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## **Examining the psychology of practitioners, institutions and structures: ‘Medically unexplained symptoms’ and biopsychosocial discourse reflexively revisited**

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### **Abstract**

*‘Medically unexplained symptoms’ (MUS), through the lens of the biopsychosocial model, are understood in mainstream psy disciplines and related literature as a primarily psychosocial phenomenon perpetuated by ‘dysfunctional’ psychology on the part of people labelled with such. Biopsychosocial discourse and practice in this field, underpinned by little empirical foundation and lacking theoretical coherency, are associated with harms sustained by people labelled with MUS. Yet, little attention is paid to the psychology of social actors and institutions whose practice and policy derive from biopsychosocial theorising, or whose vested interests (re)produce such theorising. This article contends that lack of reflexivity among psy practitioners and other social actors on individual, institutional and structural levels furthers biopsychosocial hegemony and contributes to harms. Non-reflexive behaviour on the part of practitioners*

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*within clinical and 'therapeutic' encounters and on the part of social actors within institutions and broader power structures is examined, and possible psychological underpinnings of non-reflexivity are explored. Notably, the concept of gain, drawn from dominant discourse around MUS, is applied broadly to explore what might be gained from eschewing reflexivity and from adhering to biopsychosocial narratives. Implications for practice, supervision, training and research are discussed, notably highlighting a need for critical reflexivity in all domains.*

*Keywords: Medically unexplained symptoms, Biopsychosocial model, Social injustice, Victim blaming, Reflexivity, Welfare reform, Gains from illness, Critical theory.*

## **Introduction**

In mainstream psy disciplines<sup>1</sup>, 'medically unexplained symptoms' (MUS) describe somatic manifestations purported to lack either detectable physical pathology or pathology considered sufficiently explanatory (Chew-Graham et al., 2017; Stanley et al., 2002). Also known as 'functional somatic syndromes' and 'persistent physical symptoms', MUS typically include fibromyalgia, irritable bowel syndrome, and, of particular and recent controversy, myalgic encephalomyelitis / chronic fatigue syndrome (ME/CFS) (Chalder et al., 2019; NHS, 2021). Such conditions are conceptualized through use of a biopsychosocial (BPS) model (Sharpe et al., 1997), which allegedly seeks a more holistic picture by acknowledging biological, psychological and social influences in health and

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<sup>1</sup>Psy disciplines or psy professions (Rose, 1998; see also Foucault, 1961/1988) are professional arenas focusing upon knowledge creation and practice in the realm of mental phenomena. These disciplines are concerned with constructing narratives about the nature of the self and others, making judgements regarding 'normal' and 'abnormal' cognitions, behaviour, affect regulation, personality and social function. Psy practitioners are thus those who work within these disciplines, notably here psychotherapy, psychology and psychiatry.

illness. However, MUS have been further theorised through a cognitive behavioural model (Deary et al., 2007), in practice often nestled within the broader BPS framework, which foregrounds psychosocial influences through depicting MUS as being maintained by patients'<sup>2</sup> 'dysfunctional' psychology (Browne & Chalder, 2006; Chalder et al., 2019). Whilst biological precipitating factors such as infection are not ruled out, people labelled with MUS are argued to perpetuate their ill-health through dysfunctional or unhelpful cognitions and 'maladaptive' or unhealthy behaviour, predisposed by maladaptive personality traits and behaviourally reinforced by collusive practitioners and significant others (Deary et al., 2007; Sharpe et al., 1997; see also Chalder et al., 2019; Salmon, 2000; Wessely et al., 1989). Furthermore, it has been suggested that people labelled with MUS present with physical symptoms and misattribute their ill-health to physical causes (part of a process referred to as somatisation) as part of a broader cultural phenomenon, a way of constructing a 'moral tale', whereby they can escape the stigma associated with having a psychological or psychiatric 'disorder' (Wessely, 1997; see also Ferrari & Kwan, 2001; Huibers & Wessely, 2006). It should be noted that both the cognitive behavioural and BPS model of MUS (notably of ME/CFS) have been examined in depth and charged with lack of both empirical support and theoretical coherency (Geraghty, Jason, et al., 2019; Geraghty & Blease, 2019); charges against the BPS model are supported by wider disability studies literature (Shakespeare et al., 2017).

Despite widespread criticisms of BPS discourse, people labelled with MUS are frequently problematized in BPS literature and in practice as a drain on medical resources and a demanding, hostile, 'heartsinky' patient group with little insight into the allegedly psychosocial nature of their condition (Stanley et al., 2002; Wileman et al., 2002; see also Blease et al., 2017). Accordingly, the UK National Health Service (NHS) mental health initiative, Improving Access to Psychological Therapies (IAPT) has in recent years rolled out its provision to include MUS, whilst medical doctors are encouraged to refer people labelled with MUS to IAPT or other psychological services, which may limit biomedical

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<sup>2</sup>Although I am aware that the term 'patient' can be considered disempowering, I am not convinced that alternatives (clients, service-users) are preferable and I use the term patient with an awareness of debates in this regard.

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investigations (Geraghty & Scott, 2020). Whilst cognitive behavioural therapy (CBT) remains a ‘treatment’ of choice for many MUS, psy practitioners of differing orientations within and outside the NHS tend to draw upon equally psychologizing and arguably moralizing BPS-inspired or broadly BPS-compatible narratives to conceptualize MUS (Luca, 2011; Maizels & Adamson, 2017; Penman, 2021). Importantly, BPS discourse has been criticised for ignoring indications of biological pathology, dismissing patient testimony and reinforcing an inappropriately psychologizing narrative (Blease et al., 2017; Geraghty & Blease, 2019). Such criticisms extend to charges of harm sustained by people labelled with MUS.

In the case of ME/CFS, the BPS model has been associated with multiple harms theorised through the lens of epistemic injustice (Blease et al., 2017). Testimonial (interpersonal) and hermeneutical (structural) injustices (Fricker, 2007), committed against people labelled with MUS, may engender physical, psychological, economic and social harms. These harms relate to inappropriate psychosocial interventions, lack of biomedical investigation (misdiagnosis is not uncommon), disconfirming healthcare encounters and patient withdrawal from healthcare services, amongst other factors (Geraghty & Blease, 2019). Further, the impact of stigma, conceptually overlapping with epistemic injustice and accordingly arising on an interpersonal and structural level (Buchman et al., 2017), may increase perceived health burden, disability and degree of marginalization amongst patients (Hale et al., 2021; Hunt, 2020). For example, denial of access to legitimate chronic illness and/or disability identity leads to denial of social accommodations and social protections as well as appropriate medical care with attendant biological, psychological and social harms (Hale et al., 2020). Of particular concern, notably in the case of ME/CFS, are reports of increased suicidality, which research suggests may be related to having to navigate an unaccommodating healthcare system (Devendorf et al., 2020). Yet, despite charges of theoretical incoherency, lack of empirical support and considerable evidence of patient harm, BPS hegemony persists.

BPS hegemony can arguably be discerned in the controversy over the UK National Institute for Health and Care Excellence (NICE) guidelines on the diagnosis and management of ME/CFS. Since 2007, NICE had recommended psychosocial ‘treatments’

for ME/CFS - CBT and graded exercise therapy (GET) – despite on-going debates over effectiveness and suggestion of patient harm or no benefit in a considerable portion of cases (Geraghty, Hann & Kurtev, 2019; NICE 2007/2018). A review process commencing in 2017 led NICE to determine that the quality of evidence for these psychosocial interventions was low to very low (NICE, 2020a), and new draft guidelines (NICE, 2020b) duly dropped pre-existing recommendations for such interventions, repudiating GET and downgrading CBT to a potential supportive adjunct. However, a backlash from influential BPS proponents led to charges that NICE methodology was flawed (Turner-Stokes & Wade, 2020), whilst the refusal of some BPS-aligned medical bodies to support the draft resulted in an unprecedented ‘pause’, with NICE delaying publication of the guidelines at the eleventh hour (NICE, 2021a). This, in turn, led some ME/CFS charities and advocates to argue that certain groups were controlling the agenda and that an inquiry was indicated (Invest in ME Research, 2021). The recently published final guidelines (NICE, 2021b), maintaining draft provisions vis-à-vis CBT and GET, could be construed as a heavy blow to the foundations of BPS hegemony. On the other hand, on-going resistance from socially powerful actors (Kalfas et al., 2022; White, 2022; see also SMC, 2021), questions over whether variations of GET might continue in practice under another guise (RCP, 2021; see also BACME, 2021) and the likelihood that political agendas will persist in the realm of other MUS (Stewart, 2019; see also Hale et al., 2021) are still of concern. Clearly, factors contributing to the persistence of hegemonic BPS discourse around MUS warrant further attention.

Whilst psychologization of MUS is pervasive in BPS discourse, little attention is paid to the psychology of practitioners who promote such discourse or to the psychology of institutions and power structures that have given rise to and reinforced BPS narratives. This selective attention is both curious, given the tightly held views of certain actors in the face of considerable evidence to the contrary, and ironic, since reflexivity (Etherington, 2017) is ostensibly highly valued in many psy professions. Considering that dominant narratives around MUS have been constructed by influential actors and institutions with both power and incentive to control such narratives (Hooper & Williams, 2010; see also Hunt, 2022), such selective attention is also perhaps unsurprising. In the remainder of this

article, I argue that lack of reflexivity on the part of actors and institutions whose practice and policy derive from BPS theorising, and those whose vested interests have given rise to and reinforced such theorising, notably in the psy professions, is contributing to the persistence of BPS hegemony and furthering of patient harm. From this perspective, it is noteworthy that points raised in this article likely have relevance for other patient groups where diagnostic biomarkers are lacking, or illnesses which are framed as ‘contested’. In particular, some actors involved in the psychologization of MUS are turning their sights to long Covid, and there are indications of attempts to position long Covid, or sub-groups thereof, as a form of MUS (Sharpe, 2021; Verveen et al. 2022; Willis & Chalder, 2021). This, despite indications of detectable pathology in a considerable portion of cases (Kersten et al., 2021).

In what follows, I firstly position myself reflexively to the subject matter and define key terms. I then examine non-reflexive practice on the part of psy practitioners both within clinical and/or therapeutic encounters and, along with other social actors, within broader power structures, offering possible reasons for lack of reflexivity. In particular, I explore the concept of gain (Dersh et al., 2004), typically permeating BPS narratives around MUS, and suggest that a loosely held form of this concept might prove useful in elucidating the persistence of non-reflexive BPS discourse and practice. Finally, implications for practice, training and research are discussed, foregrounding need for reflexivity of an explicitly critical nature. Given that ME/CFS appears to have been a particular target of BPS theorising and underpinning political agendas (Faulkner, 2016; Rutherford, 2007b; see also Hunt, 2022; Jackson, 1995), I focus largely on ME/CFS as an analogue of broader MUS-related issues whilst drawing upon broader MUS literature when possible and appropriate. Whilst I principally draw from findings and events in the UK, points raised here are likely transferable to other countries where BPS discourse, together with a broader agenda of austerity management, dominates health and social policy (Stewart, 2019).

## **Reflexive self-positioning and definition of terms**

As a disabled person labelled with MUS with a background in psychological therapies, I have personal and practice experience of MUS and this has inevitably informed my stance on the subject matter. I consider my disablement to be as much a product of structural, institutional and interpersonal misuse of power (or complicity in such) as it is a product of biology. I also suspect that psychosocial distress in MUS, far from being a predisposing or primary perpetuating factor, is largely secondary to such misuse of power, whilst also representing an understandable response to multiple, debilitating, bodily symptoms. Although BPS narratives would likely hold that my position on this is suggestive of an attempt to avoid the stigma associated with psychological or psychiatric ‘disorders’ (Wessely 1994; Wessely, 1997), my stance derives not from prejudice but from first-hand experience that misconceptualization results in mismanagement. Moreover, I believe that the ‘seeking to avoid mental health stigma’ narrative of MUS functions as a means to further misrepresent, other and deflate the credibility of people labelled with MUS. My focus on socio-structural factors does not seek to downplay the biological underpinnings of MUS; in fact, I consider the lack of mainstream focus on biology to be indicative of socio-structural injustices. Limited public funding into biomedical research, hegemonic BPS discourse eclipsing biomedical findings (Chalder et al., 2019; cf. Cortes Rivera et al., 2019) and discouragement of thorough biomedical investigations in clinical settings (RCP, RCPsych & RCGP, 1996; Sharpe et al., 1997) feature among these injustices. I do not support use of the term MUS which I believe is politically motivated and clinically misleading; my use of the term here is to reflect dominant discourse in healthcare and therapy settings.

Theoretically, I support a social justice-oriented approach to research and practice, informed by critical theory understood in its broadest sense (Paradis et al., 2020; see also Sloan, 2009; Teo, 2015). This approach espouses an epistemological and ontological position whereby knowledge is considered to be contextually situated and reality is shaped to some degree by social structures, including institutions such as the psy disciplines. Critical theory also highlights how power and knowledge are inextricably

linked; in the context of psy disciplines, power is central to constructing specific narratives and broader discourse around purported clinical entities and the people who are labelled with such (Foucault, 1961/1988; Rose, 1998). Such discourse informs research, practice and policy that risks furthering health and healthcare inequities (McCartney et al., 2021). Consistent with a critical approach, I contend that BPS discourse has over-emphasised the role of individual factors and eschewed analysis of socio-structural context; in clinical and therapeutic settings the patient-practitioner relationship is an important contextual factor, necessitating practitioner reflexivity (Etherington, 2017). Whilst reflexivity can be understood in numerous ways (cf. Finlay, 2002; Wilkinson, 1988; Woolgar, 1988), the term is broadly understood here as our ability to turn the lens of scrutiny back onto the self, to consider how our assumptions, beliefs and values, in turn influenced by our social positionality, impact on our ability to ‘know’ (interpret) the world and colour our ways of relating to others. During my own psy training, I was struck by an institutional disregard for reflexivity, interspersed with a form of selective attention whereby the possibility that practice and research might represent an exercise in power (Loewenthal, 2015) was overlooked.

## **Non-reflexive MUS practice, discourse and policy**

The bulk of research demonstrating dismissive, psychologizing – and arguably non-reflexive - practitioner attitudes towards MUS draws from (non-psy) medical practice (Anderson et al., 2012). For example, a UK study of General Practitioners’ (GPs’) attitudes towards people labelled with MUS (Wileman et al., 2002) demonstrated how GPs actively sought out individualistic psychosocial contributors to patients’ symptoms without considering the broader social context. This context arguably included the practitioners’ negative stereotyping: framing patients as attention-seeking, questioning their work ethic, describing patients as ‘heartsink’ and ‘frustrating’. Whilst patients were framed as lacking insight into the alleged psychosocial nature of their illness (thus adding to the narrative of unhelpful cognitions), GPs demonstrated no insight into the possibility that polysymptomatic clinical presentations might be explained biologically, even constituting a medically recognized and clinically manageable entity (cf. Crawford, 2014).



Limited research drawing from psy professions (Luca, 2011, 2012) is broadly consistent with these findings.

Luca (2011) explored narratives around MUS as constructed by 12 psychotherapists, six of psychodynamic orientation and six trained in cognitive behavioural approaches, using grounded theory methodology. Highly negative and stigmatizing viewpoints toward patients were captured; patients were typically considered to lack insight into their symptoms (understood by therapists to be of psychological origin), to be motivated by gain (for example, attention and avoidance of obligations), and as ‘complaining and difficult’. Patients were further problematized as being angry at being denied a medical diagnosis (of physical origin) and being asked to accept psychological explanations for their illness. This apparent problematization of patients for posing a challenge to psychotherapists’ understanding of MUS is somewhat akin to findings in the afore-mentioned study by Wileman et al. (2002), also consistent with broader research drawing from medical practice (Johansen & Risor, 2017) and wider themes in BPS literature (Salmon, 2000). In these cases, practitioner discomfort with perceived patient transgression of the ‘sick role’ (Parsons, 1951) and concern over power dynamics favouring the patient have been demonstrated; similar underpinnings for problematizing patients may be speculated in psy practices. All conceptualizations reported by Luca (2011) derived from an individualistic and psychologizing lens, emphasising what was deemed to be ‘wrong’ with the patient’s thinking, behaviour, or developmental trajectory. There was no indication of practitioner awareness of socio-structural context, and in particular little suggestion that practitioners had considered to what extent their behaviour and attitudes toward the patient had shaped the encounter. Similar lack of reflexivity can arguably be observed in practitioner narrative across a range of therapeutic modalities (Maizels & Adamson, 2017; Penman, 2021). Interestingly, a further study from Luca (2012), apparently using the same sample of therapists, suggested that the psychotherapists felt themselves to work in an empathic, collaborative, sensitive and open-minded way, highlighting an apparent discrepancy between practitioner behaviour and self-narrative, suggestive of a lack of personal and professional insight.

Whilst Luca (2011) reported that therapists' narratives resulted from bottom-up (experience-driven) as well as top-down (theory-driven) conceptualizations around MUS, practitioners' experience of patients is far from an exercise in objective observation. The individual practitioner's need to position themselves in a particular way, along with their inevitable implicit bias (FitzGerald & Hurst, 2017), will indubitably impact on how they experience the patient. Whilst the concept of implicit bias focuses on the individual, individual beliefs and behaviours are heavily moulded by the architecture of institutions and other social structures which are internalised by individuals (Pritlove et al., 2019). This indicates a need to examine BPS discourse beyond the micro level.

Lack of reflexivity in clinical or therapeutic MUS encounters runs parallel to a similar dynamic observed on an institutional and broader structural level, notably associated with certain influential actors whose interests reinforce and are reinforced by BPS discourse and associated practice. It is worth noting that certain psy professions – in particular psychiatry – have played a prominent role in this regard (Geraghty & Esmail, 2020; Marks, 2017). Although the BPS model is typically associated with the work of Engel (1977) in mainstream psy disciplines, disability scholars and disabled activists have argued that the model as it is applied to chronic illness and disability (including MUS) has arisen from socio-economic agendas, notably UK welfare reform embedded in a broader context of global austerity management (Jolly, 2012; Shakespeare et al., 2017; Stewart, 2019). BPS discourse is argued to have been largely (re)produced by what has been referred to as an 'academic-state-corporate nexus' (Rutherford, 2007a), a network of apparently compromising associations between certain academics (notably UK psychiatrists), the UK government and the disability insurance industry. At the arguable centre of this nexus was the Cardiff University Centre for Psychosocial and Disability Research, sponsored for some years by disability insurance company Unum and directed by a former official of the UK Department of Work and Pensions (DWP), which produced literature in some cases commissioned by the DWP (Waddell & Burton, 2004; Waddell & Aylward, 2005). These papers, which also drew significantly on the work of certain psychiatrists with a particular interest in what they refer to as 'chronic fatigue syndrome' (Sharpe et al., 1997; Wessely, 1997), lay the foundation for the UK welfare reforms

(Rutherford, 2007b). Essentially, illnesses that could be framed as psychosocial entities, and thus allegedly amenable to psychosocial interventions, could be exempted from state benefits and disability insurance payments, thus facilitating the reduction of welfare provision and (bio)medical healthcare, and boosting of corporate profits. It is probably thus not coincidental that Unum provided consultancy to the UK government on how to reduce its welfare spending, whilst influential BPS proponents in the field of MUS have provided consultancy to disability insurance companies and government departments (Hooper & Williams, 2010; Marks, 2017). Literature produced by actors associated with the Cardiff centre, and by BPS proponents with an interest in MUS, is pervaded with individualistic, psychologizing and moralizing assumptions of how people labelled with MUS can recover with the 'right' mindset, effort and motivation (Halligan et al., 2003; Waddell & Aylward, 2010).

It is noteworthy that psychologization and problematization in academic-state-corporate (BPS) discourse are reserved for patients; the possibility that healthcare professionals, health and social policy and surrounding institutions play a role in ill-health and disability is not countenanced. Moreover, conflicts of interest on the part of practitioners and influential actors who have simultaneously held the roles of practitioner, researcher and MUS policy consultant to insurance companies, the UK government and/or NHS (Hooper & Williams, 2010; Marks, 2017) either go unacknowledged or are considered unproblematic by the actors in question (White et al., 2017). Academic-state-corporate non-reflexivity is arguably supported by a broader lack of reflexivity from within the UK media and pro-BPS Science Media Centre (SMC), which briefs the UK press on science-related matters. Both the UK press and the SMC have largely reinforced psychologizing narratives around MUS, without considering how the biases among actors within these structures might impact on those narratives (Anthony, 2019; Liddle, 2019; SMC, 2020; see also Hooper & Williams, 2010). From this regard, it is of interest that MUS research demonstrates how (medical) practitioners glean information about MUS from mainstream, non-clinical, narratives such as the media (Chew-Graham et al., 2008) and it is reasonable to assume that the same applies to psy disciplines. Further, apparent biases in academic publishing, where editors of respected

journals have been reported to decline redaction of BPS-inspired MUS research widely considered to be ethically and methodologically flawed (Tuller, 2018; Tuller, 2019), arguably represent a lack of reflexivity and a form of institutional complicity (or collusion, depending on degree of intent) in othering people labelled with MUS. In these respects, the BPS model of MUS, associated discourse and power relations that (re)produce such discourse could be considered a socio-structural phenomenon – perhaps something akin to Foucault’s *dispositif* or apparatus (Foucault, 1975/1995; see also Tremain, 2018) - that should be acknowledged in a truly holistic BPS (or bio-psycho-social-structural) framework of MUS. In order to redress lack of reflexivity on an individual, institutional and structural level, the psychological underpinnings of such must be examined further. Since I will argue that the concept of gain, broadly understood, may prove fruitful in understanding non-reflexive BPS discourse and practice, the article now turns to outlining how this concept is used in dominant narratives around MUS.

## **The gains of suffering?**

The BPS model has been charged with suffering from an eclectic freedom and conceptual impoverishment which allows any pillar to be foregrounded with little scientific rationale or theoretical coherency, according to the biases and interests of whomever promotes it (Ghaemi, 2009; Stam, 2000). Apparently consistent with these charges, the concept of gain has found its way into BPS theorising in the realm of MUS with little apparent theoretical or empirical justification, albeit in a way that arguably further psychologizes, stigmatizes, and marginalizes patients (Halligan et al., 2003; see also Turner-Stokes, 2002; Wade & Halligan, 2007). It should also be noted that the conceptual boundaries of (primary, secondary, tertiary) gain are widely debated even within psy disciplines and continue to evolve, resulting in an obfuscating array of overlapping or even contradictory definitions (Dersh et al., 2004; van Egmond, 2003). The concept of primary gain has not, to my knowledge, been explicitly discussed in BPS literature around so-called MUS such as ME/CFS, IBS and fibromyalgia; however, this concept has been discussed under a broader definition of MUS (Brown, 2004) and, in psychoanalytical literature, within the context of ME/CFS (van Egmond, 2003). Primary

gain originates from psychodynamic (more specifically psychoanalytic) theory to describe how anxiety arising from unconscious intrapsychic conflict is allegedly relieved through conversion into physical symptoms (Freud, 1916-1917/1963). Primary gain can also be understood as arising from ‘compromise formation’, a partial resolution of anxiety arising from intrapsychic conflict that might manifest symbolically in dreams as well as via symptoms (Freud, 1916-1917/1963; see also Sata & Munday, 2017), or simply as the reduction of negative affect through intra-psychological means (Brown, 2004). In contrast to primary gain, the concept of secondary gain is widely discussed and/or implied within literature pertaining to MUS or so-called ‘disability syndromes’ (Halligan et al., 2003; Kwan & Friel, 2002; see also Dersh et al., 2004; Turner-Stokes, 2002; Wade & Halligan, 2007).

Secondary gain can be understood through a variety of theoretical lenses; in mainstream BPS discourse, psychodynamic understandings (Sata & Munday, 2017; van Egmond, 2003) typically give way to cognitive behavioural perspectives. Behavioural approaches tend to understand secondary gain as ‘advantages’ derived from illness that are reinforced by social contingencies (social actors, social structures, institutions), where those advantages and motivations for such are likely available to awareness (Halligan et al., 2003; see also Dersh et al., 2004; Waddell & Aylward, 2010). Meanwhile, cognitive theory has been drawn upon to suggest that secondary gains operate largely at an automatic processing level that is somewhat akin to the preconscious in psychodynamic nomenclature (Ferrari et al., 2001), although conscious motivations have not been ruled out (Ferrari & Kwan, 2001; see also Waddell & Aylward, 2010). Combined, these theoretical approaches construct a narrative of secondary gains that frequently focus on the purported advantages of the ‘sick role’ (Parsons, 1951). That is, it is suggested that people labelled with MUS consider sick role ‘gains’ to somehow outweigh the losses associated with long-term illness, thus perpetuating their suffering (Ferrari et al., 2001; Wade & Halligan, 2007; see also Bentall et al., 2002). Some theorists have attempted to further categorize secondary gains as internal or psychologically motivated, and external or motivated by factors outside of the person (Dersh et al., 2004), although this distinction would appear to be somewhat problematic. Whilst some alleged secondary gains can be

easily positioned as being externally derived (e.g. gaining of financial support), there is no consensus within the wider field of gain theory as to the conceptual boundaries between ‘internal’ secondary gain and primary gain, in particular given that primary and secondary gains are said to often co-occur (Dersh et al., 2004; Sata & Munday, 2017; van Egmond, 2003). This, arguably, highlights the highly subjective and socially constructed nature of the concept of gain and adds to the difficulty in ‘pinning down’ particular narratives in order to critique them. In BPS discourse, although the term ‘secondary gain’ is sometimes explicitly used (Bentall et al., 2002; Turner-Stokes, 2002), purported advantages of ill-health and the sick role are typically broadly termed ‘gains’ or ‘advantages’ (Stanley et al., 2002; Wade & Halligan, 2007). Still more opaquely, alleged gains are often implied rather than explicitly stated (Huibers & Wessely, 2006; Sharpe, 2002; Wessely, 1994). Despite such opacity, certain theoretical and ethical concerns are evident in the dominant (largely cognitive behavioural) construction of gains.

Firstly, the suggestion that people labelled with MUS consider sick role ‘gains’ to outweigh widely documented pervasive and multiple illness-related losses (Anderson et al., 2012; Edwards et al., 2007; see also Dersh et al., 2004) is problematic. The reasoning behind this counter-intuitive suggestion is never convincingly explained, and it has been conceded that this point represents a conceptual challenge (Fishbain, 1994). Secondly, whilst an emphasis on conscious or preconscious (automatic processing) dynamics in dominant narratives of gain carves out a therapeutic or clinical space for CBT (Pilecki et al., 2015; see also Halligan et al., 2003; Waddell & Aylward, 2010), it also raises issues relating to patient intent, volition and insight. That is, patients are positioned in such a way that raises the possibility of malingering or otherwise feigning, (Fishbain, 1994; Halligan et al., 2003), or at the very least suggests lack of insight into their own health (Turner-Stokes, 2002; Wileman et al., 2002). Further, the fact that people labelled with MUS, understandably, do not typically accept that they are motivated by gains when this idea is proposed appears to rule out the preconscious or automatic processing theory. In these cases, it would appear that recourse is then needed to other narratives: one of conscious gains refuted by the patient - arguably again implying some form of illness deception or otherwise morally questionable behaviour - or one of unconsciously

motivated gains, perhaps more in the spirit of psychodynamic theorising which is extremely difficult for patients to disprove. (Conversely, it is extremely difficult for practitioners and scholars to prove such narratives; however, the assumed epistemic authority of such actors dictates that theirs is a narrative given greater credence). Indeed, some BPS literature suggests that gains can be conscious or unconscious (Wade & Halligan, 2007), appearing to create a ‘heads I win, tails you lose’, all-bases-covered narrative which may then be weaponized against patients.

A third type of gain, tertiary gain (Dansak, 1973), is proposed in the realm of MUS or ‘disability syndromes’ to describe the theoretical gains that others seek or obtain from the patient’s illness. Examples in literature include an over-solicitous or emotionally dependent family member who purportedly gains financial benefit or a sense of identity through the caregiver role, or a physician who ‘colludes’ with their patient, perhaps deriving psychological benefit from donning the ‘patient champion’ persona, or avoiding the anxiety of possible litigation (Kwan et al., 2001). Such alleged tertiary gains are alluded to within BPS literature (Halligan et al., 2003; RCP, RCPsych & RCGP, 1996), although typically not explicitly named as such. An extreme case of purported tertiary gain may arguably be inferred, from the perspective of BPS proponents, in situations where children labelled with MUS (notably, in the case of ME/CFS) have been taken into care and parents have been accused of child abuse (Colby, 2014). In some of these cases, the diagnostic labels ‘Munchhausen’s syndrome by proxy’ or ‘fabricated or induced illness’ have been applied (O’Neill, 2020).

Psy discourse and practices around MUS thus represent, when taken as a whole, a totalizing system whereby any attempt to challenge the narrative of psychologization is framed as further evidence of dysfunctional illness behaviour or collusion or complicity with such (Spandler & Allen, 2018). Whilst every attempt is apparently made in such practices to highlight what is purportedly ‘wrong’ with the patient, there is little consideration of what might be wrong with the broader socio-structural context in which the patient resides, which includes the psychology of practitioners and others who reinforce such discourse. The exception to this, consistent with a totalizing narrative, is where individualistic ‘social’ factors are invoked to further justify the narrative of

moralizing psychologization, with suggestion that an overly generous social security system and compensation culture reinforce maladaptive illness behaviour (Halligan et al., 2003; Kwan & Friel, 2002; Sharpe, 2002). In an attempt to better understand this lack of reflexivity, I now turn to exploring a loosely held concept of gain to construct an alternative narrative of who gains from MUS and why. Here, MUS is understood as a social and clinical construct, a related set of narratives and associated practice. The following suggestions are tentatively proposed, offering an emergent interpretative framework to elucidate the persistence of BPS hegemony despite theoretical incoherency, lack of empirical support and patient harm. Consistent with my practice, I draw upon concepts across different psychotherapeutic modalities through a pluralistic lens, applying theory-based suggestions to empirical data (existing research, patient testimony, personal and professional experience) as opposed to shoehorning empirical data (such as the patient's experience) into ill-fitting theories and distorting and discarding whatever does not fit.

## **The psychology of non-reflexivity**

What might practitioners and other social actors in the realm of MUS gain, consciously or unconsciously, through eschewing reflexivity? In this case, we would not be asking what is to be gained by presenting with certain symptoms, syndromes or 'maladaptive' illness behaviour (Wessely et al., 1989), but what is to be gained by presenting a particular non-reflexive and arguably maladaptive narrative around MUS. An obvious potential driver of lack of reflexivity is that of political, economic and professional gain – approximately equivalent to external secondary gains (Dersh et al., 2004). A cynical perspective might highlight the likely professional advancement, and associated furtherance of economic and social power, for certain actors as a result of their involvement in the academic-state-corporate nexus (Jolly, 2012; Rutherford, 2007b; Stewart, 2019). It could well be argued that it is to the advantage of those involved in this nexus not to turn the lens of critical scrutiny back onto themselves or their agendas. In fact, psychologizing and stigmatizing people labelled with MUS might be said to have a dual function in this respect: it draws attention away from compromising associations and



questionable agendas, whilst justifying an approach to MUS that is advantageous to said actors.

A less cynical perspective might offer up constraining structural and institutional factors that encourage lack of reflexivity and adherence to dominant BPS discourse in psy professions. In public health service settings such as the NHS, time-limited and increasingly manualized interventions, a focus on outcomes as opposed to process and therapeutic relationship, and overarching audit culture may create an environment where practitioners feel under pressure to ‘deliver’ as per the terms of their employment, even when it sits at odds with truly patient-centred care (Proctor et al., 2019; see also Loewenthal, 2015). This is particularly evident in IAPT which is unashamedly underpinned by government policy consistent with the interests of the academic-state-corporate nexus (Layard et al., 2007). From a behavioural perspective, such structural and institutional factors create a network of contingences that could be said to reinforce practitioners’ adherence to dominant BPS discourse and practice. The gains for practitioners here could be understood as approximating internal and external secondary gains (having clear external reinforcers) and may include increased self-efficacy and self-esteem, increased employment security and increased chance of career progression. Consistent with a cognitive behavioural perspective on gains (Pilecki et al., 2015), it could be proposed that these gains and reinforcers are largely available to practitioners’ awareness and might be acknowledged if they were pointed out. That is, there is no suggestion here that there is a conscious motivation to gain; however, becoming aware of such dynamics and potential gains and reinforcers might encourage a more cautious and critical approach to BPS discourse and practice.

A further institutional factor that might reinforce lack of reflexivity is that of professional training. As previously noted, there is little emphasis on reflexivity during training, and this is (in my experience) particularly the case where the ‘scientist-practitioner’ model applies. Here, a largely positivist perspective of the value-free scientist is foregrounded; if practitioners believe that they can be ‘objective’ in the sense of the neutral, independent observer, it follows that reflexivity is unnecessary (Harding, 1992). The widespread assumption of, or at least collective striving towards, a

position of disembodied neutrality in mainstream sciences has been conceptualized as the ‘god-trick’, the pretense of seeing everything from nowhere (Haraway, 1988). Such assumptions may encourage epistemic hubris in clinical training, whereby other perspectives (such as those of patients) are more readily dismissed. Potential practitioner gains of subscribing to the ‘neutrality ideal’ (Harding, 1992) can be conceptualized as internal and external secondary gains and may include: bolstering of self-esteem and self-efficacy, acceptance into the mainstream scientific community, and building a personal and collective sense of identity which sits favourably in the social imaginary. Again, these gains and associated dynamics are likely available to awareness and could form a useful point of reflexive discussion in training and practice.

Non-reflexive adherence to an equally non-reflexive BPS discourse around MUS, and lack of reflexivity in psy practice more broadly, might also be understood through a largely intrapsychological lens, through dynamics that occur without overt reinforcers and where availability to awareness is less clear. More specifically, lack of reflexivity may bolster certain psychological strategies that function to guard against practitioner anxiety and/or discomfort through partially resolving intrapsychic conflicts. Such anxiety or discomfort is likely caused by conflicting values, beliefs and/or experiences relating to clinical or therapeutic encounters, where resolution of anxiety represents the gain. These psychological strategies may be elucidated through closer examination of victim blaming dynamics as evidenced in MUS healthcare (Anderson et al., 2012). Discourse analytical research demonstrates how medical practitioners may draw upon psychosocial narratives around MUS in order to maintain their ‘expert’ status, avoiding the discomfort of medical uncertainty or the threat of professional failure by shifting health-related responsibility (or blame) onto patients (Horton-Salway, 2002). Further, a meta-synthesis of 13 qualitative studies (Johansen & Risor, 2017) highlighted possible reasons for practitioners’ struggles within MUS encounters: the threat posed to their assumed epistemic authority, the shift in traditional power dynamics in patient-practitioner relationship, the acknowledged inability to solve patients’ problems and associated feelings of fear, failure, frustration and helplessness. (Whilst these findings principally arise from general medical practice research, it is reasonable to assume transferability to psy professions). The practitioner’s

need for certainty, their self-positioning as expert and their desire to fix or heal are thus juxtaposed against the experience of clinical uncertainty, loss of expert positioning, and threat to archetypal healer or hero identity (Wendell, 2006), engendering anxiety and discomfort. Given that many practitioners appear to have at least a surface-level awareness of such struggles (Wileman et al., 2002; see also Johansen & Risor, 2017), it is reasonable to suggest that that the dynamic of conflict is at least to some degree accessible to awareness (e.g. at a preconscious or automatic processing level). The internal conflict can thus perhaps be best understood through the lens of cognitive dissonance (Festinger, 1962), although the Rogerian concept of incongruence between self-structure and experiencing (Rogers, 1951/2003) also applies well. Depending upon how threatening certain conflicts are deemed to be to the practitioner's self-concept and worldview, and upon how unresolvable and 'primal' the underpinning dynamics of conflict are considered to be, the psychodynamic theory of (unconscious) intrapsychic conflict (Freud, 1916-1917/1963) might also be applicable.

No matter what the theoretical lens, as previously noted the gain constitutes some degree of resolution of practitioner anxiety and discomfort, reliant on the practitioner's non-reflexive adherence to mainstream BPS discourse around MUS. From a psychodynamic perspective (Freud, 1933/1965; Freud, 1936/1957), ego defences may include rationalization ('I am following evidence-based practice in interpreting physical symptoms as psychosocial'), denial ('this patient is not really ill'), displacement and / or projection (frustration at the practitioner's self is displaced onto the patient, the practitioner's lack of insight is projected onto the patient). Through a Rogerian lens, practitioner denial or distortion of experiencing (the experience of a patient's suffering for which the practitioner has no solution) mitigates threats to self-structure ('I'm the expert here', 'helping patients is what I do'). Through a lens of cognitive dissonance, reducing the salience of dissonant cognitions and/or acquiring new cognitions ('this patient is exaggerating, perhaps malingering, they do not need further biomedical investigations') increases internal psychological consistency. In this way, avoidance of personal and professional reflexivity, through adhering to a non-reflexive narrative about people labelled with MUS, helps to maintain (gain) a precarious sense of psychic equilibrium,

congruence or cognitive consistency. The gain here might thus be contended to approximate primary gain, loosely understood. That is, it is a gain relating to anxiety reduction within the internal world of the individual practitioner, albeit where accessibility to the conscious mind is debatable, and whereby the anxiety is relieved not by production of bodily symptoms, but by (re)production of an anxiety-reducing narrative about patients who challenge the scientific, clinical or therapeutic status quo. BPS discourse might therefore be understood as a form of ‘compromise formation’ (Freud, 1916-1917/1963; see also Sata & Munday, 2017).

Victim blaming dynamics in BPS practice and related discourse around MUS can be further framed in a manner that has relevance for institutions and other social structures as well as for individual practitioners. Victim blaming is likely underpinned by attributional biases, not least a (fallacious) belief in a just world (Lerner & Miller, 1978), a tendency to hold people personally accountable for their misfortunes, thus gratifying the need to believe in a just and relatively predictable world. This, in turn, can be understood as motivated by a need to maximise or a tendency to overestimate perceived control, certainty and/or (self-)efficacy (Langer, 1975); the gratification of such needs may allay anxiety and thus represent the gain. Alternatively, or in a spirit of complementarity, victim blaming can be understood as a strategy to shift the spotlight of scrutiny away from more legitimate causes of ‘misfortune’, notably overt socio-structural injustices and the misuse of power that underpins them (Ryan, 1971). In this case, the gain would likely be the avoidance of accepting personal or collective responsibility for complicity or collusion in such injustices, thus avoiding uncomfortable feelings such as guilt and preserving moral value. On a practitioner level, need or desire to maximise control and certainty (expert status) in clinical and therapeutic encounters has been evidenced, whilst there is also suggestion of practitioners’ need to take the moral high ground through ascribing to moralizing narratives about people labelled with MUS (Luca, 2011; Wileman et al., 2002; see also Salmon, 2000). Combined with the previously discussed lack of acknowledgement of broader socio-structural injustices in practitioner narratives around MUS, these clinical behaviours may be interpreted as a defence against threats to a ‘just world’ view and against acknowledgement of practitioner complicity in perpetuating

injustices. Similar dynamics can be discerned on an institutional and broader structural level.

A parallel dual need to preserve perceived control and assert moral value can be discerned in the victim blaming dynamics of academic-state-corporate nexus discourse. Narratives around MUS in the context of UK welfare reform and healthcare policy ignore socio-structural injustices as potential contributors to chronic illness and disability whilst reinforcing the neoliberal trope of free-will, conceptualizing disability as in part a ‘conscious choice’ and shifting responsibility for ill-health onto people labelled with MUS (Waddell & Aylward, 2010; see also Halligan et al., 2003). Simultaneously, this nexus-driven discourse positions actors involved in the nexus as beyond moral reproach, with claims of following the ‘evidence’ and upholding beneficence whilst constructing othering moral tales about patients (Waddell & Aylward, 2005; Waddell & Aylward, 2010; White, 2005). Similar dynamics of victim blaming, likely underpinned by need for certainty and control alongside assertion of moral legitimacy, can be discerned in the UK media’s framing of people labelled with MUS (Liddle, 2019; Pemberton, 2011) and in mainstream discourse more broadly (one only has to observe social media exchanges or listen to patient accounts of gaslighting to support this assertion). Indeed, the complicity of actors and institutions outside of the academic-state-corporate nexus and psy disciplines in furthering socio-structural injustices in the realm of MUS might be conceptualized through the lens of tertiary gains. Here, tertiary gain is understood as the advantages that others derive not from a patient’s ‘illness behaviour’ but from an ableist narrative, constructed by socially powerful actors and structures, about such purported illness behaviour. A considerable gain in this regard, which might alternatively be considered secondary gain given the centrality of the UK government in the academic-state-corporate nexus, is the gains for the UK treasury. That is, the economic benefits to be derived from IAPT formed part of its initial ‘selling point’ (Layard et al., 2007), whilst discussions among actors within the nexus acknowledged how the UK treasury would gain from cutting healthcare and social security expenditure (White, 2005).

It is noteworthy that the themes of preserving perceived personal control and preserving moral value are evocative of the dual model of scapegoating as forwarded by

Rothschild et al. (2012) (see also Hunt, 2022). Although a separate phenomenon from victim blaming, scapegoating offers another way to understand how certain actors and collectives might gain from BPS discourse around MUS. The narrative of MUS as a drain on healthcare resources and social security provisions in an increasingly overburdened health and social system (Chew-Graham et al., 2017; Waddell & Aylward, 2010), accompanied by a likely over-exaggeration of the issue of malingering, welfare and insurance fraud (Briant et al., 2013; Stewart, 2019), has arguably contributed to the broader scapegoating of chronically ill and disabled people. This, particularly since the financial crises of 2007 / 2008 and subsequent austerity measures in the UK, including increasingly stringent welfare reform (Hughes, 2015). In these cases, the unjust blaming of chronically ill and disabled people (including people labelled with MUS) for negative outcomes that are largely due to broader systemic failures certainly fits the definition of scapegoating. Consistent with the dual model of scapegoating (Rothschild et al., 2012), such dynamics can be understood as motivated by a societal defence against uncertainty (by creating a clearly identifiable and external cause for negative outcomes) and as a means by which social actors preserve moral legitimacy and defend against accountability in the face of overt socio-structural injustices, which MUS arguably exemplify. With the extra burden placed on the health, social system and wider economy by the covid-19 pandemic, and further austerity looming in the UK and beyond (Moore, 2021; Sharma et al., 2021) the risk of people with MUS being scapegoated may increase, with potential implications both for people labelled with MUS and for people with long Covid.

Given that I have noted how BPS discourse can be moulded to the biases of whomever promotes it (Ghaemi, 2009; Stam, 2000), the same charge could be raised against my attempt to construct the beginnings of a counter-discourse. However, far from seeking a differently situated totalizing system, I seek to offer a fledgling hermeneutical framework – acknowledged as theoretical and hypothetical - to illuminate the persistence of hegemonic BPS discourse and practice, despite clear harms to patients and lack of empirical and coherent theoretical support. I hope to provide a counter-narrative, by interrogating and deconstructing dominant narratives around MUS, not least by demonstrating how easily such narratives can be applied to those who (re)produce them.

This process highlights the socially constructed, potentially socially oppressive nature of what passes for medical, clinical and therapeutic wisdom, and arguably represents an area for future collaboration in the self-advocacy work of people labelled with MUS and people diagnosed (or labelled) with mental health conditions (Spandler & Allen, 2018). In particular, the above discussion highlights that we should be asking which parties in dominant narratives around MUS are in actuality consciously or unconsciously motivated by some form of gain. It would appear from the above discussion that there are numerous potential gains for practitioners, socially powerful actors and institutions involved in constructing and reinforcing dominant BPS discourse around MUS, in contrast to multiple and often profound losses for people labelled with MUS who do not recover as per mainstream society's expectations (Anderson et al., 2012; Edwards et al., 2007). In the final part of this article, I offer some suggestions as to how BPS hegemony can be resisted within psy professions.

## **Resisting biopsychosocial hegemony**

There is a clear need for greater emphasis on reflexivity in psy professions' training, supervision, research and practice. Considering that MUS discourse has arisen from and is reinforced by power differentials, explicit focus on critical reflexivity (Ng et al., 2019) is recommended. The qualifier critical emphasises the relationship between knowledge and power, and the need to challenge power structures and associated actors that (re)produce and are legitimised by dominant discourse. Importantly, critical reflexivity also emphasises an explicit commitment to social change (Ng et al., 2019). Critical reflexivity has been argued to promote epistemic humility (Thomas et al., 2020), an epistemic virtue and, it could be argued, a counterforce to hubris. Epistemic humility may also cultivate greater tolerance of clinical and therapeutic uncertainty, which in turn may guard against overly prescriptive approaches, allowing practitioners to be truly patient-centred as opposed to theory- or policy-centred. Indeed, for all the talk of patient-centred care in psy (and other healthcare) professions, research drawing upon the experiences of both patients and practitioners suggests this is rarely achieved in the realm of MUS (Åsbring & Närvänen, 2002; Åsbring & Närvänen, 2003; Wileman et al., 2002;

see also Blease et al. 2017). A critically reflexive approach, highlighting the arguably ‘maladaptive’ coping strategies of practitioners within a broader context that prioritises politics over patients, would shine new light on the barriers to patient-centred care. In respect of humility, it is also pertinent that MUS research indicates that some patients value practitioners admitting that they do not know, rather than pretending otherwise (Kornelsen et al., 2016; Sharma et al., 2020). Finally, humility holds that non-medically trained practitioners should be cognisant of their training limitations (Geraghty & Scott, 2020) and should encourage the patient to consult with medical professionals in cases of doubt, rather than ascribing all manner of somatic symptoms to psychosocial causes.

Critical reflexivity requires that practitioners are able to consider patient ‘problems’ in their wider socio-structural context (Etherington, 2017), of which the practitioner is a part. Framing ostensibly individual-level psychosocial distress as an understandable response to socio-structural injustices may thus be appropriate; practitioners should also consider to what degree they are complicit with such injustices (Loewenthal, 2015). It has been argued that socio-structural injustices require socio-structural remedies (Anderson, 2012); in this respect, structurally competent approaches (Metzl & Hansen, 2014) towards practice, training, research and supervision are essential. Structural competency acknowledges that patients’ presenting issues may be a downstream manifestation of upstream (institutional and broader structural) factors. Accordingly, to offer a practice-based example, individualistic ‘psychoeducation’ elements in many therapeutic interventions should integrate recognition of how the patient’s psychology is embedded within a broader matrix of power structures, one that will be impacted by intersectionality (Crenshaw, 1989) and thus unique to the patient. This highlights a need to learn from the patient and points towards a critically informed, dialogic approach to psychoeducation, as opposed to the dominant unidirectional banking model of education (Freire, 1993). This approach would help to equalize the patient-practitioner relationship and encourage practitioners to be allies in supporting patients to recognise the possible harms associated with mainstream BPS discourse, including harms associated with internalised ableism (Hale et al., 2020). An approach based on allyship might also constructively focus on encouraging people labelled with



MUS to assert their rights as chronically ill and disabled people, and encourage positive identity-building with supportive others (Olkin, 2017). To offer a supervision-based example, a structurally competent approach might fruitfully draw upon the seven-eyed model of supervision (Hawkins & Shohet, 2007) with explicit recognition that the ‘wider context’ includes the socio-structural context, the architecture of which will be unconsciously or preconsciously internalised by both supervisor and supervisee. Such an approach, and explicit discussion of socio-structural influences within supervision, might counter collusion between supervisor and supervisees as regards victim blaming, something I have personally experienced in training and practice. In all cases, recognition of how politics pervades psy disciplines is essential for practitioners; indeed, the pretensions of such disciplines to apolitical scientific neutrality can be considered a political act that harnesses social power and may serve to legitimise oppressive and exploitative practices (Harding, 1992).

In terms of future research directions, there is a need to explore the experiences of people labelled with MUS in psy settings; in particular, the high drop-out rates amongst people labelled with MUS referred to IAPT (Geraghty & Scott, 2020) are of interest. Exploration of alternatives to the BPS model of MUS is indicated, for example, models drawing from humanism and phenomenology have been proposed (Ghaemi, 2009; Blease et al., 2017). Given the lack of (critical) reflexivity in psy training and practice, and the apparent consequences for patients as already discussed, future models or frameworks should be informed by or integrate a critically reflexive stance. For example, a relational model (Beach & Inui, 2006) embedded within a structurally competent framework might be considered, or a critically reflexive BPS model (a relational bio-psycho-socio-structural, or bio-psycho-socio-political framework). More broadly, embedding critical reflexivity into research designs may help in reducing unintentionally exclusionary research practices (Muhammad et al., 2015). Involving people labelled with MUS, in particular multiply marginalized persons, in both research and training as co-researchers and co-educators is crucial, as is drawing upon perspectives of ‘insider’ researchers and practitioners from marginalized backgrounds. In this regard, MUS

research on patient experiences through an intersectional lens (Crenshaw, 1989; Turan et al., 2019) is indicated. That is, MUS delineates a highly heterogeneous set of patient groups and it is likely that intersection of socio-demographic (dis)advantage contributes to heterogeneity of experience (Fawcett, 2000). Achieving such inclusivity will arguably necessitate a fundamental shift in thinking and practice across the psy professions, academia and beyond, not least in breaking down institutional ableism (Brown & Leigh, 2018), but also in addressing the reluctance from some actors and structures in recognizing intersectionality within the disabled and chronically ill community (Fawcett, 2000).

## Conclusion

Critically oriented theorists have argued that dominant constructions of marginalized groups often reveal more about privileged subjects than they do about marginalized subjects (Wilkinson & Kitzinger, 1996; see also Wendell, 2006); this article would appear to support that argument. The BPS narrative around MUS of unhelpful cognitions (including attentional biases and misattribution), maladaptive behaviours (such as avoidance) and lack of insight into the true nature of MUS (Deary et al, 2007; Chalder et al., 2019; Salmon, 2000), might actually apply better to those who have constructed and reinforce such narratives than it applies to people labelled with MUS. Whilst all humans struggle with uncertainty to some degree and it is unsurprising that chronically ill persons would be no exception (Kornelsen et al., 2016), it would appear that practitioners' difficulty with dealing with uncertainty is far more detrimental to the well-being of patients. The same could be said of other social actors who are invested in constructing an anxiety-reducing, yet stigmatizing and empirically unsubstantiated discourse around MUS. Whilst people with MUS are positioned as seeking moral value through a "no blame" route to the sick role (Halligan et al., 2003; Ferrari & Kwan, 2001), it is highly possible that the need to deflect from injustice and assert moral value on the part of practitioners, socially powerful actors and society more broadly is contributing to the marginalization and disablement of people labelled with MUS.

This article suggests that some of the psychological processes that underpin lack of reflexivity and persistence of BPS hegemony may not be easily accessible to awareness, whilst others are reinforced by structural constraints. It is thus likely that much, if not most, of the epistemic and broader socio-structural injustices committed against people with MUS are unintentional. However, practitioners and others embedded in power structures – alongside all social actors - must be prepared to consider their complicity in such injustices. It has been argued that psy disciplines have often found themselves in uncomfortable alliances with powerful actors and structures, against the interests of marginalized groups (Teo, 2015) and it could be argued that BPS discourse and practice in the field of so-called MUS exemplifies this. A critically reflexive approach to such discourse and practice within psy disciplines and beyond (notably extended to non-psy medical disciplines) is therefore indicated. Critical reflexivity encourages practitioners and social actors more widely to consider what might be ‘gained’ from reinforcing marginalizing discourse and practice, whilst committing to institutional and social change, thus offering a constructive way of moving towards more equitable healthcare and a more equitable society.

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### **About the author**

Joanne Hunt (MSc, MBACP, MBPsS) is an independent disabled researcher with a background in psychological therapies. Her research interests centre on ‘contested’ chronic illness and disability, particularly through the lens of critical theory and with particular focus on health and healthcare inequities, intersectionality, stigma, epistemic and broader social injustice.