

## On being Credibly Ill

### Class and Gender in Illness Stories among Welfare Officers and Clients with Medically Unexplained Symptoms

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ON BEING CREDIBLY ILL: CLASS AND GENDER IN ILLNESS STORIES AMONG WELFARE  
OFFICERS AND CLIENTS WITH MEDICALLY UNEXPLAINED SYMPTOMS

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ABSTRACT

This paper explores the intersection of gender and class concerning welfare clients with medically unexplained symptoms. The study is conducted in Denmark using qualitative interviews with welfare officers and clients. The paper's focus is on how issues of gender and class intersect in the negotiation of illness among welfare officers and clients. The particular client group in question consists of individuals that are defined by their lack of a bio-medical diagnosis. Their 'lack' of identity accentuates how gender and class become central in the categorisation practices, constructing the ill person as either bio-medically sick or as a person who may be suffering but only from diffuse psychological problems. The paper shows that it is predominantly poorly educated women without a bio-medical diagnosis that welfare officers describe as suffering from psychological problems despite the fact that the women themselves focus on physical ailments in their illness stories. Men and better-educated women are described by the welfare officers as tired and exhausted or truly stressed after a long working life.

Keywords: sociology; identity; illness; gender; class

# ON BEING CREDIBLY ILL: CLASS AND GENDER IN ILLNESS STORIES AMONG WELFARE OFFICERS AND CLIENTS WITH MEDICALLY UNEXPLAINED SYMPTOMS

## INTRODUCTION

The construction of the identity of an ill person is a social process guided by ideas of normality, similar to what we have seen in Goffman's (1965) work on stigma. Using this approach, we become aware of factors outside the individual body that influence what it takes for a person's illness story to be seen as credible, and this makes the growing number of people who suffer from undiagnosed illnesses especially relevant in our attempt to understand the formation of patient identities (Brookes-Howell 2006; Dumit 2006; Nettleton 2006; Ring et al. 2005; Werner and Malterud 2003). These people are not just ill; they are also not 'normal'. Because few inequality studies look at how the categories of class and gender (and in our case the definition of a credible illness story) are mutually reinforcing processes (Acker 2006:442), my aim in this paper is to analyse how gender, class and illness intersect when welfare officers discuss and describe clients with medically unexplained symptoms (MUS; and when the clients themselves discuss and describe their situation). As the analysis shows, the gender of the clients and their educational background influence how welfare officers view the clients' reported pains and illness stories as credible (men and better-educated women) or not credible (poorly educated women). In order to capture this gender and class aspect of the negotiation of illness I draw on theory that focuses on the institutional aspect of identity constructions (e.g. Goffman 1965, 1990; Gubrium and Holstein 2001) and Bourdieu's (e.g. 1996, 1998) concepts of field, capital and habitus. On a more general level the study is shaped by intersectionality theory (e.g. Risman 2004) and by previous organisational research into identities and organisation. In 2003, Townsley (2003:624ff) made a seemingly off-hand remark that construed 'gender as power relations'. I want to continue that conversation but also bring the issue of class into the picture.

The relationship between identity processes and the body in organisations has been studied before. For instance, gender studies have focused on the gender identities produced in organisations (e.g. Adkins 1995; Townsley 2003; Wilson 1996), just as race and sexuality have attracted attention in organisational research (e.g. Deitch et al. 2003; Ward and Winstanley 2003). The sharpened focus on human

relations in organisations, that we have witnessed in recent times, has spurred new research that focuses on identity work and power effects (e.g. Alvesson and Willmott 2002; Ball 2005; Casey 1999; Hoobler 2005; Merilainen et al. 2004; Trethewey 1999). However, in this paper I am looking at how the identity of the credibly ill person is constructed in ways similar to other social identities such as race, class and age, which have all been shown to be gender-constructed categories (Acker 1988; Ainsworth 2002; Spelman 1990).

### THEORETICAL AND ANALYTICAL ASSUMPTIONS

Bringing the corporeal body to the forefront of the analysis requires a comment on the body. This paper's analysis is inspired by research that views the body as a locus of power, which is why specific bodies in specific time periods are defined as 'normal' and other bodies as abnormal or 'unnatural' (Blaikie et al. 2004). A central point in constructionist research on the relationship between the body and society is that the body is seen to be an 'unfinished entity' (Shilling 1994) and that research into, for instance, illness stories that cannot be conceptualised by medical discourses therefore need to bring in central sociological categories such as gender and class when negotiating a body's state of health.

Research has long problematised the dichotomy of illness and disease (Jutel 2009; Mol 2002:9ff) and has drawn the field of bio-medical diagnosis into sociology (Jutel 2009) and questioned, for example, the value of evaluating illness narratives as either 'fact' or 'fiction' (Bury 1991). This line of thought also motivates my analysis. I focus on how the suffering persons' illness story becomes credible without departing from a dualistic approach of (factual) disease as opposed to (fictional) illnesses narratives. I am dealing with individuals whose pain is not comparable with a strictly biomedical understanding, but is instead related to a complementary/ alternative/integrative/holistic medical approach (Baer and Coutler 2008; Fries 2008; Hollenberg and Muzzin 2010). Not long ago in Denmark, clients with MUS were believed to be suffering from, for example, fibromyalgia, while they are today believed to suffer from primarily stress and milder forms of depression (Mik-Meyer 2004; Mik-Meyer and Johansen 2009; Mik-Meyer et al. 2009). Names and labels change, even if the symptoms are the same.

In *Stigma* (1965), Goffman argued that any identity, in this case, individuals who suffer but cannot locate their suffering to a particular organ or set of organs, reveals information about the relation

between dominating discourses in society and specific characteristics of a group. Understanding individuals suffering from MUS as people that have problematic psyches, for instance, makes it 'natural' to work on their psychological situation. However, according to Goffman, this directs attention to the wrong unit. He argued that the meaning of any identity, e.g. 'someone who has pains in the body', has to be found in the relation between this particular group and the social context. The social context may be constituted by structural features in society (legislation, professions/class etc) and dominant understandings of central categories such as gender, illnesses (and health), which exclude particular groups in society by sustaining their status as less well, and hence less normal. For Goffman (1965:51) 'stigma management is an offshoot of something basic in society, the stereotyping or 'profiling' of our normative expectations regarding conduct and character'. The fact that any organisational frame positions the actors with distinctive moral characters is central to this argument (Goffman 1990:24). Individuals are positioned as particular types, i.e. assigned specific moral characters that reflect the specific organisational framework or 'definition of situation.'

Other scholars have called this process of categorising individuals to particular types 'institutional identity' (Gubrium and Holstein 2001). The point here is that any society at any given time supports and develops specific understandings of symptoms, which in that society and at that time appear to be meaningful ways to understand certain illnesses and, through them, certain individuals (Foucault 1983, 1990). It is therefore the dual nature of the ill identity, implying both a self and social structure, that is in focus here (Goffman 1965, 1990; Mead 1959). The ill identity is understood as social and relational, i.e. formed and negotiated in the presence of other social actors and in particular organisational contexts (Holvino 2008:15). In this paper I examine how welfare officers (Mead's specific others) (re)produce dominant discourses on gender, class and health/illnesses in their contact and identity negotiation with the person suffering from MUS. I examine how the negotiation of illness and health in this way can be seen as a process that is both constitutive of and constitutive for practice (Mik-Meyer 2007).

The ill identity is 'a nexus of multi-membership ... identity as an intersection between the local and the global' (Emslie and Hunt 2009:153). In order to analyse the local conceptions of what it takes

to produce a credible illness story, we need to bring global issues such as discourses of gender, dominant understandings among professions on illness, and structural features such as class, into the analysis.

Numerous researchers (e.g. Adid and Guerrier 2003; Alvesson and Billig 1997) have focused upon gendered organisational practices. Gender has been shown to be not just an orientation device, but also a way to differentiate individuals. Gender orders and the order 'imposes itself as self-evident, universal' (Bourdieu 1996:171). Gender is hence not only a category of analysis but more likely a 'social structure' (Risman 2004); a 'social relation of domination that is historically produced and always specific' (Holvino 2008:11). The category 'woman' orders the social world by making it natural and normal that a 'woman' is feminine, small and weak as opposed to the category 'man', which evokes masculinity, largeness and strength. Bourdieu (1996:171) writes about the dominant relationship between men and women using the paired couples 'high/ low, large/small, inside/outside, straight/crooked, etc.' When gender intersects with particular illnesses a particular understanding of the ill person develops. As the analysis will show, MUS, for example, intersect differently according to whether the suffering individual is a man or a (poorly educated) woman.

Bourdieu (1998) argues that the study of dominance and inequality follows the educational structure (that also relates to gender): the longer the training and the greater the status that a particular educational institution has, the more 'capital' the person attending the educational institution has and the more power he or she will be able to exercise in a variety of contexts. In this case, identity processes are framed by the welfare officers' status as self-supporting, in stark contrast to the clients' inability to support themselves. This structural inequality between the two groups is further strengthened by the welfare officers' longer educational background than clients who showed themselves to have little or no education (Mik-Meyer and Johansen 2009; Mik-Meyer et al. 2009). Structural inequality is also strengthened by the welfare officers' right to grant money to clients (or to keep it from them), and to decide if they are to receive sickness or welfare benefits. One can argue that the welfare officers' powerful position is structurally defined by more traditional techniques of control and repression (e.g. Lukes 1974). The negotiation of the ill identity is (also) framed by this kind of structural inequality, which influences whether clients are seen as either credibly ill or as 'whingers', as the welfare officers themselves sometimes call them.

In Goffman's terms, this 'framing' can be seen as a result of inequalities in economic, cultural and social capital to use the concepts from Bourdieu's work. Objective structures give certain actors (through their various forms of capital) different conditions for acting in the world. Arguing that welfare officers have a collective habitus, which is a sort of 'spontaneity without consciousness or will' (Bourdieu 1999:56) when they describe types of clients suffering from MUS, relates back to these structural and discursive elements in society. Therefore, the concepts of field, capital and habitus are fruitful concepts to use if one seeks to combine the local and global in identity work in organisations (Emslie and Hunt 2009) or to show the 'mutual reinforcing processes' of identity processes reproducing inequality (Acker 2006).

Modern society can be seen as split into a number of fields, each with its own resources (capital) and rules for normal behaviour (imbedded habitus). The (welfare) state is not just any player but holds a monopoly on coercive means. It represents a power centre and this has important effects on the situation of welfare professionals. In this context, such state power is not just exercised against people in society who have a low status, for example, female clients of the welfare state; we are all – clients included – actively (albeit sometimes in invisible ways) reproducing the structure of dominance every time we perceive and create the social world based on cognitive categories embedded in us, in our habitus, or through our upbringing in certain social environments (schools etc). 'Being born in a social world, we accept a whole range of postulates, axioms, which go without saying and require no inculcating' (Bourdieu 1996:168). It is from this perspective that the women's and welfare officer's stories have been analysed.

## METHODOLOGY

The Danish welfare state, like in many other western countries, has until recently had a long period of economic growth and consequently a low rate of unemployment. Only 3.5% of the Danish population was unemployed in 2008 (compared to 8.7% in other European countries; OECD 2009). As in other EU countries, the number of people on sick leave, has been rising during these years of economic growth and has, as a consequence, been an area of political interest. The cost of people on sick leave in Denmark has risen from 1.3 billion pounds (11.3 billion kroner) in 2002 to 1.6 billion pounds (13.8 billion kroner) in 2007 (Ministry of Employment 2008). It is especially the number of people on sick leave lasting more than 14



weeks that has grown, which has led the Danish government to focus predominantly on this group, in order to understand why they often end up not re-entering the labour market.

National surveys show that MUS and psychological problems are not equally distributed among men and women (Labriola 2006; Labriola et al. 2007; Mik-Meyer and Johansen 2009). For some reason it is predominantly poorly educated women who are believed to suffer from MUS and psychological problems – men and better-educated women are ‘worn down’ or described as ill despite a lack of biomedical diagnosis. The present quantitative research does not explain these gender differences in MUS, but it does record them. This paper provides possible explanations as to why it is primarily poorly educated women whose bodily pains are recorded as MUS. National surveys furthermore show that from 2002 to 2007 there has been a doubling of people given early retirement because of psychological problems. Half of the people on sick leave suffer either from pains in the body (25%) or psychological problems (24%; Høgelund et al. 2003). It is from this background that this research project was developed. The research is funded by the Danish Ministry of Employment and involved a national survey in all municipalities in Denmark (N = 98), qualitative interviews with clients suffering from MUS, welfare officers, and general practitioners. The paper is mainly based on the qualitative semi-structured interviews with welfare officers (N = 52) and clients (N = 41). The main focus of the qualitative interviews with welfare officers and clients was to gain a deeper insight in how both groups described the situation.

#### Interview with welfare officers (N=52) and clients (N=41)

Conducting a research project that is based mainly on interview material produces certain possibilities and limits for analysis. In this paper I have had an explicit focus on how different groups – welfare officers and the women suffering from MUS – describe the situation. When interviewing the welfare officers I asked a series of questions such as ‘who are these persons suffering from MUS (educational background, gender, age, social status)?’, ‘how do their symptoms relate to their situation in general?’ and ‘how do you conceptualise their illness – or the credible illness story – when there is no biomedical diagnosis?’ With the clients suffering from MUS I focused on their illness story (why and how did they develop the pain they now

suffer from) and what are the consequences (in their public as well as private life) of having symptoms that cannot be translated into known diseases by doctors?

The interview material should be viewed as a result of an active encounter between the interviewer (with my theoretically motivated research agenda) and the interviewee (confronted by this agenda; Järvinen 2000). The interviews were conducted as semi-structured interviews, keeping the interviewee's perspective and subjective experience in focus. My research assistant and I paid close attention to the interviewee's involvement in the story, specifically by asking open questions. For instance, in the actual interview situation, we often listened to long exposition on illness and symptoms because the client kept bringing these issues up in the interview. In this way our research design was also adjusted to better reflect the issues of importance of our research subjects.

In focus group interviews, which we conducted among welfare officers, the social context and the interaction between the interviewed participants had special importance for the story that is produced (Kitzinger 1994). Participants will inspire and stimulate each other during the interview and this may result in discussions on central themes, including disagreements. In our interviews, group dynamics and positioning, which are normal among colleagues who know each other, were particularly prominent. The data set for the analysis consisted of 15 focus group interviews with 52 welfare officers (each lasting approximately two hours) and 41 individual interviews with people suffering from MUS. Each of these interviews took roughly one and a half hours. All the interviews with welfare officers were conducted at their workplace and most of the client interviews took place in their homes.

Of the 52 welfare officers, 44 were women and eight were men. Forty were either educated as social workers (three and a half years of education; N = 31) or had an academic degree (minimum five years of education; N = 9). Eleven were trained at the municipality and one was originally trained as a skilled labourer. Their age ranged from 27 to 65 years: two were in their 20s, 24 were in their 30s, 14 were in their 40s, 11 were in their 50s and one was in her 60s. Most (41) had between 1 and 5 years of job experience with this particular group of clients (of these, 19 had between 3 and 5 years of experience). Six had 6–10 years of work experience, three had 11–15 years of work experience and two had 16–20 years of experience. Of the 41 clients, 39 were women and two were men. More than half, 24, had no or limited educational

backgrounds, 12 had between 2.5 years of higher education, and five were primary school teachers or nurses (3–4 years of higher education).

All interviews were taped and transcribed. For ethical reasons the identities of the interviewees quoted in this paper have been concealed. Participants in the study were made aware in advance that they would participate anonymously. In a Danish context there are strict rules for how to process and secure data. For example, I removed personal security numbers and last names from the interviews before sending them for transcription and I stored the data so only my research assistant and I could gain access to it. Besides these general rules for processing and storing the data and participant acceptance (based on descriptions of the research), no formal ethical approval to conduct a research project like this, is required in Denmark.

We selected the welfare officers from each of the five regions in Denmark. The actual selection process of this group was done by initially calling the leading welfare officer working in one of the municipalities in the region. After a brief introduction to the research project we emailed further information on the research and made contact again one to two weeks later. Two municipalities withdrew from participating because of workload. All of the rest of the municipalities contacted (N = 15) decided to participate in a focus group interview conducted by my research assistant or myself.

The clients were selected by the welfare officers in the municipalities. After a brief telephone introduction to the research project, the welfare officers received a letter explaining the project, addressed to the group of clients. The letter was then given to clients who matched our criteria. These included clients who were on sickness benefits and therefore unable to work because of health problems, and those suffering from pain that could not be diagnosed by the biomedical system, typically represented by their GP. Welfare officers then gave us the names of clients that were willing to participate. We then contacted clients by phone and arranged to interview them. Since we did not select the group of clients (welfare officers did), we of course took a critical view of the group selected (which had a high percentage of women with little educational background). The social status and gender of the 41 clients selected by welfare officers in the five regions of Denmark did, however, fit the results of our national survey among welfare officers in all municipalities (N = 98), which we had conducted before selecting the welfare officers and individual clients.

In the survey we had posed open questions about what characterised persons suffering from MUS, and found that welfare officers thought these clients were primarily women with a poor educational background (Mik-Meyer et al. 2009).

We started the analytical work by reading the material in its entirety and listing the themes the interviewees talked about. We then grouped themes and attitudes according to our research agenda. The interviews with welfare officers reflected various understandings of illness related to the description of the clients. These descriptions all involved lengthy discussions on gender and class issues. There were often lengthy, symbolically loaded, descriptions of how ‘typical’ clients suffering from MUS were thought to behave, live, think, etc. These descriptions were taken out of context (the actual interview) and grouped together in a new document making it possible for us to find patterns in ways the welfare officers discussed the client group.

Because of our focus on gender, we also looked for differences in how respectively male/female welfare officers discussed the clients’ situation. We asked ourselves; did male welfare officers have different ways of talking about the (female) clients? There were no clear signs of difference in welfare officers’ descriptions in this regard, however, and because we only had eight male welfare officers in our sample of 52 welfare officers, we decided not to bring the gender of the welfare officers into the analysis. This can of course be seen as a weakness of the study, but taking our theoretical perspective into consideration, which privileges the social context in which illness is negotiated, this is of marginal importance for the analysis. Factors such as the profession’s way of doing/thinking, norms and values, status differences between welfare officers and clients, etc., appear much more salient. This seems more likely to privilege certain understandings of a clients’ situations than the gender of the welfare worker.

The analysis of the interviews with clients followed the same pattern as with the welfare officers. When analysing client interviews, we took particular note of descriptions of gendered themes (descriptions of typical male/female ways to react) and gendered language (the choice, for example, of many emotions in the description of the illness).

## DEFINING HEALTH AND ILLNESS AMONG WELFARE OFFICERS AND CLIENTS

Before conducting an in-depth analysis of interviews, let us emphasise again that the analysis of the focus group interviews with welfare officers supports the findings from our national survey with welfare officers (Mik-Meyer and Johansen 2009; Mik-Meyer et al. 2009). As in the national survey, the typical client is described as a poorly educated woman around 40 years old, who suffers from a problematic psychological situation. More than half of the welfare officers stated that the reported pains derive from ‘lives’ – not ‘bodies’ – that ‘hurt’. As a welfare officer explained ‘This is a group of women between 30 and 40 years. They typically have a slightly tough family situation with small children.’ Another said: ‘It is a mixture. Their psychological and physical wellbeing is integrated’. Or a third welfare officer noted: ‘They are experiencing a life crisis’. This transformation of physical pain to a psychological problem is a classic way to discuss these clients’ situation. Here is another explanation by a welfare officer:

I think we often end up exploring the physical, when we perhaps should look at all the other factors ... If the husband at home is a wimp, and the children are scaling the walls and you’re tired of work, well then you feel more pain than someone who is truly happy with her work and feels good with the children and husband at home.

In these descriptions of the typical client who suffers (but cannot have her pain categorised in medical terms) she is put forward as a person with a chaotic personal life, who has a badly paid job and problematic children. The welfare officers’ description demonstrates that they are talking about a group of women different from themselves – a group that holds a different habitus. It is women who lack proper social and cultural capital – the ability to ‘take control of their lives’ as yet another welfare officer explains – and whose economical situation also positions them at a lower point in the hierarchy than the welfare officers. These women are described by welfare officers as poorly educated and hence a group of people who have many problems in their lives, illness being just one of the most recent ones.

In the interviews with welfare officers there is a tendency to describe the illness stories of the few male clients as credible. The welfare offices believed male clients to be ‘worn down’ and the pain in their body is understood as a physical problem produced by a long working life in a badly paid job (which actually could be a suitable description of many of the female clients as well). Despite the fact that these (few) men’s social class is lower than the welfare officer’s social class these men are nevertheless seen as truly sick. One can argue in this case that gender connects more strongly with illness than class does. Being a man evokes strength (hardworking etc.) and hence does not relate well with being (psychologically) ill, i.e., weak. The men’s social status therefore seems to be less important when categorising the suffering man. The idea that the illness stories of men are credible (and in contrast to the poorly educated women have the pain they describe) can perhaps explain why we only had two men referred to us by welfare officers despite the fact that men appear just as frequently as women in the sickness statistics (in our focus group interviews with welfare officers we did, though, discuss this gender difference explicitly).

Masculinity occurs in a discourse and context (e.g. Bourdieu 1996) that leaves no room for stories of MUS conceptualised as primarily a psychological exotic illness. In the interviews with welfare officers the description of the male clients was fairly neutral or even sympathetic; the few men that were not believed to be hard-working people were seen to be ill because of drug abuse (in which case their problems were not described as deriving from psychological breaches in their personalities). Men were ill, but it was an illness that was categorised as understandable, and normal. Consequently, the men’s illness stories were more credible than the women’s stories.

For the person whose body hurts, the possibilities of treatment (and possibility of having an identity as ill validated, cf. Mead 1959) depend on their gender and social status. Gender studies have long (e.g. Butler 1990; de Beauvoir 1973) shown how being male equates to being normal and being female is a kind of deviance. In this case a man’s illness story appears normal whereas a woman’s illness story is an exotic mystery. The thinking seems to be that she might not, like ill men, have the pains she describes. In this research only two male clients of the 41 clients were chosen by the welfare officers to participate. One of these men expressed frustration about how he was treated by former colleagues:

There is not anyone who has written or said ‘hi’ or ‘how are you doing?’ or something like that. Now I am of course also on Facebook, like everyone else. But no one has written to me and asked me how I was doing. That makes me sad they could have done that. Send a card! But it is also difficult. We are men, so we should just work.

None of the 39 female clients participating in the research formulated this kind of complaint that concerned lack of care and concern.

Later in the interview this same male client gave the lack of attention a gendered explanation: ‘If I were a woman, I would indeed have received flowers, don’t you think?’ By not enforcing the standard code for dealing with illness, which is to send a card or flowers, this male client was not being recognised as being ill. His identity as ill was not validated by colleagues or friends as the identities of many female clients were. In most cases when a man’s body hurts, his illness story is perceived as credible (and hence not MUS) explaining why welfare officers did not suggest that we interviewed men (and explicitly in interviews stated that men were worn down as opposed to the ‘whiny’ women). Welfare officers take men’s pains at face value, but their gender prevents their friends and colleagues from relating to them as one typically relates to an ill female by sending flowers and cards. Being ill the ‘normal’ way is therefore challenged if you are a man; their social surroundings do not validate their identity as ill. Their identity as ill is, however, validated in their contact with the welfare officers.

The opposite holds for women. The welfare officers do not perceive female clients that lack a biomedical diagnosis as credibly ill, but female clients never complained about missing cards or flowers from their personal network. In fact, many told long stories of all the attention they had received from friends and work colleagues. The illness identity of female clients (who lack a biomedical diagnosis) is thus challenged by the welfare officers, but validated by their personal network. To be categorised as suffering from MUS has different consequences for the men and women as either credibly ill or psychologically weak. This identity process not only relates to gender and class, but is also conducted in the private sphere.

When the talk was about women without a proper biomedical diagnosis a rather different description was produced by the welfare officers. There are of course also stories of women who had a

credible illness, e.g. Bosnian refugees suffering from PTSD (but not diagnosed) or a few factory workers or assistant nurses that welfare officers believed were ‘worn down.’ But these stories were the exception. More often female clients suffering from MUS were described by welfare officers as persons who ‘were whingers’, ‘had psychological problems’, ‘were simply tired of their life’, ‘had no energy’, or ‘lacked enthusiasm’. In the descriptions offered by welfare officers there was a tendency to express strong suspicion when it was a woman who suffered given her symptoms were medically unexplained. There was furthermore a tendency to apply negative labels to female clients: they were for example ‘spoiled’ and ‘perfectionists’.

In order to understand this negative conceptualisation of women’s situation we need to focus on the way the category ‘ill’ relates to gender issues such as being weak (female)/strong (male) and class/norm issues such as having wrong social/cultural capital/or the correct social/cultural capital. In other words we need to see how the dominant understandings of gender and class are woven into the discursive and culturally produced understandings that welfare officers draw on when they decide whether a client’s illness story is credible or not. The analytical issue is whether it is easier or harder to recognise and accept suffering as credible when the person is a man or a woman? This is well exemplified by the following excerpt between two welfare officers – Isabella and Maryann – who discuss clients who suffer from MUS. It goes without saying that the clients discussed are women.

Isabella: They need to feel comfort. They have been in one particular role for many years and suddenly their life has changed. Then they feel insecure. They probably cannot cope with that change or conversion.

Maryann: They are psychologically fragile. And yes you are right. It is the conversion they can’t cope with. Not too much must have happened in their life because their entire world falls apart.

Isabella: And they quickly search for the role of the victim.

Maryann: Yes. And they reject any responsibility. ... Yes, it is the victim role: ‘You need to feel sorry for me’. I know it sounds a little cynical, but I also believe that many of them need love and caring in their life.



Isabella:       And then they are trying to get it from us [laughter] ... Come to us and get a hug.

Using terms like ‘needing comfort’, ‘feeling insecure’, ‘being psychologically fragile’, ‘having your entire world falling apart’, ‘having the role of the victim’, ‘disclaiming responsibility’, ‘needing love and care’ and ‘getting a hug’ show that we are dealing with a weak person both from a gender (the social figure of the weak woman [or even child]) and class perspective (for example having your world falling apart because of a bad economic situation). This is a gendered and class description that excludes men and better-educated persons as typical members of the group. The psychological profile of a client suffering from MUS is that of a ‘whinger’, as a female client explains when she sums up her meeting with her welfare officer:

Then the welfare officer says to me: ‘But you’ve sat here for an hour, and that went fine’. So I said to him: ‘But then you have not noticed how I’ve turned and turned.’ Just because I don’t whine and say ‘Now I want to get up’ when I sit in a meeting [and suffer]. I know that afterwards I have to go home and take some pills and lay down.

This woman fights the category of the ‘whinger’, perhaps because she knows that being a member of this category will make her illness story less credible.

Another client, Bridget, is advised to stop acting like a client and see a coach instead. Again the idea is that it is the client’s mood and problematic personality that is making her ill (and not her physical pain). This client explained that she feels she is ‘losing control’ and living in a world that is ‘falling apart’. This way of emotionally describing difficult living circumstances is a typical way for many female clients to describe their situation – as Isabella, the welfare officer claimed about these women. Isabella also describes them as people whose world has fallen apart. The difference between these women and men is that Isabella suggests that this is happening because of their fragile psychological structure, whereas the client – in this case Bridget – explains that her world is falling apart because of the possibility of losing her house and other material goods (if she has to receive welfare benefits instead of sickness benefits).

These clients' problems stem not only from the discrediting of their pain as physical, but also because of the transformation of their issues into psychological shortcomings. Welfare officers fail to recognise the psychological problems they believe these women suffer as genuine illness. It can be argued that they have become 'a matter out of place' as Douglas (2003) puts it. A woman whose body hurts in ways that cannot be recognised by the biomedical discourse not only fails as an ill person within the biomedical discourse, but she also fails as an ill person within the psychological discourse. If you are believed to suffer from a psychological problem then your illness story reporting physical pain is not credible. To be legitimately ill, a credible client has to have physical pain that can be traced to dysfunction in an organ or set of organs.

#### CONCLUDING DISCUSSION

If one wants to analyse the sociality of medical diagnostic practices (Bowker and Starr 1999; Jutel 2009) then persons suffering from MUS is an important group to focus upon. The fact that persons suffering from MUS have pain that cannot be located biomedically in their physical body shows that diagnostic practices concerning this group are a social construction (Goffman 1965). In order for the welfare system to categorise the illness stories of clients as either credible or not (Werner and Malterud 2003), welfare officers cannot rely merely on the (biomedically ambiguous) reports of doctors. However, the welfare officers, need to decide whether the suffering person should receive sickness benefits (and hence is credibly ill) or welfare benefits (and hence become 'merely' a social client). Clients suffering from MUS, are defined by their lack of a biomedical diagnosis. And this 'lack'-identity accentuates how gender and class become central in the categorisation practice when welfare officers' decide if the illness story is credible or not. The intersection between gender, class and MUS makes certain perceptions of who the 'typical' person suffering from MUS is. Both the national survey and the interviews showed that MUS sufferers are women with psychological problems.

The analysis of the interviews has shown that these perceptions of client types have a formative character (cf. Foucault's 'conduct of conduct'). They construct a social order that, as Bourdieu (1996:171) puts it, makes them 'self-evident and universal'. They include (men and better-educated

women's illness stories) and exclude (poorly educated women's illness stories), respectively. It is a social order that transforms poorly educated women who claim to suffer from physical pain into persons with psychological problems.

The fact that men and better-educated women are left out of the study (it was not suggested that we should interview these two – partly overlapping – categories of people) indicates that this conversion of physical pain into psychological problems mostly occurs with poorly educated women. It can be argued that men and better-educated women become 'the absent present' (Ward and Winstanley 2003) in our research. Men and better-educated women's illness stories were taken at face value and as a consequence they were not transformed into persons with psychological problems. This underscores the importance of reflecting on gender and class in the study of people who lack a biomedical diagnosis (Ring et al. 2005). The chains of association that relate to gender and class seem most relevant to understanding how, in this case, welfare officers judge the credibility of an illness story. These associations seem to explain why it is so clear that poorly educated women experiencing physical pain are taken to be 'whingers' with 'fragile' personalities.

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