

What is in a name? Autonomic imbalance and medically unexplained symptoms in Taiwan

Jia-shin Chen 

Institute of Science, Technology and Society, National Yang Ming Chiao Tung University, Taipei, Taiwan

Correspondence

Jia-shin Chen, Institute of Science, Technology and Society, National Yang Ming Chiao Tung University (NYCU), No. 155, Sec. 2, Linong St., Beitou District, Taipei City 112, Taiwan.
Email: jschen1973@nycu.edu.tw

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Abstract

Medically unexplained symptoms (MUS) are persistent bodily symptoms without known pathology. An unofficial term has recently emerged in Taiwan to accommodate MUS: autonomic imbalance (AI). AI literally refers to disturbances of the autonomic nervous system (ANS) that innervates vital organs. However, AI is variously conceptualised by different parties. This study intends to investigate what is in the name of AI. It draws on available databases and in-depth interviews with AI sufferers and Western and Chinese medicine physicians. Some physicians research ANS functions through heart rate variability measurements. Research findings show that physicians regard AI as a convenient term for clinical communication and a euphemistic substitute for MUS or even psychiatric diagnoses. It is not a 'real thing'. However, AI sufferers treat AI as a bona fide disease, only that it has not been officially classified. AI is therefore an unfaithful translation, or an uncontrolled equivocation, of MUS. The paper concludes by discussing the implications of treating AI as an equivocation. These implications include the limitations of the current diagnostic criteria, the necessity to rethink the dichotomy of mind and body, and the underlying realities exposed or masked by 'diagnosis'.

KEYWORDS

autonomic imbalance, Chinese medicine, diagnosis, equivocation, medically unexplained symptom, translation, Western medicine

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INTRODUCTION

Patients with medically unexplained symptoms (MUS) by definition are a challenge to clinicians. According to Chalder and Willis (2017: 187), MUS are ‘persistent bodily symptoms with functional disability but no explanatory pathology’, and therefore without an official name. Either these symptoms are unaccounted for by medical nosology or are simply too many tentative impressions without ever reaching a final diagnosis. People with MUS are either treated lightly or transferred to psychiatric care because objective examinations show nothing wrong. These people share the experience of chronic frustration caused by repeated visits to various doctors without getting a definite diagnosis.

In recent years, a term has been used in Taiwan to accommodate these troubling symptoms: 自律神經失調 (*zilushenjing shitiao*), which is translated into English as ‘autonomic imbalance’ (AI) (Wang, 2017). AI literally refers to the disturbances of the autonomic nervous system (ANS). ANS includes two subsystems, the sympathetic nervous system (SNS) and the parasympathetic nervous system (PNS), whose functions are often antagonistic. For example, sympathetic discharges result in elevated heartbeat and heightened blood pressure, whereas parasympathetic discharges lead to lowered blood pressure and slower heart rate. The ANS innervates major organs, including the heart, lungs, blood vessels, bowels, skin and genitals, so its dysfunction may manifest varied general and physical symptoms. General symptoms include feelings of anxiety, restlessness, inability to concentrate and poor memory. Physical symptoms often involve a multiplicity of organs and systems, examples of which include headache, tinnitus, dry mouth, shortness of breath, palpitation, chest tightness, nausea, gastric spasm, abdominal distension, constipation, dyspepsia, urine frequency, pain of various sorts, sweating over palms and soles, and appetite changes (Guo, 2012). The combinations of variegated symptoms make pinpointing a specific diagnosis extremely difficult, thus resulting in a nosological alternative to MUS.

Identifying the time when AI emerged in Taiwan is difficult, but this term is generally perceived to have become popular approximately 15 years ago (Wang, 2017). Many people, as will be shown later, believe that this term has replaced an earlier term, neurasthenia (神經衰弱, *shenjin shuairou*). Archival review shows that this term might have come from Japan because AI appeared in a number of translated newspaper articles and self-help books by psychosomatic medicine practitioners in Japan, where the notion has long existed and indicated a variety of physical symptoms in some life stages, such as menopause (Lock, 1993; Ohnuki-Tierney, 1984).

Fangcat, as she likes to call herself on the web, is a recovered sufferer of AI. She described her onset of illness almost 10 years ago on her blog. ‘Getting on the train, I began to feel uncomfortable all over my body’, she reminisced the day that completely changed her life. As she had a history of low blood pressure and low blood sugar, she first tried a sugary beverage but to no avail.

Symptoms started to aggravate in seconds. First I felt dizzy and weak, and my vision narrowed. Unfamiliar symptoms followed—the outer world seemed darkened, like I was watching a broken TV with fuzzy signals. Suddenly I felt suffocated, just like my chest was struck by a hammer. Palpitation, numbness over my extremities, intense nausea, and feelings of dying.... (Fangcat, n.d.)

She was diagnosed with panic disorder initially by a psychiatrist, but she was not convinced. Over the next three years, with disabling symptoms off and on, she shopped around several treatment options, such as psychiatric medications to neuromodulation therapy. A physician said that she is a case of congenital autonomic imbalance (先天自律神經失調, *xiantian zilushenjing shitiao*). This ‘diagnosis’ made perfect sense to her because it explained not only this acute-turned-chronic illness course but also her pre-existing

ill health conditions since childhood (insomnia, allergy, asthma, frequent fever, hypotension and hypoglycaemia). For her, panic is simply one part of her congenital AI, and her current psychiatrist/therapist seems to concur.

Although not listed in official diagnostic criteria, AI seems to expand in clinical encounters to cover MUS in Taiwan. Dr. Yu-Xiang Guo, a renowned specialist in AI, describes the 'illness' in his book (2012): 'autonomic imbalance..... manifests itself in different guises to different persons'. Furthermore, 'autonomic imbalance can be seen as a typical illness of civilisation'. However, 'it is not a trivial problem', Dr. Guo claims. It is 'the biggest killer in the 21st century for humankind'.

For physicians and patients, what do they really talk about when they talk about autonomic imbalance? This question has motivated this study, which intends to address local components to enrich the present understanding of MUS. Sociological research on uncertain illnesses (e.g. MUS) has been accumulating recently (Nettleton, 2006). Most studies are centred on the issues of diagnostic uncertainty, legitimacy of the sick role and patients' resistance against psychological explanation. These concerns are often entwined in the attempt, usually initiated by sufferers and their advocacy groups, to seek an officially recognised diagnostic label as a foundation upon which medical research and insurance compensation can be granted. A typical example is chronic fatigue syndrome in the 1980 s, which may be traced genealogically back to myalgic encephalitis recognised 50 years earlier (Aronowitz, 1998). Other examples include tension headache, fibromyalgia, irritable bowel syndrome and multiple chemical sensitivity. Diverse as these diagnoses may seem, Childer and Willis (2017) advanced a trans-diagnostic approach which 'lumps' them together as one, that is persistent physical symptoms (PPS). Henningsen et al. (2011), by contrast, suggested using the term 'bodily distress syndrome' (BDS).

PPS, BDS or AI is intended to replace the usage of MUS, a common phenomenon in primary practice. People often come to medical attention with symptoms whose aetiology is ambiguous and treatment difficult (Creed, 2009). How does having a name by doctor–patient consensus help? Physicians have repeatedly argued for the importance of naming (that is, diagnosing) in medical practice, as they tend to believe diagnosis frames and facilitates subsequent interventions that eventually influence patient outcomes. By contrast, sociologists associate diagnoses with social conditions and processes that complicate the claimed value neutrality and objectivity of these clinical diagnoses (Jutel, 2010). Diagnoses are viewed as constructs co-produced by the social and the natural.

While a medical diagnosis is 'readily recognized as the official label that classifies disease or a medically-related problem' (Jutel & Nettleson, 2011:794), it can also be viewed as a translation. For physicians and researchers, a diagnosis translates clinical signs and symptoms into something that implies certain pathologies and outcomes. For sufferers, a diagnosis translates into a new identity. For example, diabetes mellitus signifies a malfunctioning pancreas which necessitates medical intervention and a new life which demands constant monitoring of food intake. In this light, diagnosis as translation is destined to be understood differently because it is situated simultaneously in the diverse worlds of patients, physicians and many others involved.

Eduardo Viveiros de Castro (2004) addressed the work of anthropologists as a form of translation. Herein I propose that physicians do similar work because both professions aim to translate something foreign into a language familiar to themselves. However, as an Italian adage goes, 'Traduttore, traditore' (translator, traitor). Translation is known for its tendency to betray original meanings, or, in Viveiros de Castro's words, *uncontrolled equivocation*.

In that case, towards which side should anthropologists (or physicians in this context) be leaning? Drawing on decades of research experience with Amerindian peoples, Viveiros de Castro (2004) argued that anthropologists should lean towards the side of the researched rather than the side of the researchers. That is, the equivocation should be *controlled* so that the original meanings do not get lost during translation. This opinion stems from Walter Benjamin's ideas about the translator's role.

In an article titled *The Task of the Translator*, Benjamin (2007: 81) insisted, ‘The basic error of the translator is that he preserves the state in which his own language happens to be instead of allowing his language to be powerfully affected by the foreign tongue’.

This anthropological insight has sociological repercussions. While Jutel (2011: 3) argues that ‘diagnosis provides a cultural expression of what a given society is prepared to accept as normal and what it feels should be treated’, this statement fails to address the diverse interpretations of normalcy and elaborations of potential treatment by physicians and patients. Aware that diagnosis as translation is usually unfaithful, sociologists of diagnosis will come to grips with the multiple factors—social, cultural and epistemic, to name a few—implicated in the making of uncontrolled equivocation.

For example, in many occasions, diagnosing and treating those with MUS has become the job of psychiatrists. The rationale behind this phenomenon is straightforward but problematic. It is straightforward in that, because the troubling physical symptoms cannot be satisfactorily explained by medicine, they can simply be due to abnormal psychological states. What primary care physicians see as MUS may simply be bodily manifestations of underlying anxiety, depression and what not. Charles Rosenberg (2006: 411) put it succinctly, ‘Psychiatry remains the legatee of the emotional, the behavioural, and the imperfectly understood’. MUS clearly fit in the ‘imperfectly understood’ category. However, this does not mean that psychiatry *knows* what these symptoms truly are. On the contrary, a psychiatric diagnosis for MUS may merely signify that the issue is with the ‘patient’, thus denying that diagnosis in psychiatry is mostly made by exclusion. Therefore, claiming MUS as a psychiatric territory is problematic.

Worse, the introduction of psychiatry may put the people with MUS in a double disadvantage: they are not just ill; they are mentally ill. Having MUS or uncertain illnesses becomes a precondition that prompts those afflicted to fight for respect and legitimacy (Dumit, 2006; Nettleton, 2006). They often form organisations to strive for their identity in the kingdom of the sick. Their grievance and longing are written in their bodies. This feature of embodiment is seen in examples of fibromyalgia and chronic fatigue syndrome (Aronowitz, 1998; Brown et al., 2004). However, this characteristic is absent from the case of AI in Taiwan. Although AI has never entered the formal classificatory system of Taiwan's national health insurance (NHI), its exculpatory effects for people with MUS are apparent. For example, Dr. Yo is a general practitioner who thinks positively of AI from his 10-year experience of primary care. Heart rate variability (HRV), which measures ANS functioning and substantiates the presence of AI, helps reassure many patients about the authenticity of their MUS, which are often ridiculed and ignored. This AI ‘diagnosis’ is not a formal one, Dr. Yo admitted, but it gives legitimacy to sufferers even if the legitimacy is partial. In this sense, the popularity of AI, or MUS that it represents, is a pervasive, silent yet unofficially recognised phenomenon. Given the fact that symptoms without a diagnosis are found in approximately one third of primary care encounters (Rosendal et al., 2015), the clinical use of AI as a label for MUS should be evaluated more seriously.

This study intends to examine how AI is conceptualised by various parties in Taiwan and how these conceptualisations constitute a popular term that is understood so differently. A simple way of putting it is to ask, ‘What is in the name of autonomic imbalance?’ Inspired by known scholarship on sociology of diagnosis (Jutel, 2011) and anthropological insights about translation and equivocation (Viveiros de Castro, 2004), this study suggests that AI be treated as a controlled equivocation from which both physicians and patients are invited to ask what has been ‘betrayed’ by this term.

MATERIALS AND METHODS

The paper draws on a qualitative study from 2015 to 2019 that aimed to examine the rise of AI in contemporary Taiwan. The study was approved by the institutional review board (IRB) of National

Yang-Ming University (YM103110E and YM105115E). The data for analysis include relevant archives collected throughout this period and, more importantly, in-depth interviews with 20 participants. These participants were recruited through snowball sampling, and they included Western medicine physicians ($N = 13$), Chinese medicine physicians ($N = 3$), clinical researchers ($N = 6$) and AI sufferers who were key organisers of online AI forums ($N = 3$). Some interviewees had multiple identities: five of the Western medicine physicians were also clinical researchers, and one AI sufferer, Mr. Yang, was soon to obtain a licence in Chinese medicine. The interviewed physicians and researchers were all male except one (Dr. Wu, a Western medicine physician/clinical researcher), whereas one of the three AI sufferers was female (Ms. Chin). The participants were invited to talk about their knowledge of and experience with this condition called AI for approximately 1 to 2 hours. The interviews were carried out in Chinese Mandarin with informed consent. They were transcribed verbatim and kept in a safe place as IRB required. Quotations in this paper were translated into English by the author. Participants were given pseudonyms for the sake of confidentiality.

The archival review covered English and Chinese databases, including Web of Science, Taiwan News Smart Web, and Airiti Library, among many others. The latter two databases contained major Taiwanese newspapers and journal articles. Many keywords were used, such as autonomic nerves (自律神經), autonomic imbalance (自律神經失調), neurasthenia (神經衰弱) and HRV (心率變異性). Most materials on AI were published in the past 20 years, evidencing the recent popularity of this term.

Collected archives, along with transcribed interviews, were analysed following the suggested steps of situational analysis (Clarke, 2005; Clarke et al., 2017). Situational analysis is a modified grounded theory. It is characterised by drawing different maps about the situation in question, namely situational, social worlds/arenas and positional maps where human and non-human actors encounter, organise, interact and perform. The method is rooted in the tradition of symbolic interactionism and the tradition of Chicago Sociology (Clarke et al., 2017). It has been applied in various domains of research and proven useful in making sense of sophisticated situations (Clarke & Charmaz, 2014).

RESEARCH FINDINGS: WHAT IS IN THE NAME OF AUTONOMIC IMBALANCE?

To begin with, all interviewed participants agreed that AI is a vague concept. As the ANS is vital in many systems, its dysfunction will certainly produce a plurality of bodily symptoms. For some, AI predominantly affects digestive functions; for others, it mainly concerns the heart and breathing. However, this label is reserved for cases where specific and definite diagnosis cannot be reached. Unlike autonomic dysreflexia or neuropathy, which are more medically established with pathological foci, AI seems to be a catch-all phrase for all unspecified, unclassifiable and unexplained symptoms. Such variegated manifestations pose an obstacle for all parties involved to reach a consensus about what it really is. Considering the multiple traditions of health belief and healing practice rooted in the history of Taiwan (Kleinman, 1981), perspectives from physicians and patients are usually divergent. However, the knowledge gap between them is becoming narrower because of the Internet. In the following section, perspectives from three major parties involved in the use of AI are described: Western medicine physicians (including general practitioners and psychiatrists), AI sufferers and Chinese medicine physicians.

Western medicine physicians' perspective

Most interviewed Western medicine physicians tend to treat AI as a convenient communicative term to circumvent the need to disclose patients' symptoms as medically unexplained or mentally ill. These physicians are either general practitioners or private practice psychiatrists. For practicing psychiatrists, the use of AI in clinical encounters may avoid revealing stigmatised diagnoses such as depression or anxiety. For them, using the term is not entirely misleading because emotional disturbances manifest themselves somatically through neurological systems. AI is thus an easy way to stay 'neurological', although the real diagnosis is a psychiatric one or no definite diagnosis at all.

Dr. Chen is a psychiatrist who started a private clinic in an old neighbourhood two years prior to my visit. In front of his clinic, a red banner listed his specialty, which included treating AI and neurasthenia. He told me, 'Autonomic imbalance refers to many somatic symptoms, but it does not involve the brain. I mean, ordinary people do not associate this term with one's brain, thought and emotion'. He shared that neurasthenia was addressed on the banner because 'it is an even older term to which many elder people [in this community] can relate'. Both neurasthenia and AI are concepts used to address MUS, but age sets them apart.

By contrast, for Dr. Wu, a psychiatric working in a medical centre, AI is an all-too-ambiguous concept. She recounted the time when she first heard about the term approximately in 2008: 'For a hospital psychiatrist, [AI] seemed like a bogus concept, an unorthodox medicine'. However, when she knew about the association of HRV with AI (addressed later), she took a new perspective. 'I took it as a syndrome. It is not a disease', she explained. In accordance with Arthur Kleinman's somatisation thesis about Chinese people (Kleinman, 1982, 1988; Ware & Kleinman, 1992), Dr. Wu thinks that neurasthenia and AI probably are the same because they all indicate ill-defined symptoms without a proper name. In her opinion, the former is simply replaced by the latter because 'imbalance (失調) sounds better than asthenia (衰弱)'. Other interviewees express similar feelings that imbalance implies temporariness, adjustability and reversibility, thus giving those afflicted more hope of improvement. In addition, rhetorically, imbalance sounds more acceptable to young people with such symptoms who usually do not view themselves as weak.

Herein, two significant features of AI are noted: the association with an earlier concept of neurasthenia and the association with HRV. The first association is beyond the scope of this article and warrants another article. Hence, this paper addresses the second association.

For psychiatrist/researchers such as Dr. Chou, the use of HRV as a research tool promoted and complicated the notion of AI. He attributed the rise of AI in recent years partly to the efforts of his colleague, Dr. Chien, with whom he collaborated in many HRV studies among different types of patients. For two decades, Dr. Chien has published many articles addressing the effects of ageing, gender and other parameters on HRV in normal and diseased populations. He also participated in the research and development of HRV-based machines that are applicable in the Internet of Things. As Dr. Chien explained to me, HRV measuring ANS functions is a scientific instrument that has existed for decades to monitor clinical statuses of foetuses or dying patients. It measures variations of heartbeat and transforms the measurements mathematically. However, it was not until 1996 when HRV parameters were standardised that HRV began to be applied as a tool to measure ANS activities in various conditions (Task Force, 1996). HRV machines of varying kinds were applied in medical research. However, the rise of AI cannot be accounted for by science and medicine. The link between HRV and AI is a result of 'market mechanisms', by which Dr. Chien referred to the collective efforts of the profit-driven companies selling these machines and the hospitals and clinics that use these machines to convince their patients.

Dr. Sun used to be a student of Dr. Chien. He viewed AI as a clinical euphemism for somatoform disorder, a psychiatric diagnosis describing people with multi-system MUS that are allegedly related to psychological factors. He noted the huge gap between AI as known by common people and ANS abnormalities as measured by HRV.

I have been doing HRV research to see if there is any connection between the two. It seems that the ideas in folk belief [such as AI] have their own logic, which are not completely wrong to my knowledge. They are simply uncorroborated. However, there has been no direct and local evidence to prove the correlation of HRV with some kind of psychopathology.

Dr. Chou shared this reservation about the value of HRV with regard to mental illnesses because he barely found a robust association between HRV measurements and mental conditions, somatoform or not. The current HRV measurement takes only 5 minutes or shorter. Therefore, the readings are more likely indicative of a temporary state rather than a lasting condition. In addition, HRV only measures cardiac rhythmic variations which are only one part of ANS functions, so extrapolating HRV readings to the entirety of ANS functions is problematic. If AI, as defined by HRV abnormalities, were to become something 'really out there', it would not likely be a known mental illness. He concluded, 'the ANS functions measured by HRV simply does not correspond well to mental disorders'.

Obviously, AI's nosological status is ambiguous at best and convoluted in most cases. Unity in conceptualisation is impossible, let alone unity in practice. Regarding the diagnoses they entered for the sake of NHI, I received numerous answers from psychiatrists: depression (major depressive disorder or dysthymia), somatoform disorder (uniquely advocated by Dr. Sun) and, most often, anxiety spectrum problems ranging from panic to generalised anxiety disorder. By contrast, general practitioners that I interviewed simply typed in so-called 'symptom diagnoses', such as 'palpitation', 'nausea' and 'dyspnoea'. They rarely made psychiatric diagnoses such as 'anxiety disorders, not otherwise specified'. AI seems to be a semiotic quagmire through which MUS are expressed. However, the name gives MUS a physical appearance with a scintilla of scientificity and nothing more.

Sufferers' perspective

Three key influencers were selected because they managed major Internet groups for AI sufferers. They embody the image of an average AI sufferer—someone in their 30s or 40s with a college or higher education, either regularly employed or living a freelance life. For Ms. Chin, AI is a bona fide disease, not a communicative façade that hides an unwelcome psychiatric diagnosis such as anxiety, depression and what not. Among the AI sufferers who are running online forums for others, AI is a disease entity as authentic as obesity. Ms. Chin explained, 'A disease is defined when your bodily dysfunction leads to your discomfort or the inability to execute certain work. AI is something just like that. If obesity can be a disease, why can't AI?'.

Mr. Xu is another AI patient. His illness began 6 years ago when he was studying in the United States. He was initially stricken by an acute onset of vomiting and diarrhoea, followed by poor appetite and sleep. He became totally incapacitated. A variety of unexplained symptoms ensued: rash, deep yellow urine and worsened stamina. He flew back to Taiwan and sought medical help, but nothing worked. Bedridden, he tried every available treatment in the next 18 months, be it Western medicine, Chinese medicine or folk therapy. He regained strength and confidence bit by bit, and he started to do some simple work: helping a retailer friend in a night market. A few years later, he resumed

office work in a company. I asked him if he considered himself cured? He answered adamantly, 'No, certainly not. There is no such a thing as cure. I have not returned to the state before the onset. All my physical conditions and functions have changed'.

Mr. Xu concurred with Ms. Chin in terms of AI's authenticity. He tried to make sense of his protracted illness course. He compared AI to a common chronic illness, '[it's] like diabetes'. He continued, 'though I am not a doctor, I learn from my illness. I think it is a disease of the brain'.

However, sufferers' belief in the authenticity of AI may result in communication problems between them and physicians (Western medicine or Chinese medicine), especially when this 'disease entity' is not legitimated by the latter. Their sense of authority over their own suffering is often neglected. Therefore, their insistence on having a bona fide disease matters even more (Peters et al., 1998). Mr. Xu explained how he knew it was AI,

You can only attribute to it [AI], but if you say that to a doctor, the doctor won't believe it. They know that this is something people use when they cannot find a cause, but they won't tell you this is it [AI]. Strictly speaking, AI is a diagnosis you gather from non-medical settings. They [physicians] will say, yes, you could have this and that, but nothing is for sure. Every Western medicine physician is uncertain about it. By contrast, Chinese medicine physicians have their own way of speaking. They will translate it into their own language.

Mr. Xu admitted the role of stress in AI symptoms, as was evident in his case, but it was not 'all in the mind'. He described a symptom in the early phase of his illness: loss of digestive tract motility. He once tried to convince his sceptical physician by ingesting a lot of food. Four hours later, X-ray examination showed all food stuffed and intact in his stomach. His physician finally believed his digestive tract stopped peristalsis. However, the physician could do nothing but prescribe probiotics.

The illegitimate status of their illness has resulted in deep frustration. Mr. Yang is a major influencer among AI patients because he has written a book about his struggles with AI. He also organised an online self-help forum where he got acquainted with Ms. Chin and Mr. Xu. He told me, 'I would rather have cancer than AI. If I had cancer, I could surely have some days off from work and my family would take good care of me. But when I was devastated by AI, no one paid attention to me'.

Thus, even if physicians consider AI a euphemism out of convenience, this term does not ease the way for its sufferers. The variegated MUS put their bearers in a difficult situation where recognition is next to impossible, not to mention sympathy and care for their incapacity. Added to the frustration of not being recognised is the chagrin during doctor seeking. All of the interviewed sufferers told a similar story, where they shopped high and low for a doctor who truly knew what was wrong with them. This 'true healer' could be a Chinese medicine physician (Mr. Yang), a Western medicine physician (Ms. Chin) or both (in the case of Mr. Xu). However, finally settling on a certain regimen to stabilise themselves took several years and numerous trial and errors. The story is all too common to these AI sufferers. It constitutes a trigger for them to seek and meet people with similar conditions through online platforms. Mr. Xu is content with sharing information and offering encouragement. Ms. Chin chooses to make a living by giving advice and introducing potentially helpful products, such as probiotics and self-help books. Mr. Yang has even made a drastic career turn. He was a student of economics when AI struck him down, but the illness experiences led him to the study of Chinese medicine. Now he is an intern and will obtain a licence soon. His book is titled 'Illness Is Your Teacher'. He truly lives it.

Chinese medicine physicians' perspective

Mr. Yang's positive experience with Chinese medicine echoes that of many other AI sufferers. Because Chinese medicine is an important part of the professional sector of Taiwan's healthcare system (Kleinman, 1981), this section addresses the use of AI among Chinese medicine physicians.

At first glance, AI and Chinese medicine make strange bedfellows because AI is founded on the anatomy of the ANS whose concept is absent from Chinese medicine. Quite to my surprise, the Chinese medicine physicians I interviewed stressed that AI fits perfectly with Chinese medicine theories because of their similarity in terms of functional dichotomy. Of the two ANS subsystems, SNS functions characterise the state of heightened alertness, such in reactions of fight or flight, whereas PNS activities result in tranquillity and relaxation. Chinese medicine physicians compare the PNS to *yin* (陰) and the SNS to *yang* (陽). The balance of the ANS as a whole is thus comparable to the harmony of *yin* and *yang*, and AI refers to their disharmony. Dr. Yen-Yin Kung (2016: 258), chief of Traditional and Integrative Medicine in Taipei's Veteran General Hospital, expressed his opinion in this cited paragraph: 'ANS activities can be seen as the holistic performance of the human body adapting to inner and outer stimuli because the ANS coordinates general physiological functions. These functions are similar to the notion of "Qi" in Chinese medicine theory'.

In addition, this functional dichotomy (*yin/yang* vs. PNS/SNS) is further endowed with gender connotations. Given that *yin* and *yang* signify women/femininity and men/masculinity, respectively, in Chinese medicine theory, PNS and SNS have also become gendered. This dichotomy is rendered even more 'scientific' by empirical research indicating that women before 50 generally exhibit higher PNS activities than male counterparts and that the difference between sexes dissipates when women stop menstruation (Kuo et al., 1999). The findings imply that female hormones play a major role (Lai, 2016: 92–93). Through the measurement of ANS activities, HRV translates gender differences into the division of *yin* and *yang*.

Medical theory is one thing, but therapeutic practice is another. Most Chinese medicine physicians dwell on the superficial analogy of functional dichotomy in spite of the scientific evidence, of which I doubt they know. Like their Western medicine colleagues, they believe that AI is nothing but a communicative term. However, the issue is not about the negative effects that may be attached to the use of diagnostic labels, but about the lack of Chinese medicine knowledge among the public. Dr. Han lamented, 'when you tell [a patient] that his illness is the result of deficient *yin*, excessive fire, or insufficient liver and kidney functions, he probably has no idea what that is'. Dr. Sheng used to be a clinical psychologist who worked with psychiatrists in a mental institution. He turned to practicing Chinese medicine 10 years ago. He concurred with Dr. Han on the lack of knowledge among general people, so he was trying to incorporate academic psychology and Chinese medical theory in his public writing. He described his clinical encounters with AI patients.

Chinese medicine as a system has difficulty entering colloquial settings, so we use terms of Western medicine when we do health education. Because the public has no basic knowledge of Chinese medicine, it will be easier for them to realise if we use such biomedical terms as 'autonomic imbalance'. To my [psychological] knowledge, autonomic imbalance is what we call psychosomatic illnesses.

I went on to ask what AI was to his Chinese medical knowledge. He admitted that this issue is complicated. Chinese medicine has many ways of associating and explaining multiple somatic symptoms, so AI may signify different things when the composition of symptom clusters is different. Chinese medicine, he further explained, addresses five visceral organs (heart, liver, spleen, lung, and kidney) to indicate

different vital functions. 'AI is associated with all five of them. It depends on where and how you make your case', he concluded with an ambiguous statement. Interestingly, when I posed this question to other Chinese medicine physicians, I got the same answer.

In the end, AI has no real impact on the way Chinese medicine is practiced even though AI fits well with the *yin-yang* theory. Clinically, these Chinese medicine physicians keep practicing their traditional ways of diagnosing—inspection, listening/smelling, inquiring and palpation—before reaching a diagnosis in the framework of contemporary Chinese medicine. For them, AI may be theoretically relevant, but it is practically irrelevant. This finding reflects the disjuncture of theory and practice in contemporary Chinese medicine, where theory is often denigrated as esoteric philosophy and therapeutics exalted as treasures out of thousands of years of experience (*jingyan*) (Lei, 2002, 2014).

DISCUSSION: AUTONOMIC IMBALANCE AS A TRANSLATION OF MUS

Both physicians and patients agree that AI refers to real suffering beyond medical explanation, that is MUS, but they differ with regard to what this name signifies and whether it is legitimate. On the one hand, it is a useful translation. Generally speaking, physicians find this term convenient in clinical communications, researchers find it partially though unstably corroborated by HRV measurements, and patients find it a label with which they can identify themselves.

On the other hand, it is an unfaithful translation. Its meaning is vastly different not only between groups but within groups. The one who says it and the one who hears it understand the term in different ways, but both parties seem to be content with what they comprehend. The incoherence of perceived meanings can sometimes be exposed when, for example, the patient demands a certificate from the physician for legal purposes. The physician is mandated to write down an official diagnosis, but AI is not an official one.

From what has been discussed, what is to be betrayed in the use of AI? How should AI be conceptualised to enhance the fidelity of clinical encounters rather than offer a façade for what is unknown or silenced?

To begin with, both physicians and patients are probably not taking AI seriously enough as they are *not controlling* this equivocation. Physicians see it as an easy way out, either as an escape from telling the patient about his or her stigmatising mental diagnoses or as an alternative explanation that avoids spending time introducing to patients their imbalance of vitality or 'Qi'.

This translation can be deceiving for people who label themselves as AI sufferers, too. They translate their physical complaints into AI without being conscious of the original 'languages' of their own bodies. The mistranslation is likely to exist in two ways. One is when excessive physiological expressions are wrongly equated with symptoms. Physiological manifestations are too easily seen as symptoms that indicate underlying pathology (Henningesen et al., 2011). AI prevents patients from appreciating and redefining their bodies' sensations. The other mistranslation occurs when AI patients use this term, with all its neurological connotations, to describe their own suffering and obstruct other forms of understanding. In other words, AI both translates and masks the origins of uncertain illnesses which are no less likely to be psychological, social or both. Benjamin (2007: 76) described the task of an ideal translator as 'finding that intended effects [Intention] upon the language into which he is translating which produces in it the echo of the original'. AI, as it is now, remains an uncontrolled translation for physicians and patients that fails to produce in it 'the echo of the original'.

Sociologically, the popularisation of this ill-defined concept is associated with the combination of social, cultural and epistemic factors, such as the conceptual overlap with neurasthenia, the clinical

need for a communicative term that avoids stigmatising diagnoses, the expanding use of HRV in clinical and research settings, the lack of Chinese medicine knowledge among the public, and the desire of those afflicted for a legitimate identity even with an unofficial name. In addition, as has been addressed, businesses that promote HRV are implicated in the popularisation of AI. They offer HRV-testing machines and HRV-measuring wearable equipment even though HRV cannot conclusively reify AI either for physicians or for sufferers.

CONCLUSION

This study is the first that addresses the idea of AI in association with MUS. It sheds light on MUS by highlighting the implications of naming in clinical settings. The study uncovers a few aspects that warrant further attention.

Firstly, the popularity of AI in the clinic and beyond illustrates the limitations of the current diagnostic criteria for MUS. Research shows that MUS confront primary physicians who act as gatekeepers of legitimacy (Mik-Meyer & Obling, 2012), but the current diagnostic criteria operate on a logic that fails to address the complexity of humanity. They fall short especially in primary care, where unclassifiable symptoms abound, thus leading to the birth of the International Classification of Primary Care (ICPC). The ICPC, as Armstrong (2011) indicated, shifted the foreground of clinical classification from doctor-discovered pathologies to patient-disclosed symptoms.

Classifying MUS in dispute has two directions: lumping and splitting. Lumping refers to putting symptoms together in the name of a syndrome, such as somatic symptom disorder (adopted in DSM-5) and bodily distress syndrome (Henningsen et al., 2011). Splitting, in contrast, addresses individual symptoms as basic units for further understanding. In this sense, AI is lumping because it puts various somatic symptoms together in a name. Physicians who prefer single symptoms (e.g. diarrhoea) or single system manifestations (e.g. irritable bowel syndrome) are choosing an expression of splitting.

However, lumping and splitting are more than an issue of nosology. What is at stake is how MUS are understood and treated. AI may seem like a communicative term for both Western and Chinese medicine physicians, but it is treated differently. Dr. Sheng compared their different ways of knowing. He noted that Western medicine tends to isolate and categorise not-yet-understood phenomena as a specific syndrome (e.g. irritable bowel syndrome) and study it anew in a thorough manner. Treatment is then targeted at the symptom or the organ system. By contrast, Chinese medicine tends to assimilate these phenomena into an extant epistemic structure (e.g. excessiveness or insufficiency of the five organs) and explain them as one of the myriad illness appearances. Treatment complies with this known epistemic structure and aims at the presumed true cause in a holistic sense, for example excessive 'liver fire'.

Secondly, AI is an equivocation that inevitably causes misunderstanding, and the misunderstanding is largely rooted in the dichotomy of mind and body. It needs to be controlled to the point that the intended meanings in the original language (the variegated and capricious bodily manifestations) are 'echoed' in the translation (MUS, AI or other terminological equivalents). A controlled equivocation allows all parties involved to understand the misunderstood, but AI in its current form is incapable of doing this. To follow the suggestion of Walter Benjamin to search for the 'echo of the original', physicians and MUS sufferers need to realise the equivocating effects of the label and dare to explore what lies under these clinical manifestations, be it physical, psychiatric or more.

As Rosenberg (2006) noted, psychiatry is for those conditions whose aetiology was not known. The underlying assumption is what cannot be accounted for in bodily terms must belong with the mind. Hence, people with MUS are so often referred to psychiatric services. In this dichotomised

frame, psychiatry is defined as such because the division of mind and body is rigid and problematic. In recent years, the brain paradigm has re-emerged in mental health (Frazzetto & Anker, 2009; Ortega & Vidal, 2011; Rose & Abi-Rachad, 2013). Although some scholars lament the disappearance of the mind, now is a good time to challenge this mind–body dichotomy. My point here is not to stay neurological and abolish psychological aspects altogether but simply to call for the rethinking of the dichotomy and its social impacts on diagnosing individuals and collectives, as Jutel indicated (Jutel, 2011, 2015; Jutel & Nettleton, 2011).

Thirdly, is AI going to be an official diagnosis someday as Ms. Chin expects? Dr. Chau (a psychiatrist/HRV researcher) and Ms. Chin were positive about it. Dr. Chau compared HRV machines to sphygmomanometers: ‘A sphygmomanometer measures blood pressure, and a diagnosis of hypertension eventually emerged. I feel this [HRV] may become something like it’. He implied that AI may follow the logic and become a formal diagnosis someday. However, this anticipation is optimistic because HRV is not yet stable as a biomarker. For now, AI is a clinical syndrome at best. It is a long way from being a syndrome to being a formal diagnosis.

Furthermore, proving AI to be ‘real’ does not solve problems for MUS sufferers or their healers. Even a formal diagnosis indicative of a ‘real’ disease can still be an uncontrolled and toxic equivocation at times. Taussig (1980) discussed the processes and effects of reification in clinical encounters where medicine shapes the consciousness of the patient by masking and reinforcing existing structural power issues. Although AI has never been used intentionally for this purpose, determining whether it exerts such effects unintentionally when it replaces MUS is difficult. The presence of AI or MUS urges physicians and sufferers to question and explore the meanings of this illness individually and collectively.

The obsolete diagnosis of neurasthenia should be revisited and compared with AI. Previous research has shown that neurasthenia may act as a collective usage for treating physicians and help-seeking patients among the Chinese. Neurasthenia, originally a diagnosis in late 19th-century America, became a substitute for clinical depression in the 1980 s China partly due to the somatisation tendency of Chinese people and partly due to the tremendous traumatic experiences from the Cultural Revolution (Kleinman, 1982; Lee & Kleinman, 2007; Ware & Kleinman, 1992). Neurasthenia was not only popular in China but also in Taiwan several decades ago (Rin & Huang, 1989), but the label has been rarely used in both places recently (Lee & Kleinman, 2007). If neurasthenia is a cover-up for depression from collective trauma, AI is a label for what? Is it something like depression in Japan that acts as a signifier for those who are distressed by burnout from work (Kitanaka, 2012)? Or does AI represent the price a civilised man has to pay (Guo, 2012), just as neurasthenia was considered an illness of civilisation (Beard, 1859, 1879)?

In summary, the exploration of AI as a concept for MUS proves to be a fruitful journey. It uncovers intentional and unintentional implications of a clinical usage for all parties involved in the AI ‘fever’. How much longer AI will prevail in Taiwan is unclear. Nevertheless, most of my interviewees agreed that it will last for some time because bodily and mental symptoms that are medically unexplained will always exist. These residual phenomena outside the current diagnostic frame are a reminder of how little knowledge we have on the ways in which the human body and mind interact with each other and the greater world. As Hamlet said, ‘there are more things in heaven and earth, Horatio, than are dreamt of in your philosophy’.

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AUTHOR CONTRIBUTION

The author collected data through archival search and in-depth interviews, analysed the collected data, and finished the draft that led to this article.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ORCID

Jia-shin Chen  <https://orcid.org/0000-0002-8521-677X>

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