifically, Western culture's contemporary valorization of biomedicine.

Of course, if certainty is a happy object, uncertainty, its inverse, continuously becomes identified as the cause of unhappiness. This unhappiness of uncertainty was vividly apparent throughout my fieldwork. The two moments with David that the heavy, hovering intensities in the room spiked into something explosive were when the spectre of uncertainty – "Like if it means nothing then what is true? If I hit myself with a hammer, is that not real? Is that… I can't even trust, what can I trust?" and my imagined assurance that his suffering was *maybe* psychological, *maybe* physiological – slunk closest to him. The approach of uncertainty (and simultaneous retreat of certainty) produced in him, in the room, in me, a swirling mess of negative affect. While these moments with David, the charged heaviness in the air, the discharges and impacts, startled me, thinking with them made me attune to the less explosive currents of negative affect that had wrapped around my ankles throughout my time at 1 North, the strange flashes that lingered in the back of my mind. For instance, one day as I distractedly watched the radiology rounds on Zoom,[38] I was startled by an interrupting voice. Q. one of the most senior neuropsychiatrists at the program was loudly asking if he could "take the floor." He

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[38] Weekly lunchtime Zoom sessions at 1 North in which all the neuropsychiatrists join radiologists on a call to discuss, review, and ask questions about recent imaging they've ordered.

was usually calm and loquacious with a confidence that I often found grating, but that was clearly accrued over decades of clinical practice. However, he seemed unusually nervous on the Zoom call. His voice was loud even through my computer's tinny speaker as he explained that he had ordered imaging because it had recently emerged that a "psychogenic paraplegic" he'd treated for over a decade had once been found to have a cyst in his spine at T2, a finding that could explain his symptoms. Q., flustered and anxious, jabbered at the radiologist, "I had no awareness of that! I wanted to make sure I wasn't missing anything. Ordered imaging to fully rule it out." The radiologist started to speak, but Q. interrupted him before the man got out even a few words, his voice rising unsteadily, "*Must* put this to rest. I need to know he's psychogenic, *because that's what he is*." Surprised by his harsh tone, I put down my lunch and stared at the screen; I'd never seen Q. so anxious. Something here had thrown him, unsteadied and overwhelmed him. The radiologist, looking as confused as I felt, reassured Q.; he didn't see anything on the scans. Q. nodded and sighed in relief, "Good. Good, good." This potential cyst undid Q.'s certainty and caused a tidal wave of negative affect. Considering these scenes, I suggest that uncertainty, as the inverse of certainty, is often identified as a source of unhappiness in the clinic and can even be thought of as an 'unhappy object' in its own right, one that travels with a range of negative affects – miserable, terrifying, swarming intensities that can be alternatively verbalized as anger, frustration, fear, or anxiety. Where certainty seems to promise a path to the clinical good life, uncertainty feels as if it promises unhappiness, feels as if it will inevitably lead to therapeutic failure, lack of control, and unending suffering.

Beyond these individual scenes, the widespread emphasis on somatoform disorders as a diagnosis of inclusion rather than a diagnosis of exclusion[39] is also revealing in regard to the

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[39] Also often known as a 'positive diagnosis' or 'rule-in diagnosis' as opposed to a 'negative' or 'rule-out' diagnosis.

negative affective associations of uncertainty. Broadly, this distinction refers to whether you can diagnose an illness through the presence of a sign – positive blood test, specific rash, pattern of deficit, etc. – versus a diagnosis that is chosen after ruling out every other option (nothing showed up on other tests so it must be this). Throughout my fieldwork, in conversations, on webinars, and in the literature (see for example Espay et al. 2018 or Lidstone et al. 2020), researchers, clinicians, and patient advocates repeatedly emphasized that somatoform disorders are, and should be communicated as, a positive diagnosis – although it is important to note here that the signature positive sign is incongruity, the deficit does not follow the pattern it should in terms of physiology or it fluctuates from moment to moment. However, in practice, somatoform disorders are almost always an exclusionary diagnosis that is arrived upon after attempting to rule out every other option. No patient made it to 1 North without years of extensive tests checking for any other possibility and clinicians at 1 North commonly ordered their own tests as well. As a resident once told me after we saw a somatoform patient, "Remember, functional diagnoses are based on exclusion. Always have to check for organic pathology first." This follows the standard practice most clinicians use to diagnose somatoform disorders – in a review of neurologists' work with these patients, Kanaan et al. describe the diagnostic process as such: "Indicators… required caution in interpretation: caution, because there were few certainties, because the 'positive signs' of conversion were unreliable" (2009, 2891). However, despite this reality of practice, the need to portray somatoform disorders as a positive diagnosis persists. I was often confused by this, unclear why someone was placing so much importance on somatoform disorders 'having positive signs' or being 'a diagnosis of inclusion.' Affect helps us situate this impulse. Negative diagnoses are inherently uncertain and as such are generally distasteful to patients and clinicians. As Monica Greco argues, "there are many ways in which the category of somatoform disorders is deemed problematic. The most important of these, perhaps, is the emphasis on the exclusion of organic factors as a main diagnostic criterion" (2012, 2366). The uncertainty of a diagnosis of exclusion brings with it a range of negative affects, making these diagnoses almost universally disliked within medicine. We flinch from uncertainty; we want a glowing picture, not a lacunae or negative space defined only by its edges. Furthermore, even if we are able to set aside the distaste we feel for uncertainty, to accept a negative diagnosis risks transforming us into "affect aliens,"[40] into someone who does not share the group's affective associations, who is oriented incorrectly (Ahmed 2010). There are stakes to the affective associations we hold and share – evident in the firmness with which clinicians and patient advocates insist on the positive diagnosis framing. While affect is not immediately apparent in a line at the beginning of an article declaring, "*lesson*: The diagnosis… should be 'ruled in' based on the presence of positive signs" (Lidstone et al. 2020, 62), I argue it is present in the reasoning behind such a concerted effort to transform the diagnostic process. The emphasis on somatoform disorders as a positive diagnosis can thus perhaps be understood as both an individual affective response (uncertainty feels terrible and so I will attempt to avoid it in this work) and a wider legitimizing affective project – we all hate uncertainty, but don't worry, you can certainly diagnose somatoform disorders, you won't be an affect alien if you like to work with them. Undercurrents of positive and negative affect thus shape patients' and clinicians' actions, both as individuals and members of the wider Western medical community.

Approaching uncertainty as an unhappy object accompanied by a range of negative affective associations that drives people away from it, also offers a new way into understanding

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[40] To become an affect alien is often to be alienated from the affective community and broadly disliked; in Ahmed's work the central "affect aliens" she identifies are: the angry Black woman, the queer child, and the feminist kill-joy.

the fraught relationship between clinicians and somatoform patients. Somatoform patients are often considered infamous in medical settings which in turn is answered by patients being fundamentally distrustful of clinicians (Kirmayer 1994, Ringsberg and Krantz 2006, FND Portal 2022). This difficult relationship has traditionally been theorized as being produced by clinicians' desire to feel competent – summarized succinctly by a clinician at 1 North who told me: "Even in healthcare settings, there's often a sense of like 'ugh, this person is going to be difficult,' or 'we're not gonna be able to help this person'; there is sometimes a sort of defeatist attitude about it because it's less straightforward in the sense of medicalized treatment" – and patients' attempts to access care (as I discuss in chapter two). However, thinking with affect adds to this picture. Since somatoform disorders are so inherently uncertain, I suggest that one can approach the somatoform patient as an unhappy object themselves. 1 North is a neuropsychiatric unit that specializes in treating somatoform disorders; as such, I never saw the standard dismissal, 'these symptoms are not real. You are not truly suffering. I do not have time for you,' that so many patients tell stories about. Furthermore, when I directly asked clinicians about this, they generally denied that somatoform patients were any more difficult than their other patients.[41] The clinicians I spent time with were deeply committed to their patients and sympathetic to the difficulties of their lives. However, that is not to say the relationship between patients and clinicians at 1 North was not fraught. One day, after a phone call with an outpatient who sobbed and fought, insisting that her symptoms were physiological,[42] B. slumped back into his chair looking much older than he had that morning. Something in the room felt thin and drooping and when I asked B., usually so thoughtful, so attentive to teaching, if there could be a

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[41] A senior neuropsychiatrist once told me, "Some [somatoform patients] can be very difficult, they need a lot of support… but there are a lot of difficult people around, some of them are not even psychiatric, some are your colleagues!"

[42] Apparently a common refrain in their conversations, even though she had been B.'s patient for years.

physiological component to the woman’s symptoms he just shrugged. We sat in silence as he stared out the window for a long moment before he said, “This is why I can’t do somatoform patients all day. It’s too much. I couldn’t bear it.” His hands fluttered at his chest as he said this, as if he was trying to disperse some sort of clinging fog. Similarly, following another clinician down the hall one day, I asked him about a somatoform patient he had seemed irritated with; he sighed and looked at me, voice flat, “You get tired of the bloodwork coming back normal, symptoms without cause.” While I never witnessed the anger and aggression so often directed at patients (although I think of clinicians’ sharp fears of misdiagnosis and the senior neuropsychiatrist’s almost shout in our interview as he described the difficulty of navigating the inherent uncertainty of somatoform patients – “They’re *treacherous*”[43]), there was a pervasive sense of exhaustion in the relationship between clinicians and somatoform patients.[44] The uncertainty so fundamental in somatoform disorders spills over onto the patients’ themselves and thus their presence in the clinic becomes associated with waves of negative intensities, even amongst the clinicians who are the most committed to them. This is not entirely without precedent. Teresa Brennan, drawing on a wide array of research on depression, notes how depressed people often become further isolated because of the anger and aggression they evoke in those around them; quoting James Coyne she notes that the “rejection of depressed persons results from the negative mood they induce in others” (2004, 44). While Brennan is mostly interested in this as evidence for the ways in which we become recipients of others’ “energetic attention” (2004, 45), I suggest we may also be able to think of this as the ways in which the affective associations of an object (in this case uncertainty) can accumulate in a body or role

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[43] See chapter one.

[44] I was not immune to this. Despite my curiosity and focus, I often felt overwhelmingly tired and spent after encountering somatoform patients in a way that I didn’t with other patients. And, of course, there was the day with David.

(somatoform patient), turning a person into an affective object themselves. The negative affects of uncertainty are so overwhelming, so sticky that they become associated not just with the disorder but with the patients, transforming them into unhappy objects that clinicians, consciously or unconsciously, turn away from.

Immediacy and the otherwise

Investigating affect is not only adding a curious texture to the story I am trying to tell. Affective associations are so powerful because they feel so undeniably true. Alia Al-Saji, in her work on affect and racism, argues that affect's ability to shape our thought and action lies in its "felt immediacy" (2014, 140). Affective associations become so vivid, so entrenched, because they *feel natural* to us.[45] It feels as if our affective reactions tell us something about the world without any cultural mediation. Our bodies respond before we can even think, therefore, we interpret the response as being true, being justified – this made me feel bad and so it must be bad. As such, affect serves to "inextricably color and configure perception. Though affect is pre-intentional, on the phenomenological account, it can provide the motivating and material support" (Al-Saji 2014, 140) – support for racist judgments in Al-Saji's case and hatred of uncertainty in my own. Uncertainty becomes a justified, seemingly evolutionary fear, rather than one built on Western valorization of biomedicine and its values of objectivity, transparency, and control. Thus, affect is not only a way to understand why patients and clinicians both continuously enact a regime of certainty, even when they consciously recognize that it is not pragmatic nor therapeutic, but also a mechanism in this enactment. Affect has a sustaining,

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[45] To be clear, arguing that an affective association is culturally-mediated (unnatural, to use Al-Saji's words) does not belittle the reality of the phenomenological unpleasantness of uncertainty. To say that something is constructed, that there are other possibilities, does not deny experience. To say it with Samuele Collu, "Everything is real in its effects" (*Into the Loop,* forthcoming).

circular logic; as Al-Saji argues, “affect does not here break out of the circle of the ‘I cannot see otherwise’; indeed, it guards this circle and contributes to its closure… What ‘otherwise’ is not only occluded from vision, but also from feeling, imagination, and understanding” (2010, 141). The perceived immediacy of affect shapes the normative field within the clinic, making it incredibly difficult to feel otherwise, to accept uncertainty as a legitimate mode. As Ahmed argues about the role affect plays in establishing horizons, “in rejecting the proximity of certain objects, we define the places that we know we do not wish to go, the things we do not wish to have, touch, taste, hear, feel, see, those things we do not want to keep within reach” (2010, 32). When certainty fails, as somatoform symptoms or life circumstances change, the uncertainty that rushes in feels horrible, threatening, dangerous, and so patients return to the clinic, pursuing ever-more certainty. Despite acknowledgements of uncertainty’s fundamental presence in medicine, of its therapeutic possibilities, affect makes it difficult to break out of the loop that a regime of certainty creates – medicine is a certain practice, it must provide me with an exact answer because then I will be okay. The immediacy of the affective attachments of (un)certainty thus go beyond simply an epistemic mood and become a normative field that feels impossible to see beyond.

Horizons

At the beginning of this chapter, I suggested that affect may help explain the presence and persistence of the social imaginary of medicine as a regime of certainty, or at the very least its texture. As Ahmed says, “affect is what sticks, or what sustains or preserves the connection between ideas, values, and objects” (2010, 29). Uncertainty’s status as an unhappy object and certainty’s as a happy one – the surging angry, panicked waves that accompany uncertainty in contrast to the soothing happiness of certainty – is mediated by our contemporary cultural fascination with biomedicine and its valuation of objectivity and empiricism. However, these affective associations feel so natural, so true, that we instinctively flinch from uncertainty, judge it to be threatening and dangerous, even when we logically know it might offer new therapeutic possibilities – perhaps a way to move forwards without settling, certainly, on whether your suffering is physical or psychic. Uncertainty *feels* wrong, dangerous, terrifying and so it continues to be so. As such, affect can disrupt even the most thoughtful attempt to embrace uncertainty in the clinic. However, affect's power to shape action and thought largely comes from its invisibility. Therefore, looking directly at affect, attending to its presence, to the currents of force and feeling in the clinic, can interrupt this inevitable confirming loop. As Al-Saji argues, "we see *according to* these affective attachments, and hence do not see them; they function as a normative level, as unconscious and 'neutral' ground, selectively demarcating and configuring what is seen. Only by altering this frame, making it at once marginally visible, can perceptions and acts themselves be susceptible to change" (2010, 160, emphasis original). Affect is both an essential part of the phenomenological experience of the clinic and a force that shapes the horizons in this space. It is so easy to let affect guide us without thinking, but if we feel it, hold it, look at it, it might be possible to act differently, to do what feels so unhappy.

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David finally looks away and I quickly thank him and get up from my chair. I step around the navy curtain blocking the bed from view and look back. My face feels flushed and tight. Why can't they do surgery? Why can't they cut open his back and investigate his spine? They should just do it – then wouldn't he know and be okay? Wouldn't this awful, crushing force finally dissipate? But I know this logic is tangled. It would be a traumatic surgery, likely doing more harm than good. It might not provide any certainty or not one that could hold. He likely would just be in more pain, with even less mobility. I know this, but it’s hard to remember it in this breathless black hole of a room. I shake my head, trying to clear the overwhelming sense of recoil from the uncertainty he is living in and, without any clear intention, walk down the hall, past the nurses’ station, through the labyrinthine series of carpeted hallways and wooden doors, faster and faster until I’m almost running. I need to get away from that snapping, smoldering, muddy swamp of feeling. I cross the bright entryway and burst through the two sets of doors, tripping slightly as my shoes catch on fallen helicopter seeds. I round the corner and pull off my mask. Closing my eyes, I tilt my face up to the grey sky and take a trembling breath. High above, a seagull lets out a keening cry.

CONCLUSION

Presence

A window is open. It’s strange to feel breeze in the clinic; the space generally seems so cut off from the rest of the world – I may be able to see the trees moving through the windows in patients’ rooms, but I’m not used to feeling it. But today a gentle gust rustles the curtains as well as the blossoming trees outside and the room smells fresh and green, no lurking layer of antiseptic.

I’m sitting with Alana, the occupational therapist at 1 North, in her darkened office – the fluorescents left off. She’s bright, friendly, and thoughtful, eager to discuss somatoform disorders. We’re talking about how she engages with the so-often rigid ideas of the physical and mental in somatoform disorders, if she regards unsettling that dichotomy to be part of her job. She starts nodding before I’ve finished my question, “Oh absolutely!” She tells me about the openness of her approach, the way she tries to highlight how changes in mood and the body, crests and crashes, are normal – “Isn’t that a great thing that we don’t live life on a plateau?” Somatoform disorders are her specific area of interest and she smiles easily and often when she talks about them, gesturing at the air as she speaks.

I ask her about how this openness translates to diagnosis and she sighs. It’s comfortably warm in the office and I wait quietly, the clock on the wall ticking softly, a faint whisper of leaves from outside. When she finally answers, she speaks slowly.

“There were certainly patients I’ve encountered where the diagnosis has been really ambiguous to them,” she says carefully, “and I think, that’s often when I’ve noticed that there have been difficulties in accepting it. I think clinicians are often, I mean I don’t diagnose so it’s probably unfair for me to judge, but I do think that there’s some fear around somatoform disorders.”

“And by ambiguous diagnosis do you mean things like, you know ‘it’s not organic’ or it’s ‘medically unexplained’ or…?”

She sighs and uncrosses her legs, leaning back in her office chair. “Yeah, I think that um– I like ‘medically unexplained’ because I appreciate that we don't know everything and I think that that’s important to acknowledge… but I think– it’s really frustrating because we live in a society where we expect a diagnosis from our doctors.” I pause my note taking, ready to ask a follow up question, but she continues, leaning forward. “Why do we have to diagnose? Like why do doctors feel the need to actually give a label to this? Cause surely, in a way, that’s reinforcing some of the expectations that are problematic right?” Her words are tumbling over each other and her eyes are bright. “You know, we’re sort of reinforcing the idea that as a society we *need* certainty to feel that we’re comfortable or can function or that we are… at peace with ourselves and with the world around us.” She laughs, somewhat embarrassedly, “Yeah, I think that I’m fortunate in the sense that I'm not involved in the diagnosing. Like ‘I’m not a doctor,’ I don’t really care! If what I can do can help in someone’s rehabilitation and recovery, it doesn’t matter to me what the organic pathology is or isn’t, or if there is one or isn’t one.” She pauses, takes a breath, and shakes her head. “You know just because you have a firm diagnosis doesn't mean that you’re without uncertainty. Even in disorders we know so much about, the trajectories are unclear, unknown and I think we expect that just because we *know* that then we can *do* something about it, that that fixes it, but actually I think that’s doing a disservice to how complex we are as people.”

We sit together quietly for a moment. I'm thinking of Charlie; of David; of the woman whose throat was burning, whose memory was failing; of the man whose back was rotting with pain. They all wanted answers, clarity, truth. They needed certainty so much and B., K., all the other clinicians, felt compelled to give it to them. And yet. And yet. And yet. The certainties I saw offered in the clinic were so provisional, so contingent. They couldn't *hold*.

"Is there something in this area that you wish we could know? Know for sure?" I'm digging for something, maybe a bedrock desire for certainty? Something in all of this that even Alana thinks must be certain? I'm not sure.

"Huh, that's a good question…" She tucks her hair behind her ears, considers. "I don't think there's ever going to be a time when this kind of disorder goes away. There's never gonna be a time where we know everything about how the brain works or how the body works and that's what makes us human beings so fascinating and also this area of work so fascinating." She seems energized by this openness, this complexity. "All that we really *certainly* know, truly, is that you have this moment right now that you're living in. So that almost makes some of those things irrelevant. There's a time and place for them, but I think our work should be more focused on how to accept the present moment and *move* with it."

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I thank Alana for her time and wander slowly back up the hall towards the ward. Her words walk with me, hanging in the air, simultaneously alien and familiar, shadows in the summer. I pass the spot where I watched B. say goodbye to Charlie when she was discharged and I pause, the memory so vivid it feels like they are there again. Standing at the place where the hallways joined, she looked up at him, suddenly contemplative, "We're not done right?" she asked. And he smiled, shook his head and placed his hand on her shoulder. In that moment, lingering against the wall, I was frustrated by the limits of his gesture, that silence between them. It felt like the embodiment of the inability to give each other the answers they both desired. But now, with Alana's words echoing through me, I wonder if there was something else there. Was that the presence that Alana spoke of? Perhaps if we look closer, if we linger, if we hesitate, something else might emerge – a moment of a medicine beyond, besides certainty. I'm not sure. Did Charlie experience it as an end (of care, of trying) or a promise of a therapeutic future? Was that a moment of closure or a promise of persistence for B.? This image of the two of them, his hand on her shoulder, flickers – a capitulation / a line of flight / a failure / a possibility.

An uncertain medicine

Throughout this thesis, I have explored patient and clinician orientations to medical uncertainty within the context of somatoform disorders to try and understand how these relationships with uncertainty shape the conditions of possibility within the clinic. I have argued that both patients and clinicians widely acknowledge the presence and even utility of uncertainty in medicine. However, in the clinical encounter, both parties continuously flinch from it – enacting a medicine whose goal is the search for and provision of certainty. I have argued that this response reveals a social imaginary of medicine as a regime of certainty – a system that can and should provide us with access to a certain, objective truth and thus makes uncertainty an unacceptable clinical mode. Yes, medicine can pierce through opacity, it can tell us what is truly happening in our bodies and as such it can control it; any uncertainty is just a failure, an error. Furthermore, I have suggested that while certainty may be therapeutic in the moment, in the long term, in the context of somatoform disorders, it may be unable to hold – fracturing under time, under the evolution of symptoms and the appearance of new ones – and thus that this regime traps patients and clinicians in a loop of failure – continuously striving for an impossible certainty. I have linked the persistence of this regime to patients' need to access care and clinicians' anxieties about their authority, but also to the negative affective associations of uncertainty in North America.

Medicine in the West has become a certainty machine; it declares it can provide certainty, that that is its job, it will find you answers. And yet it so often cannot. Uncertainty is a fundamental feature of medicine, it is not an error, a failure that must be fixed. As Annemarie Mol argues, "medical practice is never so certain that it might not be different; reality is never so solid that it is singular. There are always alternatives. There is no body-isolated that may offer us a place beyond doubt" (2002, 164). If medicine is only about certain, firm answers, it will always, eventually fail. There must be more than a constant, breathless, quest for certainty. Is there not another medicine? This is not a radical question. In the 1990s, the physician-philosopher Drew Leder argued that Western medicine was losing its central hermeneutic nature. He described this "flight from interpretation" as a crisis and argued that "modern medicine… has been bewitched by [a] different ideal – that of achieving a purified objectivity. Interpretation necessarily implies the existence of subjectivity, ambiguity, opacity. In trying to overcome these bars to absolute knowledge, medicine has sought to escape its hermeneutical foundations" (1990, 19). In the 30 years since Leder's claim, it seems that this flight has not reversed; the positivist dream has become more beloved – just a few more years and then we will know everything, we will know for sure. But perhaps this is not the work that we should ask of medicine. B.'s hand on Charlie's shoulder, standing with her at that crossroads – literal and figurative, as so many are – contained so many uncertainties, but it perhaps also promised presence. Recognizing that uncertainty is not a flaw that will eventually be extinguished, that our moral assumptions of it (it is inherently bad) are an embodied trace of a culture that prizes certainty and control (or at the very least an existential fear magnified by culture), perhaps allows us to consider how medicine might be otherwise. Uncertainty is difficult to abide; however, it is our continued distaste for it that effaces the therapeutic possibilities it may also offer. An intimacy with uncertainty in the clinic contains possibilities for an approach to suffering and healing not governed by dualism or dichotomies – not an 'either/or,' but an 'and,' a 'many simultaneously;' a medicine perhaps less rigidly based on knowledge and more on doing, on being. In her work on ontology in medicine, Annemarie Mol has argued that,

> In many places, science held (or continues to hold) the promise of closure through fact-finding… In an attempt to disrupt these promises, it may help to call 'what to do?' a political question. The term politics resonates openness, indeterminacy. It helps to underline that the question 'what to do' can be closed neither by facts nor arguments. That it will forever come with tensions—or doubt. (2002, 177).

I am not convinced that the reframing of politics is sufficient here, but I am compelled by the question that Mol centres – 'what to do?' I hear this question in the present, the *presence,* that Alana speaks of; I see it in the image of Charlie in B. in the hallway late on a summer afternoon.

The place where the ground gives way

Uncertainty is difficult; despite my concerns about the rigidity and brittleness of certainty as a therapeutic ethos, I do not deny its comforts or happinesses. As Binswanger writes about the suffering of uncertainty, "harmony with the world has been rent, the ground beneath its feet has been taken away, leaving it suspended and hovering" (1982, 83). However, sorrow, anger, or fear at the instability of uncertainty is not mutually exclusive of therapeutic possibilities. Even Binswanger admits this, continuing: "Now such hovering of our existence need not necessarily assume a downward direction; it can also signify liberation and the possibility of ascending"

(1986, 83). The ground was never solid to begin with in medicine, and especially in somatoform disorders. Certainty – performed, contingent, temporary – rarely seems to save somatoform patients and it might even marginalize them further. An affinity with, or at least acceptance of, uncertainty might offer a new path. What would it mean for medicine to provide care not from a stable ground, but while falling?[46]

This thesis offers very few answers. I cannot, and indeed refuse to, make a claim on what somatoform disorders *really* are. I cannot say how we should move beyond the imaginary of medicine as a regime of certainty. I have suggested that understanding the affective roots of it, of others' stakes in certainty, may perhaps be helpful. To spend time with the people actively challenging certainty in medicine (the Dingdingdong Collective or those who advocate for a subjunctive medicine[47] for example), with the people daring to become affect aliens (to use Ahmed's words), might reveal more. It is easy to say that these are faults of this work, and I accept them; there is much I did not, could not do. I am an anthropologist who, for two short summer months, went to a neuropsychiatric hospital and tried to think about uncertainty in medicine. My hesitation, my attempt to suspend the analytical desire, my own uncertainty, is a part of what I found. Uncertainty is threatening for many reasons, but there is not only chaos in it; there is multiplicity and movement and simultaneity. A flicker is not a closed door, it is the opening of many, all at once. Is a medicine not based on an insistence, a need for certainty, possible? Can we invite a posture that leans towards, rather than away from, uncertainty in a culture that prizes certainty so deeply? Will a therapeutics of uncertainty help Charlie and David? I don't know. Maybe. Maybe. *Maybe.*

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[46] Jenn Ashworth's *Notes Made While Falling* is on my mind, and in my language, here: "Our real work… is to get comfy falling… and to learn to both watch and speak from a position of precarity. The ground opens up" (2019, 185).

[47] See the introduction and chapter two.

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