Negotiating Disconnection

A grounded theory study of therapeutic engagement of patients with "medically unexplained symptoms"

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1   Abstract

"Medically unexplained symptoms" or "MUS" is a term used to reference a poorly understood phenomenon in which patients[1] experience subjectively compelling and distressing somatic symptoms which are not explained by underlying physical pathology. The literature on MUS is replete with controversy regarding the diagnosis and classification of this problem. A dualistic diagnostic system that seeks to classify disorders as either "physical" or "mental" disenfranchises patients with MUS who are so firmly at the intersection, causing problems that reverberate throughout the system. Effective treatment of MUS has been impeded by a complex array of barriers, including structural problems in the health system, lack of consensus over MUS aetiology, lack of effective therapies, and a shortage of suitably trained therapists. A pluralistic review of the clinical literature highlights that no single, universally accepted, and empirically supported model of MUS currently prevails. Furthermore, issues with patient engagement have been consistently highlighted as a problem. Despite this, few exploratory studies on treatment have been conducted so at present, relatively little is understood about either therapists' or patients' experiences of therapy for MUS. This research has used a constructivist grounded theory approach to explore the process of therapeutic engagement based on depth interviews with specialist clinicians who work with the most complex patients with MUS in primary care. Through a process of constant comparison the analysis identified how multiple interacting layers of disconnections (systemic, interpersonal and intra-psychic) impede engagement. The research introduces a new theoretical framework "negotiating disconnection" that conceptualises the process of engagement in terms of a series of stages: "drawing in" (negotiating systemic disconnection), "meeting patients where they're at" (connecting in the disconnection) and "nudging forward" (cultivating new connections), and illustrates how the different stages of engagement are negotiated by clinicians. The model shows that it is critical for mental health clinicians to engage the medical system and collaborate closely with GPs in order to engage these patients. However, it also points to some of the challenges that may be encountered doing this, reflecting the complexities of organisational and cultural change. At a clinical practitioner level, the model illustrates the importance of adopting a flexible, pluralistic and integrative approach that is person and process-led. The model emphasises the importance of clinicians and doctors, who must both embrace a holistic (biopsychosocial) stance towards MUS and to be sensitively attuned to its complex phenomenology. Implications for service structure, psychological therapy provision, training and future research are discussed, as well as implications for Counselling Psychology.

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[1] In this study I refer to clients as patients throughout, reflecting the NHS context of this research and the terminology used in the service where the research was hosted.

2 Acknowledgments

3   Introduction

This section provides an introduction to the topic of medically unexplained symptoms, exploring issues relating to terminology, diagnosis, and stigma, and the considerable challenges of providing effective care for these patients within our health system. A critical literature review then examines this topic in more depth, examining theoretical models of MUS and the treatment literature, in order to locate a salient practice-relevant research question (Section 5, p. 23). This is followed by sections presenting the research methodology (section 7, p. 41), the results of the analysis including a full explication of the model (section 8, p. 51), a discussion exploring the model and its implications for practice, service development, and future research (section 9, p. 86), and concluding comments (section 10, p. 110). Three short reflexive statements are incorporated in the thesis, examining the author's relationship to the topic and the research process at key stages: at the beginning when the topic area was first chosen (section 4, p. 21), following the literature review (section 6, p. 39), and at the end of the research process (section 11, p. 112).

3.1   The concept of "medically unexplained symptoms"

"Medically unexplained symptoms" (or "MUS") is an umbrella term that refers to a broad range of overlapping and poorly understood conditions in which patients experience persistent, subjectively compelling, and distressing somatic symptoms (e.g., pain, fatigue, dizziness, etc.) not explained by underlying medical illness (Brown, 2006). MUS is a common but perplexing problem whose aetiology is poorly understood. Experts concur that it most likely reflects a complex interaction between multiple aetiological factors, including both biological and psychosocial influences (Brown, 2007). First introduced in 1980, the term MUS caught on quickly and its use became routine throughout the clinical literature (Watkins, 2002). It gained popularity among healthcare professionals as a "catch all" generic term that is diagnostically neutral and can represent the broad and diverse range of patients who present with somatic complaints with no identifiable organic cause (Henningsen, Fink, Hausteiner-Wiehle & Rief, 2011; Webb, 2010). Despite its widespread use, the term MUS is somewhat nebulous and ill-defined, and has been frequently criticised for reinforcing dualism. As noted by Brown (2007), when doctors are unable to locate an organic cause, an automatic inference may be made regarding potential psychological origins of the symptoms, which may not always be justified. Furthermore, the label denies patients a positive explanation for their symptoms and may be taken to imply, unhelpfully, that the health system cannot help (Creed et al., 2010). A seemingly intractable debate regarding terminology and classification of this problem is evident in the literature (Henningsen et al., 2011). The term MUS is one of a range of constantly evolving labels and/or diagnoses that have been used to describe symptoms without organic explanation.

Others include somatoform disorders, somatisation, functional disorders, functional somatic syndromes, psychosomatic disorders, and psychophysiological disorders. The controversy over terminology may be partly political, reflecting ownership of this problem within a dualistic health system, that is, within physical health or mental health/psychiatry. It perhaps also partly reflects the acceptability of these labels, as patients are likely to reject labels that are perceived to dismiss the reality of their symptoms or suggest they are "all in the mind". Creed et al. (2010) generated a list of criteria for evaluating generic terms for MUS that included, amongst other things, acceptability to both patients and health professionals. However, as the authors note, it has been exceptionally challenging to locate a single term which satisfies their broad-ranging criteria. This is further complicated by the fact that cultural diversity means that specific labels may vary in their acceptability across different countries and cultures (Henningsen et al., 2011). One term that seems to have potential in relation to Creed's criteria is "persistent physical symptoms" or "PPS" (Picariello, Ali, Moss-Morris & Chalder, 2015).

3.2 Historical context and evolution of thinking about MUS

Before the label MUS entered the discourse, one of its predecessors was the concept of somatisation, which itself originated in the Freudian concept of hysteria (Freud, 1896) (subsequently renamed Briquet's Syndrome). The term somatisation was first used in psychoanalysis in the early 1900s to represent physical symptoms linked with an assumed underlying psychological conflict (Marin & Carron, 2002). Although the concept of somatisation has a long history, its precise meaning has shifted over time. For example, Lipowski initially defined it as a tendency to experience, conceptualise and/or communicate psychological states or contents as bodily sensations or functional changes, but later extended the definition to also include help seeking for these symptoms (Lipowski, 1968, 1987). Extending the complexity of the concept, Kirmayer & Robbins (1991) distinguished between "presenting somatisation" (somatic symptoms relating to underlying anxiety and depression), "hypochondriacal somatisation" (health anxiety) and "functional somatisation" (functional somatic symptoms), yet these different sub-types are often not clearly distinguished in the literature. Peveler, Kilkenny & Kinmouth (1997) found that these categories have face validity in primary care, although they conceded that there was a degree of overlap between them. The label "somatisation disorder" was first introduced as a diagnosis in DSM-III in 1980 (replacing Briquet's syndrome). Questions of validity aside, it had limited clinical utility as the diagnosis required a long and complex list of symptoms and it was very rare for patients to meet the diagnostic criteria (Creed & Barsky, 2004). Furthermore, the label "somatiser" assumed pejorative connotations, reinforced by negative discourse about these "heart-sink" patients (Butler & Evans, 1999).

In recent decades, understanding of the MUS phenomenon has evolved considerably. Coinciding with the emergence of the biopsychosocial model (Engel, 1977, 1982) and the cognitive revolution in psychology, there has been a shift towards cognitive-behavioural and information processing models of MUS. Emerging interdisciplinary fields such as psychoneuroimmunology have explored potential psychobiological mechanisms leading to a growing body of research implicating chronic stress (Rubin & Wessely, 2006). Compelling evidence is emerging suggesting that MUS phenomena are associated with physiological disturbance. Indeed, Luyten, Van Houdenhove, Lemma, Target, & Fonagy (2013) have conceptualised MUS as a "*biopsychosocial crash*" (p. 252), involving disrupted allostasis (McEwen & Wingfield, 2003), and disturbed stress regulation processes, mediated by HPA axis dysfunction (Heim et al., 2009; Tak & Rosmalen, 2010). More recently, attention has shifted to the role of emotional dysregulation, creating links with contemporary psychodynamic approaches emphasising the developmental origins of this. Despite all these advances, a complete understanding of MUS phenomena remains elusive (Brown, 2016).

3.3 The "conundrum" of MUS diagnosis

The classification of MUS is a highly complex and conceptually challenging task and has been described as a "*diagnostic conundrum*" (McFarlane, Ellis, Barton, Browne & Van Hoff, 2008, p. 369). Two competing classification systems exist in psychiatry and medicine, perpetuating a false dichotomy of "mind" versus "body" disorders (Strassnig, Stowell, First & Pincus, 2006). Until recently, MUS were represented (in psychiatry) in the "somatoform" and "dissociative disorders" categories of the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000) and ICD-10 Classifications of Mental and Behavioural Disorder (ICD-10; World Health Organisation, 1992). In general medicine they were classified as "functional somatic syndromes" (FSS) on axis III of DSM-IV, which corresponds to medical complaints, such as chronic fatigue syndrome (CFS), irritable bowel syndrome (IBS) and fibromyalgia. Further complicating matters, there is high co-morbidity with anxiety and depression (Kroenke et al., 1994).

The above classification system is highly contentious. The dualistic diagnostic system positions patients' problems as either psychiatric or medical as though the two can be clearly separated and distinguished from one another, a notion that is questionable (Sharpe & Carson, 2001). Some authors (e.g. Mayou, Kirmayer, Simon, Kroenke, & Sharpe, 2005) believe that there is a significant overlap between these categories and have called for the somatoform disorders category to be abolished altogether and redistributed to FSSs under axis III. Others contest the idea of a complete overlap (Brown, 2004). Patients with MUS present in multiple sub-specialities of medicine and, as a result, multiple idiosyncratic and overlapping FSS diagnoses

have evolved (McFarlane et al., 2008). Some researchers assert that there is considerable overlap between the different individual FSSs (Wessely, Nimnuan, & Sharpe, 1999), although there is also disagreement in this area. Depending on where they are seen in the health system, patients may receive either a psychiatric or medical (functional) diagnosis. Research shows that the label assigned seems to be influenced more by the speciality and interest of the doctor than by the patient's actual symptom profile (Fink, Rosendal, & Olesen, 2005; Fink, Toft, Hansen, Ørnbøl, & Olesen, 2007).

In addition to the above issues, the psychiatric classification of MUS in DSM-IV was itself also fraught with internal problems. Critics noted that there was significant overlap between the different conditions specified within the somatoform disorders category and criticised these diagnoses for their unacceptability to patients, lack of coherence, and ambiguity (Mayou et al., 2005). Perhaps most problematically, the diagnosis of a somatoform disorder in DSM-IV hinged upon the absence of an organic explanation for somatic symptoms, reinforcing dualism. The dualistic diagnostic classification system certainly does not sit well with a biopsychosocial framework which favours understanding health in a holistic way. Examining these dilemmas, Strassnig et al. (2006) advocated a paradigm shift towards "general medical/psychiatry interface disorders", to reduce stigma and improve acceptability of diagnoses to both patients and clinicians.

3.4   The issue of stigma and labelling in MUS

Issues of stigma have been well documented in relation to MUS (e.g. see Strassnig et al., 2006). According to Jones et al. (1984) individuals who are stigmatised bear a mark that identifies them as "*deviant, flawed, limited, spoiled, or generally undesirable*" (p. 6). The process of labelling plays a central role in stigma (Link, 1987) as labels applied may "spoil" the sufferer's personal and social identity (Goffman, 1968). However, in our health system diagnostic labels are needed to legitimise problems and provide a treatment pathway (Peveler, Kilkenny, & Kinmonth, 1997). This is of course highly problematic for patients with MUS who do not fit into the dualistic classification system. If physical causes are ruled out patients may feel blamed for their symptoms, especially if doctors communicate this information insensitively (McFarlane et al., 2008). Issues of stigma may also be exacerbated by the complex context of the doctor-patient consultation. Numerous studies have shown that consultations with patients with MUS can be fraught with tension and that doctors feel severely challenged by these patients (e.g. Salmon, 2007). Foucault (1973) argued that doctors exercise power through their moral authority over patients, which comes from their ability to use their knowledge to explain illness and provide treatment. From this standpoint, patients with MUS may present a threat to their doctors' medical competence (Kirmayer, Groleau, Looper, & Dao, 2004). As the authors

note, this may lead some doctors to react defensively, shifting blame from the limits of medicine to individual patient characteristics. Commenting on stigma, Brown (2007), observed that patients can be mortified by the receipt of a "medically unexplained" diagnosis because the latter is often taken to imply that symptoms are *imagined, feigned or 'all in the mind', or that the sufferer is 'mad' or otherwise mentally unwell"* (p. 778). Multiple studies have highlighted MUS patients' fears of being labelled as mentally ill or malingering (Chianello, 2010). These fears are perhaps all too understandable given the unfavourable cultural attitudes towards mental illness in our society. Although attitudes are gradually improving, significant stigma continues to surround mental illness compared with physical illness (Weiner, Perry, & Magnusson, 1988). Regrettably, people are more inclined to hold those labelled "mentally ill" responsible for their condition and to believe that help is not deserved (Corrigan & Watson, 2002).

Although the term "medically unexplained" is considered aetiologically neutral because it is de-coupled from any individual diagnosis, research by Stone et al. (2002) found that it had strong negative connotations for patients. In fact, the research indicated that patients reacted negatively to many of the labels tested, but especially those which had psychological connotations. Despite concerns about its pejorative tone, Stone and colleagues found that patients considered the term "functional symptoms" more acceptable, however further research is needed to determine the generalisability of this finding. A more recent quantitative study showed significant variability in generic label preferences (Marks & Hunter, 2015). Out of the seven alternatives suggested, the strongest preferences were for "persistent physical symptoms" (20%), "functional symptoms" (17%), and "medically unexplained symptoms" (15%), and nearly a quarter of the participants said they had no preference. However, this study was conducted among healthy individuals and it's possible that a study among patients would yield different results.

3.5 Recent improvements in diagnostic classification

In DSM-5, there has been an attempt to address criticisms of the previous psychiatric classifications of MUS, with the abolition of the somatoform disorders category and the creation of a new category "somatic symptom and related disorders" (APA, 2013). The changes in DSM-5 were a welcome, if modest, step in the right direction as they have helped to address at least some of the deficiencies in the preceding edition. The total number of constituent diagnoses has been reduced and a new singular diagnosis, "somatic symptom disorder" (SSD), has replaced prior diagnoses of "somatisation disorder" and "undifferentiated somatoform disorder". The most important shift in DSM-5 is that it more clearly acknowledges the complex intersection between mental and physical health. Perhaps most helpfully, DSM-5 has eliminated the problematic "medically unexplained" requirement from its diagnostic criteria, so individuals who attract these diagnoses may or may not have a diagnosed medical condition (Mayou, 2014).

The revised diagnoses focus on positive symptoms, thereby categorising a problem or condition on the basis of what it is rather than what it isn't, which may be inherently more engaging for patients. Therefore, individuals may meet the criteria for SSD if they are experiencing distressing somatic symptoms and they are also exhibiting "maladaptive" (unhelpful) thoughts, feelings, and behaviours alongside their somatic symptoms (APA, 2013). Clearly specifying the cognitive, emotional and behavioural components may reduce the tendency for doctors to automatically apply a psychiatric diagnosis to patients with somatic symptoms of unclear aetiology. DSM-5 has also taken a step forward to alleviate stigma by eliminating two of the most pejorative and offensive diagnoses, namely, somatisation disorder and "hypochondriasis". Patients who would have previously met the criteria for hypochondriasis in DSM-IV would be diagnosed with SSD in DSM-5 if they are also experiencing somatic symptoms alongside their health anxiety and are significantly preoccupied with the symptoms (APA, 2013). Those who are more concerned with the implications of bodily symptoms or sensations as a possible indication of undiagnosed serious disease, would be diagnosed with "illness anxiety disorder" (Mayou, 2014). Similarly individuals presenting with chronic pain conditions would be diagnosed with SSD with predominant pain. Once again, the removal of the medically unexplained criteria helps to reduce the stigma by removing the connotation that the pain is psychogenic in origin. This is also much more in keeping with contemporary understanding that chronic pain is a complex biopsychosocial phenomenon (Melzack, 2005). Another new sub-category in DSM-5 is "psychological factors affecting a medical condition", which recognises the fact that many people with medically diagnosed conditions may experience significant difficulties in adjustment and functioning due to psychosocial factors. This new category also helpfully crosses the bridge between medicine and psychiatry, pointing to the need for a more integrated and holistic approach.

3.6   Use of the term MUS

As the above discussion illustrates, the terminology used to describe somatic symptoms with no identifiable organic cause has been hotly debated and different labels have gone in and out of fashion over the years. Despite the vigorous debate, it has not yet been possible to identify a singular label that meet the criteria developed by Creed and colleagues (Creed et al., 2010). In relation to terminology, it seems that we are in a state of flux at present, partly triggered by the introduction of DSM-5 in 2013. Although MUS has been problematised like its predecessor somatisation, a replacement generic term had not yet clearly established. The new diagnosis SSD seems more descriptive and may therefore be less likely to elicit the negative associations of the previous diagnoses. However, it did not meet Creed's criteria for evaluating diagnostic terms and the authors predict that it will not be embraced by patients or doctors (Creed et al., 2010). Although the terms persistent physical symptoms or functional somatic symptoms seem

to have better potential, it is not yet entirely clear which of these will be most strongly embraced and enter the discourse to replace the term MUS. At the time when this research was initially conceived (in 2011), the term MUS remained the most widely known and familiar term (Henningsen et al., 2011). Because it was the conventional umbrella term at the time, it felt appropriate to use it for research conducted among clinicians working in primary care, especially as it was also conventionally used in the service that hosted this research. For these reasons, the author chose to employ the term MUS in this study, despite recognising its limitations.[2]

3.7   Phenomenology of MUS

Patients with MUS are in an unenviable predicament. Experiencing subjectively compelling somatic symptoms, they experience a high level of uncertainty, confusion and frustration (Nettleton, 2006). Patients may transfer from one medical specialist to another in the search for a definitive diagnosis to access treatment or, at least, to legitimise their suffering, and in doing so, become enmeshed in a conflictual relationship with the healthcare system (Brown, 2007). However, the receipt of a medically unexplained diagnosis may itself be distressing depending on its perceived meaning (Stone, Colyer, Feltbower, Carson & Sharpe, 2004), particularly if the diagnosis is seen as controversial (e.g., CFS) or stigmatising (e.g., somatisation). Many patients with MUS who attend therapy have a long history of fruitless investigations and failed treatments, and feel both misunderstood and stigmatised (Blom et al., 2012). Phenomenological studies highlight the intense distress that is frequently associated with an unexplained diagnosis (Rhodes, McPhillips-Tangum, Markham, & Klenk, 1999), prolonged uncertainty (Nettleton, 2006), and the stress of feeling perpetually in "diagnostic limbo" (Corbin & Strauss, 1985). As "diagnostic misfits" in a dualistic system, patients with MUS cannot inhabit a legitimate sick role (Glenton, 2003). A contested diagnosis may result in lack of support or suspicion from others, including health professionals (Nettleton, 2006). The work of Charmaz has documented the deleterious impact of chronic illness on a person's life, associated with loss of identity, marginalisation, isolation, feeling/being a burden, and loss of independence (Charmaz, 1991, 1983, 2002a, 2002b, 2008b). Patients with MUS may potentially experience all these issues alongside the additional specific stresses of having symptoms that are deemed medically unexplained.

Because patients with MUS experience debilitating physical symptoms and distress related to their symptoms, it seems reasonable to assume they may have much in common with patients with a diagnosed long-term condition (LTC). Indeed, there is co-morbidity between these groups, and in primary care, some of the most challenging patients with MUS are those who

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[2] The author has reflected further on her use of the term MUS in reflexive statement part 3

also have a coexisting LTC (Naylor et al., 2016). However, patients with MUS who do not have a diagnosed LTC present unique challenges. These patients, more than any other, are defined by being "*placeless*" in our health system (Seabrook, 2017, p. 39) and are arguably one of the most disenfranchised and marginalised groups in the health system.

3.8 The challenge of MUS for the health system

MUS is an enormous, costly and intractable problem for the health system and has been estimated to cost the NHS in England £3 billion every year (Department of Health, 2011). Between 25-50% of somatic complaints seen in primary care are medically unexplained (Burton, 2003), and this is even higher in secondary care (Creed, Barksy, & Leiknes, 2011). Although many patients in primary care experience natural remission of their symptoms, 10-15% experience chronic and disabling MUS (Kroenke et al., 1997). As symptom severity and chronicity increases this can have a profound impact on functioning, leading to long term disability and suffering (Creed et al., 2011). Among this group, co-morbid personality, relationship, and physical health problems are common (Kirmayer, Robbins, & Paris, 1994; Taylor, Mann, White, & Goldberg, 2000). MUS is especially challenging in primary care because GPs are often left managing these most complex cases (Carrington, Rock, & Stern, 2012).

Significant financial, political, & logistical barriers have impeded development of effective MUS services. Unresolved difficulties with classification constitute one of many barriers to improving care for these patients (Henningsen et al., 2011). Historically, MUS patients have been primarily managed by medical professionals and psychotherapeutic service provision has been very patchy (Fink, Burton, De Bie, Söllner, & Fritzsche, 2011). Over the last decade the majority of primary care provision of mental health services has been delivered through the Improving Access to Psychological Therapy program (IAPT), which was not specifically set up to cater for these patients. Therefore, MUS patients flounder in a dualistic health system which cannot effectively cater to their needs, feeling dismissed by the medical system yet reluctant to engage with mental health services (Gonzalez, Williams, Noël, & Lee, 2005). Other barriers to improving services include the lack of consensus regarding MUS aetiology, lack of effective therapies (Witthöft & Hiller, 2010), and a shortage of suitably trained therapists (Brown, 2007).

3.9 Recent developments and future plans

Various new developments have occurred that are beginning to address the problems highlighted above. In 2009, an innovative new primary care psychotherapy service was established in Hackney targeting complex patients in primary care (including patients with MUS), who don't meet the criteria for and/or struggle to engage with existing primary care

services or secondary care mental health services. In addition, following the publication of the Government strategy "*No Health without Mental Health*" (Department of Health, 2011), there has been a drive to significantly expand psychological treatment for MUS and LTC nationally. In 2012, fifteen IAPT pathfinder sites were selected to pilot a variety of innovative approaches to treating MUS drawing broadly on CBT paradigms, including "third wave" approaches (de Lusignan et al., 2013). Following on from this, subsequent positive practice guidance for MUS recommended better integration with physical health services (Department of Health, 2015). Enshrined in the Five Year Forward View (NHS England, 2016a), an expansion of services for patients with MUS (and LTC) has now commenced and will be rolled out over the next five years through new "Integrated IAPT" and Liaison Psychiatry services. A key assumption underpinning this strategy is that investing in expanding access to psychological support for patients with LTC and MUS will help to reduce costs throughout the rest of the system. Although the changes that are in motion now have been at least partially driven by economic pressures, the current strategy provides a rare and unprecedented opportunity to transform care for patients with MUS.

3.10 Counselling Psychology's engagement with MUS

Thus far, the Counselling Psychology discipline has made a limited contribution to research and clinical practice in this specialist area. There may be several reasons for this. The most likely reason is that the problem of MUS is, by definition, embedded within the medical system. This has traditionally been territory of Clinical Health Psychologists and Counselling Psychologists are just beginning to get established in this context (Jones Nielsen & Nicholas, 2016). However, a further influential factor is that Counselling Psychology as a profession has not engaged much with practice based research of any kind, so the profession's visibility in clinical-focused research is rather poor generally (Henton, 2012). Despite the lack of engagement so far, Counselling Psychologists seem well-placed to contribute to research and practice focused on the needs of patients with MUS. The humanistic values of the profession, including its non-pathologising stance and its emphasis on clients' subjective experiences and the therapeutic relationship, may be well matched with the needs of MUS patients, who often feel misunderstood, frustrated, and marginalised. This phenomenological stance is especially valuable for exploring experiences which may have been overlooked, denied, or minimised.

3.11 The contribution of this research

As a practitioner doctorate, the aim of this thesis is to contribute to research that informs clinical practice targeting patients with MUS. As the review in section 5 will highlight, there has been a dearth of practice-relevant research in this area. The MUS clinical treatment literature is dominated by efficacy studies which are important for commissioners and service managers, but

provide little practical guidance for clinical practice (Morrow-Bradley & Elliott, 1986). The review reveals that engagement is a significant clinical problem for this patient group (Schneider, Beisenherz, & Freyberger, 1990). Congruent with this, early pilot work evaluating treatments for MUS and LTC in IAPT services showed that clinicians found it especially hard to engage patients with MUS, compared to those with LTC (de Lusignan et al., 2013). Despite frequent reports of this problem, to the author's knowledge, no studies have explored this specific issue for this patient group.

Having identified a clear gap, the author has explored the process of engagement using Grounded Theory (GT), and created a broad theoretical framework for thinking about this problem that can be used to inform therapeutic practice. The research was conducted among experienced clinicians working in a specialist service in primary care that targets the more complex patients with MUS. The research introduces a new theoretical construct "negotiating disconnection" that conceptualises the process of engagement across three key stages. This construct integrates the underlying components of the framework: "drawing in" (negotiating systemic disconnection), "meeting patients where they're at" (connecting in the disconnection) and "nudging forward" (cultivating new connections), that illustrate how clinicians negotiate the different stages of engagement. Negotiating disconnection captures the essence of the process in just a few words, creating a theory that is memorable, useful and sharable.

Overall, the model highlights the central importance of engaging the medical system (in this context, GPs) to engage this patient group by forming strong relationships with GPs and engaging in genuine collaborative practice. It also draws attention to some of the challenges that clinicians may encounter trying to work in this way, relating to the complexities of organisational and cultural change. It shows that more training is needed to help support GP's efforts to promote psychological therapy to these patients, and to support GPs in managing long-term relationships with these patients. The research illustrates that efforts to create more integrated provision of physical and mental health services can promote engagement of these patients, thereby facilitating the provision of more holistic, biopsychosocial care.

At a more immediate practice level, the model highlights the specific challenges that "hard-to-engage" patients with MUS present, and how clinicians can adapt their practice to address these barriers and promote engagement in the therapeutic process. Although this research was conducted in a psychoanalytically-informed service, the findings suggest that a pure psychoanalytic stance is not that helpful for practitioners in engaging these patients. To engage these patients, experienced clinicians tended to work in a flexible, person and process-led way, integrating techniques from other modalities as needed, and working collaboratively. Finally, the detailed foundations of the model show that for patients with MUS, the fine nuances of

doctors' and clinicians' words and actions really do matter. It is not just what is said but how it is said and what might be implied or understood that seems to influence engagement. To promote engagement, it seems to be helpful for both doctors and psychological therapists to be sensitively attuned to the phenomenological experience of these patients and to use this understanding to facilitate engaging communications.

In view of the current transformation of the healthcare system this research is both timely and relevant. Because of the model's systemic emphasis it can provide valuable guidance to senior managers who are charged with developing new therapeutic services for patients with MUS. As a piece of practice-based research, it may also be valuable for clinicians of all modalities who are working with this patient group, but especially the many new practitioners who will be entering this field in the next few years. Last but not least, the research will contribute to a much-needed expansion of Counselling Psychology's professional presence in an important, somewhat neglected, and now rapidly expanding field of clinical practice.

4   Reflexive statement (part 1)

My desire to conduct doctoral research on MUS reflects my interest in the intersection between mental and physical health, including the impact of psychological factors on physical health and vice versa. MUS is a complex but intriguing area for me, in which many personal and professional questions remain unanswered. Intellectually, I find myself drawn a problem which seems to defy explanation, however ultimately, my interest in this topic originates from my own personal experiences. In the last decade I have experienced two episodes of MUS, leading to health anxiety on each occasion. My own experiences were thankfully quite circumscribed, and were well managed by the medical professionals that I encountered. Nevertheless, I fully appreciate the dilemma of subjectively distressing, unexplained physical symptoms. I remember the strength of my conviction that there was something very wrong physically. Although I recognised that I felt stressed at the time, I didn't believe that stress could contribute to the development of such debilitating physical symptoms. Like the majority of MUS patients, therefore, I did not consider seeking psychological help for the problem. Luckily my physical symptoms resolved after external stressors subsided, however, this also meant that my beliefs about the nature of these physical symptoms were challenged.

Going into this research, I held a range of preconceptions about this topic, which will inevitably have influenced the nature of my enquiry. To be specific, I believed that MUS symptoms are both biological and psychological, and that chronic stress and stress sensitivity may be central to the problem. I viewed the symptoms as very much real, reflecting altered functioning of bodily systems. Although genetic susceptibility may predispose certain individuals to MUS, I had already begun to accept that psychological factors may also contribute to the onset of these symptoms, and affect how people cope once symptoms occur. Because of my own experiences, I appreciated both the importance and the challenge of helping MUS patients (who may be as sceptical as I was) to understand the powerful role that psychological stress may play in the development of this problem. Experts readily acknowledge the vital need to create a safe therapeutic environment for patients with MUS (Heijmans et al., 2011) and the importance of empathy and validation for this patient group (Epstein et al., 2007). In my personal opinion this is best achieved by establishing a curious, unknowing, and un-blaming stance, to reduce patient alienation. The starting point needs to be a genuine acknowledgement that symptoms are "real" (i.e. subjectively compelling) for the sufferer, a prerequisite for working sensitively and respectfully with this patient group.

My views regarding psychologically-informed treatments for MUS have also been influenced by my recent experience working on two randomised controlled trials (RCTs) evaluating Group CBT for women who are experiencing menopausal symptoms (Ayers, Smith, Hellier, Mann &

Hunter, 2012; Mann et al., 2012). As the qualitative researcher for the trials, I witnessed first-hand how psychological approaches can help individuals cope with physical symptoms (Balabanovic, Ayers, & Hunter, 2012, 2013). This has strongly reinforced my confidence in biopsychosocial approaches to understanding and treating physical symptoms.

The literature on somatisation is replete with negative discourse about patients with MUS, especially the medical literature. For example, Lin et al. (1991) notes that somatisation patients have been variously described as "*frustrating, difficult, hateful, 'black holes' or problem patients*" (p. 241). Reflecting my own personal relation to the field, I struggle with the pathologisation of patients with MUS, and literature which perpetuates this negative discourse. My impression is that there is a bias in the MUS literature towards a service-centred understanding of the problem, emphasising the problem that MUS creates for health system. This seems to lose sight of the problem of MUS for the individual, the nature of their experience, and how they can be genuinely helped. Of course, this doctor-centred focus is not surprising given the challenge that MUS presents to the medical profession, by definition, representing its limitations. However, in reality, it seems that the difficulties encountered are sometimes exacerbated by poor understanding and management of this problem by some healthcare professionals. Anecdotal reports from patients suggest that some doctors may make insensitive or dismissive comments "*there's nothing wrong with you.*"

In the next section I present my critical literature review on this topic area. In section 6, I will reflect on my experience of conducting this review, what I learned from this experience, and how this has influenced my research method.

5 Critical literature review

5.1 Aims

This review explores theoretical models of MUS and the associated treatment literature. Reflecting an intention to develop a "big picture" understanding MUS, the review is purposefully broad in scope, and does not focus on individual MUS conditions documented in the literature. In the spirit of upholding the pluralistic values of counselling psychology (McAteer, 2010), the literature synthesised spanned a range of different aetiological and treatment models of MUS. The review begins with an exposition of the most influential theoretical models of MUS, followed by an examination of the treatment literature. The latter is dominated by randomised controlled trials (RCTs) reflecting the prevailing paradigm of evidence-based-practice (EBP), which privileges a positivist research agenda. Nevertheless, the review will focus on approaches which have accumulated a minimal "evidence base" as defined by these principles (cognitive-behavioural and psychodynamic approaches). This is a pragmatic decision as the research undertaken for this thesis will necessarily focus on theoretical frameworks employed within the NHS. The review concludes with selected research relevant to the issue of patient engagement and the proposed research question.

5.2 Method

A narrative review was conducted. To generate an initial corpus of literature, a search was conducted of the PsycINFO database to locate articles containing the following search terms in the abstract: "(MUS OR MUPs OR somatiz(s)ation OR somatoform disorders) AND (models OR treatment OR therapy experience OR treatment experience)". This generated over 1800 articles. After skimming 250 abstracts based on title relevance, approximately 100 articles were selected and located to form the basis for this review. Although the parallel and extensive literatures on FSSs and chronic pain were highly relevant, it was beyond the scope of this review to cover these also.

5.3 Theoretical frameworks

5.3.1 The emergence of cognitive-behavioural models of MUS.

In the wake of the cognitive revolution in psychology which started in the 1970s, a variety of different cognitive-behavioural (CBT) models of MUS emerged.

5.3.1.1 Early CBT (amplification) models.

Many early CBT models of MUS originated within the symptom perception framework (Pennebaker, 1982). According to this framework, physical symptom experiences reflect

cognitive-perceptual processes including symptom attention, detection and interpretation. A key assumption is that symptom perception is influenced by top-down processing. Symptom perception models of MUS assume maladaptive cognitive-perceptual and appraisal processes relating to somatic information (Bogaerts et al., 2010). Within this framework, many CBT models of MUS (e.g. Mayou, Bass, & Sharpe, 1995) are based on the premise that normal bodily sensations are interpreted in a catastrophic manner (reflecting maladaptive underlying beliefs), thereby increasing emotional arousal and intensifying these sensations. The misinterpreted somatic symptoms are assumed to reflect minor physical pathology, somatic symptoms of anxiety or depression, and/or enhanced awareness due to body-focused attention. Symptom misinterpretations then trigger coping behaviours which can maintain symptoms. For example, patients may ruminate about the causes and/or implications of their symptoms (Warwick & Salkovskis, 1990). This amplifies body and symptom-focused attention, thus reinforcing the vicious cycle. Numerous other models emphasise similar processes (e.g. Barsky, 1992; Kirmayer & Taillefer, 1997; Salkovskis, 1989; Sharpe, Peveler, & Mayou, 1992). Although these earlier models have been influential in shaping various CBT treatment protocols for MUS, a key limitation is that they all assume that individuals misinterpret minor, benign physical symptoms. They cannot therefore account for more severe or unusual MUS symptoms, such as paralysis or non-epileptic seizures (Brown, 2006).

5.3.1.2   *Psychobiological models.*

Rief & Barsky (2005) introduced a psychobiological MUS model giving greater emphasis to potential physiological underpinnings. Their two-stage model characterises MUS as a disruption in the filtering processes that determine which physiological sensations enter conscious awareness. In the first stage, somatic symptoms may be generated by a range of physiological factors including sustained activation of the hypothalamic-pituitary-adrenocortical (HPA) axis. In the second stage, deficient filtering leads to the amplification and/or failure to effectively inhibit somatic sensations. The authors attribute this "faulty filtering" to a range of factors including uncertainty regarding symptom meaning and lack of distraction, etc. Rief and Barsky's model is in-keeping with growing evidence suggesting that MUS is associated with various kinds of biological disturbances, such as central sensitisation (Yunus, 2008, 2009). Central sensitisation occurs when there is an exaggerated response to (stressful) stimuli following prior exposure and a lowered threshold for pain perception (Rygh et al., 2005). Emerging evidence suggests that central sensitisation may underlie many FSSs (Kindler, Bennett, & Jones, 2011). Disturbances in the autonomic, neuroendocrine, and immune systems have also been implicated (Tak, Bakker, & Rosmalen, 2009).

Proponents of psychobiological models (e.g. Yunus) view FSSs as legitimate medical problems. However, psychobiological models beg the question of why certain individuals are predisposed to such disturbances in the first place. Such concerns are a more primary interest for contemporary psychoanalytic-oriented researchers (see 5.3.2.3). Because psychobiological models acknowledge somatic functional disturbance they may have more face validity for patients. Based on these models, psychophysiological treatments employing biofeedback have been suggested. Some consider these approaches as promising "Trojan horse" techniques to help patients confront underlying emotional issues (Katsamanis et al., 2011, p. 219).

5.3.1.3   *Contemporary information processing models.*

Contemporary information processing models of MUS give greater attention to the role of memory and expectations (Brown, 2004; Rief & Broadbent, 2007). According to Brown, MUS reflects the influence of "rogue representations" of illness in memory, acquired via prior exposure to symptoms (in self or others), socio-cultural exposure, or verbal communications. MUS results when the primary, non-conscious attention system is biased by overactive knowledge structures in memory, and automatically selects rogue symptom representations. If sufficiently activated, these memories may be misinterpreted as a current illness episode. Phenomenologically, this is experienced as a subjectively compelling sensory experience (i.e. "real" symptoms). In Brown's account, symptoms are maintained via persistent attention to the rogue illness representations, controlled by the secondary (conscious) attention system. MUS is thus characterised as a "*false alarm of a highly sensitised information processing system*" (Witthöft & Hiller, 2010, p. 266). As pointed out by Witthöft & Hiller, Brown's model is unique in specifying potential cognitive origins of MUS, as a perceptual error driven by disturbances in the automatic attention system. Unlike other models, therefore, it can explain why MUS can occur in the absence of other psychopathology (Wessely, 2001). The notion of rogue illness representations also fits with the fact that MUS is often precipitated by physical illness, or associated with childhood illness exposure (Craig, Boardman, & Daly-Jones, 1993). The model implies that treatment should focus on redirecting secondary attention resources to reduce activation of rogue illness representations to correct the bias in the primary attention system.

5.3.1.4   *Longitudinal and integrative models of MUS.*

More recently, several authors have developed elaborated multifactorial models of MUS which integrate earlier theoretical and empirical contributions (e.g. Brown, 2006; Deary, Chalder, & Sharpe, 2007). Employing the standard CBT framework (Beck, 1976), Deary et al. distinguish between those factors that predispose, precipitate and perpetuate MUS, synthesising all the empirically supported contributory factors. Uniquely, the authors draw upon systems theory to

propose a model of perpetuation that is both idiosyncratic and "autopoietic" (i.e. autonomous and self-maintaining). According to Deary et al., predisposing factors include: various personality dimensions (e.g. neuroticism, introspection, and absorption); childhood sexual, physical and/or emotional abuse (Ford, 1997; Roelofs & Spinhoven, 2007); and illness beliefs, shaped by family and culture. Episodes of MUS are often precipitated by stressful life events, including loss or threat of loss (Lipowski, 1988), dilemmas (Hatcher & House, 2003), and recent onset of physical illness. Once an episode is triggered, a wide variety of factors may maintain it, including: cognitive factors (attention and attributional processes, rumination, and underlying illness beliefs); physiological factors (HPA axis dysregulation, sustained physiological arousal, and sensitisation); behavioural factors (e.g. avoidance and compensatory behaviour); and sociocultural factors (e.g. complex interactions with family members or the health system, etc.). These factors may interact; for example, protracted stress may trigger prolonged activation of the physiological stress system, fuelled by perseverative cognition (Brosschot, Pieper, & Thayer, 2005). Once again, the authors do not focus on the origins of the various predisposing personality characteristics and biological vulnerabilities, the latter being simply attributed to non-specific negative early experiences or trauma. Nonetheless, from a therapeutic standpoint Deary et al.'s model has considerable utility for case conceptualisation as it can account for all the different MUS phenomena within a common explanatory framework.

5.3.2 Psychodynamic and psychoanalytic models.

Psychodynamic theories of MUS/somatisation phenomena could roughly be categorised into conflict/defence models (including Freud's classical drive theory and its contemporary derivatives), or deficit models (espoused by object relations and attachment theorists, as well as self psychology theorists) (De Laplante, 2002). Before outlining these perspectives it is useful to introduce the construct of "alexithymia" as this has assumed a central position in psychodynamic theories of MUS. Introduced by Sifneos (1973), the term literally means "no words for feelings". It emerged from observations that patients with psychosomatic issues seemed to struggle to identify and express their feelings (Kooiman, 1998). Psychoanalysts have historically often invoked this construct to explain psychosomatic phenomena.

5.3.2.1 Early defence models (Freudian and neo Freudian).

The earliest psychoanalytic theory of MUS phenomena originated from Freud's work on hysteria and conversion (Freud, 1896). A fundamental tenet of his theory was that human motivation is fuelled by unconscious sexual and aggressive drives. Freud believed that hysteria was a by-product of unconscious intra-psychic conflicts within and between these drives and the outside world. If unresolved, the imbalance in psychic energy is converted into somatic symptoms to prevent forbidden impulses from being enacted. Thus "hysterical" conversion

symptoms were seen to be symbolic of the repressed, forbidden impulses. Contemporary Freudians continue to formulate MUS drawing upon Freud's structural model of the mind (Freud, 1923) although motivational drives are more broadly conceived. For example, chronic pain has been linked with unconscious guilt resulting from intra-psychic conflict (Engel, 1959), whereby pain becomes a means of assuaging guilt through suffering. According to Kreitler & Niv (2007), an unconscious conflict between a wish to pursue one's own desires (id) versus obligation to meet those of others (superego or reality-based needs) is common among chronic pain patients.

5.3.2.2   *Early deficit models (object relations and attachment theory).*

Since Freud, there has been a proliferation of different schools falling under the broader psychodynamic "umbrella" (Lemma, 2003). Of these, object relations (O/R) and attachment theory have made significant theoretical contributions to the understanding of MUS. A central tenet of these approaches is that human functioning is driven by our relational needs. In contrast with defence model proponents, O/R and attachment theorists focus on the impact of early relationships (the first few years of life) in shaping an individual's future personality and relationships. Infants must make the transition from a state of fusion and dependence towards independence and differentiation (Mahler, 1967). Disturbances during this individuation process may lead to developmental deficits, conferring vulnerability to later psychopathology.

To explain how this process might contribute to MUS, it is useful to draw on the work of Winnicott, one of the early O/R theorists. According to Winnicott (1958), new born infants express all distress somatically, as they are unable to distinguish between physical and emotional pain. A "good enough" mother provides a "holding environment" which helps to regulate her infant's emotional state (Winnicott, 1965). After repeatedly experiencing its mother's soothing presence the baby eventually forms an internal representation of her, which can be evoked in her absence to "self-soothe". However, this developmental process can be disrupted if there is misattunement between mother and baby e.g. poor attention to the baby's emotional needs (Winnicott, 1958). This may impair the child's ability to identify and verbalise their feelings, and to differentiate between physical and emotional responses, thus explaining alexithymic traits. Instead of promoting integration, this leads to a split between the psyche and the soma (Winnicott, 1989). In Winnicott's account, the primary function of the somatic symptoms is to express affect which has not been registered mentally (Shoenberg, 2001, 2007).

However, other psychodynamic theorists have emphasised secondary gains, such as access to caring others, as more central to the dynamic of somatisation (Blaustein & Tuber, 1998). From an attachment theory perspective, infants are instinctively motivated by a need to sustain close relationships (attachments) in order to receive care and avoid danger (Bowlby, 1977). Based on

their early experiences with caregivers, children develop "internal working models" of relationships providing a blueprint for navigating future relationships. A child who is exposed an insensitive or rejecting primary caregiver may develop faulty representations of self and others leading to future relationship difficulties. Building on Bowlby's ideas, subsequent work has differentiated between infants with "secure" and "insecure" models of attachment (Ainsworth, Blehar, Waters, & Wall, 1978), and between ensuing, enduring adult attachment styles (Bartholomew & Horowitz, 1991).

Empirically there is evidence supporting a correlation between insecure attachment and unexplained somatic symptoms, although this is weaker than the relationship with "overt" psychological problems (Taylor et al., 2000). Also, adult attachment style has been shown to influence patterns of care seeking behaviour under stress (Brennan & Shaver, 1995). Reflecting these observations, Stuart and Noyes developed a model conceptualising somatisation as a maladaptive communication of distress related to anxious attachment (Stuart & Noyes, 1999, 2006). Their model elucidates different care seeking strategies relating to the attachment styles identified by Bartholomew and Horowitz. The main weakness of this model is that it glosses over somatic symptomatology which is not a target of treatment. Patients' subjective experience of somatic symptoms may thus potentially be dismissed or minimised.

Object relations theory has also been applied to understand how individuals relate to their MUS symptoms. For example, Grzesiak, Ury, & Dworkin (1996) argue that chronic pain can often represent "*the superimposition of psychodynamic issues on sensory memories*" (p.162). The authors suggest that "pain prone" patients develop transferential responses to their pain mirroring relations with past caregivers or authority figures.

5.3.2.3   *Contemporary psychoanalytic perspectives.*

In the past thirty years there has been a surge of interest in emotional processing within mainstream academic psychology, driven by advances in understanding the neurobiological basis of emotion (Damasio, 1999; LeDoux, 1995, 1998). Creating a bridge with psychoanalytic ideas, various contributors have proposed an association between emotional regulation (a more broadly defined construct than alexithymia) and MUS phenomena. Several cognitive emotional-processing theories of somatisation have been developed. According to Lane & Schwartz (1987), somatisation is conceptualised as a developmental deficit related to reduced emotional awareness and undifferentiated arousal. Somatic distress occurs because schemata relating to emotional processing are insufficiently complex (lacking cognitive content), thus limiting emotional reactions to somatic sensations and action tendencies. Differences in language aside, the parallel with Winnicott's ideas is striking.

Meanwhile, contemporary psychoanalytic theorists now view impaired emotional regulation (associated with disturbed attachment behaviour) as a causal mechanism for MUS phenomena. Reflecting advances in the understanding of emotional regulation, Taylor, Bagby, & Parker (1997) have reconceptualised alexithymia more broadly as an affect regulation disorder in which impaired cognitive and interpersonal regulation of emotion lead individuals selectively attend to, amplify and misinterpret bodily sensations associated with emotional arousal (cf Barsky, 1992). Considering the interpersonal regulation of affect, insecurely attached children learn that their needs will not be met and may therefore resort (unconsciously) to "secondary attachment strategies" when under stress, reflecting this negative expectation (Mikulincer, Shaver, & Pereg, 2003; Sbarra & Hazan, 2008). Individuals with a preoccupied attachment style may amplify their distress (attachment activating) whereas individuals with a dismissive attachment style may play down their distress or mask their emotions (attachment deactivating). The latter group are of particular interest, given the postulated link between emotional inhibition and physiological arousal and somatic symptomatology (Pennebaker, 1989; Pennebaker, Hughes, & O'Heeron, 1987). However in both cases, implicit relational models involving negative view of self and/or other may jeopardise effective co-regulation of stress (Gunnar & Quevedo, 2007).

An important, related development is the theory of mentalisation (Fonagy, Gergely, Jurist, & Target, 2002), as it explains mechanisms by which attachment disruptions can impair later emotional functioning. Mentalisation is concerned with the ability to reflect on mental states of self and others. Inadequate mirroring of an infant's affective state can lead to long-term impairments in the child's ability to mentalise, particularly during times of stress. Disturbances in mentalisation impact an individual's ability to represent, tolerate and regulate affect (Allen, Fonagy, & Bateman, 2008). Fonagy & Target (2000) suggest that when mentalisation fails the individual regresses to a pre-reflective (minimally self-conscious) bodily (as opposed to psychological) experience of self (the "psychic equivalence" mode). In this state of "hyperembodiment", psychological pain is felt as real physical pain.

Integrating mentalisation, attachment and neurobiology concepts, some psychoanalytically-oriented researchers are now characterising FSSs as part of a spectrum of stress-related disorders. According to Luyten et al. (2011), developmentally acquired personality characteristics (e.g. self-critical perfectionism) may be associated both with chronic stress-generation, and use of maladaptive attachment strategies in response to stress. This may eventually disrupt stress-system functioning which may account for many of the somatic symptoms reported by FSS patients (Van Houdenhove, Luyten, & Tiber Egle, 2009ab). Linking this with mentalisation concepts of psychic equivalence and hyperembodiment, Luyten suggests that there is dissociation between the subjective perception of stress and physiological stress

(Luyten, 2011). Based on this conceptualisation of MUS, Dynamic Interpersonal Therapy (DIT) has been recommended as an appropriate treatment model for these patients (Luyten, van Houdenhove, Lemma, Target, & Fonagy, 2012)

5.3.2.4 *The relationship between MUS and trauma.*

Unexplained somatic complaints are common among individuals who have a history of trauma (Gillock et al., 2005), including early attachment trauma, and are often reported by individuals diagnosed with complex PTSD (Scaer, 2014). A theory of causality of MUS has been developed, which synthesises literature from attachment theory, affective neuroscience, and the biology of the autonomic nervous system (Russell, 2015; Russell, Abbass, Allder, & Neborsky, 2016). Affective neuroscientists argue that seven emotional systems are hardwired into sub-cortical structures of the brain to promote attachment and survival (Panksepp & Biven, 2012). Applying Malan's "triangle of conflict" (Malan, 1995), Neborksy (2010) suggests that emotions that provoke threat or harm or abandonment by the caregiver trigger anxiety and defence mechanisms, promoting affect dissociation instead of affect regulation. Through fear conditioning this process becomes automatic and unconscious.

Drawing on these ideas, Abbass (2005) views somatisation (or MUS) as the outcome of unconscious strivings to inhibit intense feelings, through use of unconscious defence mechanisms. If the anxiety elicited is too high and defences are overwhelmed, the "fight or flight" stress response is triggered (Cannon, 1932), and anxiety is channelled through the body via different pathways. These pathways include "striated muscle tension" and "smooth muscle tension," reflecting sympathetic activation related to mobilization for fight or flight, and "cognitive perceptual disruption" and "conversion," reflecting parasympathetic activation associated with freeze or flop response (p. 216). Each of these pathways is associated with different kinds of somatic symptoms. This model helps to explain research which has shown that patients who are prone to MUS have a tendency to block or inhibit anger (Venable, Carlson, & Wilson, 2001). Abbass advocates Intensive Short-Term Dynamic Psychotherapy (ISTDP) as an effective treatment for MUS as it directly targets the defences that patients use to disconnect from feelings that they find threatening. The treatment aims to help patients experience these feelings and to learn they are tolerable, thereby reducing the suffering associated with somatisation (Abbass, Campbell, Magee, & Tarzwell, 2009).

In his seminal work, Scaer (2014) postulates a link between the late somatic complaints of complex PTSD and dysregulation of the autonomic system due to extreme or chronic stress. Drawing on the polyvagal theory of emotion (Porges, 2001), he suggests that when mammals experience states of extreme terror or helplessness, a primitive system (the dorsal vagal complex) is activated leading to immobilisation (the freeze and flop response). Scaer associates

the immobilisation with dissociative phenomena, including dissociative physical symptoms linked to the trauma. He further postulates that those who experienced more serious or repetitive trauma, especially early childhood trauma, are sensitised to experiencing the freeze and flop response when under stress. It is these individuals who are most prone to experiencing the most extreme dissociative MUS symptoms, such as functional neurological symptoms (non-epileptic seizures, paralysis, fainting, etc.).

5.3.2.5 *Empirical evidence for contemporary psychodynamic models.*

In summary, contemporary psychoanalytic, attachment-based theories of somatisation suggest that impairments in affect regulation lie at the heart of MUS. However, a recent meta-analysis by De Gucht & Heiser (2003) found only a small to moderate association between somatisation and the related construct of alexithymia. Moreover, affect regulation deficits are not universal among somatoform patients and not all individuals with these deficits develop MUS, so this explanation seems to lack specificity (Waller & Scheidt, 2006). Having said that, another study by Waller, Scheidt, & Hartmann (2004) improved specificity using attachment theory concepts. In this study among patients with somatoform disorders, they found an elevated prevalence of individuals with an insecure-dismissing attachment style and associated deficits in emotional awareness. There is, however, a danger of overgeneralization here as patients with MUS are a heterogeneous group. Many experience mild and transient forms as an adjustment reaction to a stressful situation (Katon, Lin, von Korff, & Russo, 1991) and not all patients who present with MUS exhibit psychological difficulties (Mayou, 1993). Finally, assuming that there is a connection between affect regulation and MUS, the precise pathways by which this leads to somatic symptoms has not yet been completely established. Evidence does suggest that disturbances in attachment behaviour and affect regulation may have long-term influences on physiological functioning (Hofer, 1995). However, the evidence is not conclusive.

5.4 MUS psychotherapy treatment literature

5.4.1 Outcomes evidence.

This section examines the treatment literature for MUS. In the era of evidence-based practice (EBP), this is dominated by RCTs which establish if changes in outcomes can be causally attributed to the treatment (Cooper, 2008). Because RCTs are tightly controlled experimental studies they have high internal validity; however their ecological validity is questionable. Effectiveness studies are needed to establish if results can be generalised to a typical clinical setting (Nathan, Stuart, & Dolan, 2003). This review focuses on RCTs addressing general MUS (including somatisation disorder, undifferentiated somatoform disorder, etc.), and has excluded trials for other singular MUS-related diagnostic categories (e.g. CFS). Because of space

limitations, it is largely based on reviews and meta-analyses. Overall, relatively few RCTs have been conducted for MUS compared with other more overt psychological conditions (Kroenke, 2007), and the majority conducted have focused on CBT-related interventions. There have been very few effectiveness studies.

5.4.1.1   *CBT treatment efficacy.*

Several meta-analytic reviews of CBT-related treatments for MUS have been published since 2000. Looper & Kirmayer (2002) synthesised the results of thirty trials for somatoform disorder treatments (by DSM category). Five trials reviewed evaluated interventions for undifferentiated somatoform disorder (in primary care). Only those utilizing individual CBT demonstrated reduced symptoms and distress though effect sizes were typically only moderate (0.33-0.88). Two studies examining group CBT for general MUS found this to be efficacious (Lidbeck, 1997, 2003). Other reviews published at a similar time have yielded broadly consistent conclusions. For example, Nezu, Maguth Nezu, & Lombardo (2001) synthesised the results of RCTs for both MUS and three FSSs and found mostly medium effects for both somatic symptoms and psychological distress.

A more recent meta-analysis of psychological therapies for chronic multiple MUS was published by Kleinstäuber, Witthöft, & Hiller (2010). This study examined all therapeutic modalities but employed very strict quality-related inclusion criteria. The majority of the trials that met these criteria were for CBT-related interventions. Although the review found medium-to-large within-group effect sizes (i.e. pre-post treatment comparisons), the between-group effects sizes (i.e. comparing treatment to control) were small-to-medium, though stable over time. Key moderator variables identified included the number of sessions and specialist therapist training. Overall, the authors concluded that the efficacy of psychotherapy (CBT) for MUS is only modestly beneficial, compared to anxiety where the effects are mostly large. Also, it has minimal impact on co-morbid mood problems.

In summary, the outcomes literature reviewed suggests that CBT-based treatment is only moderately beneficial for treating MUS, and only if delivered by a specialist therapist. This is potentially an optimistic appraisal given the sampling biases inherent in these trials (Kroenke & Swindle, 2000). Moreover, no firm conclusions can be drawn regarding the relative utility of different CBT components (Kroenke, 2007). Overall, one is left with little sense of why the different treatments work or don't work. Third wave experiential CBT therapies show potential (van Ravesteijn, Lucassen, Bor, van Weel, & Speckens, 2013), however more research is needed to build an evidence base for this.

5.4.1.2   Psychodynamic treatment efficacy.

Three meta-analytic reviews were located examining outcomes of Short Term Dynamic Psychotherapy (STDP) for somatisation. Two of these reviews found that STDP provided better outcomes than minimal treatment controls for patients with somatisation (Anderson & Lambert, 1995; Leichsenring, Rabung, & Leibing, 2004). A more recent review by Abbass, Kisely, & Kroenke (2009) examined twenty-three studies of treatments for somatic symptoms, including thirteen RCTs. More than half the studies pertained to MUS-related conditions (predominantly IBS and chronic pain) and a variety of STPPs were covered (e.g. Davanloo, 1980; Hobson, 1985; Malan, 1976). Over 90% of studies reported significant effects on physical and psychological symptoms. As no effect sizes were reported it is difficult to compare this with the CBT outcomes above. However the authors concluded that STPP may be effective for treating patients suffering from somatic symptoms and warrants further research. In relation to IBS specifically, several trials indicated that adapted Psychodynamic Interpersonal Therapy or PIT (Guthrie, 1999) is efficacious in improving physical and psychological symptoms, relative to controls (Creed et al., 2003; Guthrie, Creed, Dawson, & Tomenson, 1991; Hamilton et al., 2000). Other brief dynamic approaches also look promising, including ISTDP (Abbass et al., 2010; Abbass, Campbell et al., 2009; Abbass, Lovas and Purdy, 2008) and DIT, which is due to be trialled shortly (Luyten, personal communication, January 7th 2017)

5.4.1.3   The limitations of evidence-based practice.

The increasing reliance on RCTs to evaluate psychological therapies is a trend resisted by many counselling and psychotherapy practitioners (e.g. McLeod, 2001). In somewhat polarised debates, RCTs have been described as everything from "*vital*" to "*irrelevant*" (Persons & Silberschatz, 1998). The limitations of RCTs have been well documented, including the use of unitary medical diagnoses for sampling purposes and standardized therapy manuals, amongst other things. The emphasis on experimental control results in trials with "*impeccable internal validity*", but limited ecological validity or real world applicability (Howard, Moras, Brill, Martinovich, & Lutz, 1996). Furthermore, as noted by Deary et al. (2007), relatively few trials are large enough or refined enough to identify the so-called active ingredients mediating changes in outcome, something of central interest to practitioners.

5.4.2   The value of practice-based evidence.

Counselling and psychotherapy practitioners have long been calling for a more pluralistic approach to the evaluation of psychotherapy practice (Howard, 1983). In particular, greater emphasis on practice-based evidence (PBE) is advocated, recognising the fact that therapists' expertise develops from direct clinical experience (Martin, Slemon, Hiebert, Hallberg, &

Cummings, 1989). PBE pools this knowledge and is a rich source of learning for fellow professionals, as well as informing future research efforts (McLeod, 2001). Along similar lines, Barkham & Mellor-Clark (2003) advocate a bidirectional program of psychotherapeutic research incorporating both EBP and PBE.

5.4.2.1   *Practice-based evidence for MUS.*

Despite these calls to action, only a handful of qualitative studies have explored therapists' experiences working with patients with MUS. Luca (2010, 2011) used grounded theory to conduct research among experienced therapists working with MUS patients in the NHS, exploring how they conceptualise MUS and the interventions they employ. The research tackles an important topic in this area. Given the myriad of different theories regarding the aetiology of this problem (Van Ravenzwaaij et al., 2010), conceptualisation of MUS presents a formidable challenge for practitioners, both conceptually and clinically. Luca found that therapists employing either CBT or psychodynamic modalities tend to conceptualise MUS utilizing a combination of "top-down theoretical concepts" (derived from training) and "bottom-up experience-driven'" concepts (derived from practice). Therapists of both orientations espoused both common and modality-specific conceptualisation concepts, and often borrowed concepts from each others' modalities, thus highlighting the importance of working flexibly and integratively with this patient group.

Looking more closely at Luca's explication of the bottom-up experience-driven conceptualisations, the "*concrete*" and "*difficult and complaining*" nature of MUS patients is highlighted, together with their resistance to linking physical symptoms with psychological experiences. Previous research has highlighted how doctors struggle to be empathic with these patients (Epstein et al., 2006; Salmon, Ring, Dowrick, & Humphris, 2005). It is notable, therefore, that experienced therapists are not immune to these same challenges with empathy. However, it seems incongruent with other research which has suggested that MUS clients are willing to discuss the psychological aspects of their condition provided that their physiological suffering is validated (e.g. Salmon et al., 2005). Also, one is left grappling with the question of how clinicians can therapeutically address, or work in the context of patients' difficult and complaining behaviour.

An interesting study by Burbaum et al. (2010) explored the interactional dynamics between therapists and MUS patients, perhaps shedding some light on the problems highlighted by Luca. Using a conversation analysis framework (Sacks, Schegloff, & Jefferson, 1974), the authors performed a detailed microanalysis of 144 reattribution-oriented therapy sessions (Goldberg, Gask, & O'Dowd, 1989). They found that patients found even subtle reattribution-oriented suggestions as "face-threatening" and used defensive linguistic strategies to undermine the

process. They concluded that therapists should approach this in a patient-centred rather than a persuasive way.

McLeod (2001) has observed that qualitative methods examining conversational dynamics (similar to the above) have shown how therapists can exert considerable control over sessions, highlighting the importance of such research techniques for providing feedback that can promote user-friendly and empowering practice. Alluding to similar ideas, van Ravesteijn, van Dijk, & Lucassen (2011) contest the notion that an active reattribution strategy, however carefully implemented, can be patient-centred. Based on their work using mindfulness with this patient group, the authors suggest that patients respond more favourably to treatment that is sensitively positioned as "training" rather than therapy, noting that patients often develop their own psychosocial attributions as training unfolds.

5.5   The issue of patient engagement in psychotherapy

A significant barrier to the provision of psychotherapy for MUS is patients' reluctance to engage with psychological treatment in the first place. Psychotherapy motivation is significantly lower among individuals diagnosed with somatoform disorders compared with other "psychiatric" conditions, and that patients frequently reject referrals, or drop out early (Schneider, Beisenherz, & Freyberger, 1990). This is problematic, given that somatic symptom improvement is predicted by positive initial expectations and active engagement (Timmer, Bleichhardt, & Rief, 2006). An influential concept pertaining to patient engagement is the notion of the therapeutic or working alliance (Bordin, 1979). This concept has psychoanalytic origins and builds on the work of Greenson (1967), who noted the distinction between the transference relationship and the real relationship, suggesting that is it the latter that allows the therapist and clients to unite against the client's pain and self-defeating behaviour. Building on these insights, Bordin (1979) developed the concept of the working alliance arguing that this is what makes it possible for a patient to accept and follow treatment. Growing attention to the role of "common factors" in promoting treatment gains across different therapeutic modalities led to the development of a scale measuring the working alliance. The Working Alliance Inventory (WAI: Horvath & Greenberg, 1989) measures three different facets of this construct - bonds, tasks and goals. It very much captures a sense of a mutuality and collaboration between the clinician and the patient and could therefore be seen as intimately related to patient engagement. The high dropout rate observed amongst patients with MUS who undertake psychotherapy suggests that there may be significant challenges in building and/or maintaining a positive therapeutic alliance with these patients.

5.5.1 Strategies to improve patient engagement via GPs.

Chianello (2010) notes that doctors play a central role in influencing patient motivation during the consultation process through their endorsement of specific treatments (Di Blasi, Harkness, Ernst, Georgiou, & Kleijnen, 2001). However ultimately, patients' responses to referral depend on the meaning they attach to this. Barsky & Borus (1999) suggest that referral poses a threat to MUS patients because it is incongruous with their self-concept, a claim substantiated by various qualitative studies (e.g. May, Rose, & Johnstone, 2000). Extending this idea, Chianello suggests that referral generates cognitive dissonance, and that therapy is rejected to resolve this aversive state. Chianello designed a simulated enhanced consultation script to overcome the recognised barriers to engagement. Grounded in the literature, it addresses the key sensitivities of patients with MUS. Firstly, it explicitly challenges dualistic thinking, emphasising a multidimensional understanding of MUS. Secondly, it dispels the myth that therapy referral implies that symptoms are not real (Kirmayer, 2000). Thirdly, it positions therapy as a means to help patients cope with their symptom-related distress, regardless of aetiology. Finally, the doctor explicitly endorses the value of therapy and allays patients' fears of medical abandonment (Kirmayer, 1994). When tested experimentally against a control consultation script (usual care), the enhanced consultation script was found to increase motivation in four out of the five of measures of motivation employed (with a medium effect size), an impressive result for a simulation study. The study highlights issues that are highly relevant for practitioners working psychotherapeutically with MUS patients. Therapists who are attuned to the sensitivities addressed by Chianello may be more effective in promoting engagement during the early stages of psychotherapy. In addition to the above, it is known that a medically unexplained diagnosis can evoke considerable distress (Rhodes et al., 1999), and explicit acknowledgement and reflection on this may be helpful to patients. There is of course a distinction between a diagnosis, which may confer legitimacy or otherwise, and understanding, which may promote acceptance. Given that patients with MUS are highly sensitive to the issue of aetiology, sensitive formulation with patients suffering MUS may be crucial.

5.5.2 Lessons learned from the doctor-patient relationship.

Therapists trying to engage patients with MUS in psychotherapy can also learn from the MUS doctor-patient literature, particularly studies of consultation which have dispelled some myths about these patients. For example, several studies have shown that MUS patients will openly discuss psychological issues with a little encouragement (Peters, Stanley, Rose, & Salmon, 1998; Salmon et al., 2005). In fact, patients often do present clues about relevant psychological factors although doctors often fail to engage with them (Salmon, Dowrick, Ring, & Humphris, 2004). Doctors often experience highly negative emotions working with patients with MUS,

characterising them as "*difficult*" and "*frustrating*" (Hahn, 2001). Often infused with conflict, the relationship has been characterised as a power struggle or a contest for authority (Salmon, 2007). Dualistic attitudes fuel this opposition as patients try to preserve their self-concept by reinforcing a somatic explanation for their symptoms. Some patients may escalate their symptom reporting or engage in doctor shopping to try to diagnose their assumed medical illness (Dowrick, Ring, Humphris, & Salmon, 2004). However, various studies show that doctors can actively contribute to the tension due to their lack of empathy (e.g. Epstein et al., 2006). Often ill-equipped to manage MUS patients, they can also sometimes be drawn into collusion, which can backfire by undermining the patient's confidence in their doctor's expertise (Hartz et al., 2000; Salmon, Peters, & Stanley, 1999). Employing a biopsychosocial framework from the outset may help to avoid this tension (Edwards, Stern, Clarke, Ivbijaro, & Kasney, 2010).

Clinician researchers who specialise in this area note that challenging dynamics may also occur in therapy, including emotional avoidance, distancing and criticism, or alternatively, "clinging and claiming" behaviour (Luyten et al., 2012; Maunder & Hunter, 2004). Psychoanalytical theoretical concepts can be used to conceptualise the challenging relational dynamics described above as a re-enactment of childhood conflicts, played out during consultation sessions. Both parties may contribute to these difficult dynamics. As previously noted by Ciechanowski, Walker, Katon, & Russo (2002), professionals working with patients with MUS should consider their own contribution to spiralling negative dynamics.

5.6   Summary, conclusion and research question

This review highlights that no single, universally accepted, and empirically supported model of MUS currently prevails. Both CBT and psychodynamic perspectives contribute to understanding different aspects of this complex problem. There is a growing body of evidence suggesting links been MUS and problems with affect regulation, interpersonal functioning, and associated stress system dysfunction. To date, however, MUS treatment trials have largely focused on brief CBT interventions. By and large, these have been found to be only moderately effective. Relatively few qualitative treatment studies have been conducted, so little is understood about therapists' or patients' experiences of CBT for MUS, or how the work or the experience could be improved. Given the modest effects of treatments evaluated to date, there is a clear, urgent need for new more effective treatments for MUS. According to Witthölf & Hiller (2010), cognitive interpersonal therapies delivered by specialist therapists offer the greatest potential for treating MUS. Although the evidence is limited, controlled trials suggest that brief dynamic approaches may have potential. There is developing evidence supporting the potential of ISTDP and a strong theoretical rationale for trialling DIT.

Irrespective of the treatment model, the literature suggests that psychotherapeutic treatments for MUS can often fall at the first hurdle as patients with MUS are often reluctant to engage with talking therapies per se, and often drop out early. Although research has explored ways in which GPs can improve patient's engagement in psychotherapy for MUS, no research has specifically explored how therapists try to engage these patients. Therefore, this research will seek to address the question of how clinicians promote therapeutic engagement in brief (psychodynamically informed) individual therapy for MUS, as well as exploring implications for practice.

6   Reflexive statement (part 2)

Reviewing the MUS literature was a very challenging exercise for me, both personally and intellectually. In view of my personal experience of MUS I had to work hard to adopt a non-defensive stance towards the material. It would have been easy to uncritically accept perspectives that were consistent with my own prior or preferred understandings, and/or to defensively reject perspectives that may seem unfamiliar or threatening (e.g. some psychoanalytic material). Prior to conducting the review I had little knowledge of psychodynamic theory and my relationship to this modality was somewhat ambivalent. My impression was that psychoanalytic theory was rather dark and pathologising, focusing on the "bad" in people, and overlooking their strength and resilience. However, I was also curious to know what it could contribute to my understanding of MUS and to my ongoing clinical practice. Appreciating my own ambivalence and sensitivity to this topic, I applied principles of phenomenology to the review process. I endeavoured, as far as possible, to "*bracket-off*" (Smith, Flowers, & Larkin, 2009, p. 13) my own personal understandings of MUS and focus on how different authors/clinicians make sense of the phenomenon. I monitored my emotional reactions to the material and examined these in my reflective journal and in personal therapy.

As expected, some of the older psychoanalytic material felt difficult to process both intellectually and emotionally. I found myself bristling at some psychoanalytic conceptualisations of MUS, for example as; a defensive regression to primitive (pre-verbal) psychic functioning (Schur 1955), a somatic expression of unconscious conflict between aggressive, sexual and dependency needs and a punitive superego (Mintz, 1995), or a "latent psychotic state" or "psychotic island" (Rosenfeld, 2001). Experiencing feelings of confusion, suspicion, and irritation at times, I persevered and stayed with the struggle to transcend the off-putting language and find psychoanalytic ideas that I could digest. Some of the ideas I came across resonated quite powerfully, already being part of my own personal formulation, for example, the hypothesised links between MUS and self-critical perfectionism (Luyten et al., 2011, 2012, 2013). I have gradually come to accept that my drive to achieve, conscientiousness, and tenacity, have most likely played a strong contributory role in my MUS experience, especially when these tendencies have been blocked by situations that are outside of my control.

Conducting the review has made me more fully aware of my own more slightly more positivistic leanings, relative to my chosen profession. Having studied sciences earlier in life I am fairly strongly rooted in the scientific tradition. In my former marketing research career I managed many quantitative and experimental research studies. I admit that I have a tendency to feel suspicious of theories that cannot be proven or tested, and can struggle to absorb material until I am satisfied that I fully understand and accept its basic principles. As I scanned the

literature I noticed that I was naturally drawn to biopsychosocial models of MUS. Given how much remains unknown about MUS, I am wary of the temptation to designate anything medically unexplained as purely psychological. Biopsychosocial models of MUS appeal to me because they acknowledge the complexity of the MUS phenomenon, and therefore converge with my own preconceptions. I also noticed that I found it easier to digest the contemporary psychoanalytic literature compared with classical psychoanalytic ideas about MUS. With hindsight, this was perhaps because the main contemporary models which I reviewed (the embodied mentalisation approach of Luyten and the ISTDP model of Russell and Abbass) were both biopsychosocial models. Both integrated the latest findings from affective neuroscience and stress neurobiology, as well as attending to the social/relational dimensions of the problem.

I was relieved to see evidence of a marriage between psychoanalytic perspectives and the comfort and safety of "hard science" and empirical research. Rightly or wrongly, this link somehow satisfied my insatiable thirst for "proof" enabling me to open up my mind to these ideas. Scepticism was a factor that led me to be somewhat resistant to psychoanalytic ideas in the first place. However, I am aware that this scepticism has softened during the course of my training and research, driven largely by my personal and clinical experiences. Although I have evolved considerably over the years reflecting my gradual move towards qualitative and exploratory research later in my career, some remnants of my hard science background remain influential. It is perhaps this history and evolution that shaped my decision to select a realist constructionist framework for my research, marrying critical realist ontology and constructivist epistemology (see section 7). In a way, I was/am perhaps seeking to hold onto the best of both positions.

During the review process I was struck by the multiple connections between contemporary cognitive and psychoanalytic perspectives on MUS. I was left with the impression that they are much more complementary that I had assumed, despite focusing on different levels of analysis (macro/maintenance versus micro/cause, etc.). Conducting this literature review opened my eyes to the richness of contemporary psychoanalytic theory. I was left with the strong impression that different aetiological and treatment models of MUS can all contribute to understanding and treating different facets of the problem. It marked a turning point in my professional development, supporting my ongoing development as a pluralistic and integrated practitioner.

7 Method

7.1 Research context

The research was conducted in the City & Hackney Primary Care Psychotherapy Consultation Service (PCPCS), a service which works with patients with complex needs who are either ineligible or have difficulties engaging with other services (Carrington et al., 2012). Nearly half the patients accessing the service have moderate to severe and chronic MUS-related problems. The patients referred to the service typically have highly complex presentations involving unexplained physical symptoms, co-existing and potentially related mental health issues (including personality disorders), as well as challenging social problems (Carrington et al., 2012). The service offers therapy and consultation services that are informed by psychoanalytic and systemic principles. The author completed a clinical placement in the above service during her second year of training; however, the proposal for this study was developed prior to commencing this clinical placement. It was approved as a service evaluation study by the Risk and Governance Advisor for the Tavistock & Portman NHS Foundation Trust, in agreement with the service lead (see Appendix 1, p. 135). For this reason, it was not necessary to seek NHS authorisation via the Integrated Research Application System (IRAS). University ethics approval was granted for the study in February 2013 (See Appendix 2, p. 136).

7.2 Research methodology

7.2.1 Choice of qualitative methodology.

The aim of this study was to elicit clinicians' perspectives on how the process of engagement unfolds during therapy. In line with the open-ended and exploratory nature of this research, a qualitative methodology was considered most suitable. Qualitative methods are considered valuable for exploring complex health interventions, such as psychotherapy (Oakley, Strange, Bonell, Allen, & Stephenson, 2006). The rich and detailed data that emerge can provide unique insights into the process of psychotherapy, highlighting the impact of individual differences and contextual factors (see review by Hodgetts & Wright, 2007). Within Counselling Psychology, practice-based-research is considered a valuable source of input to inform clinical practice (Barkham & Mellor-Clark, 2000). The participants in this study have significant expertise in relation to MUS gained through specialist clinical practice, supervision and interaction with colleagues. This study synthesises their collective expertise in relation to the topic of patient engagement.

7.2.2   Selection of qualitative method.

A grounded theory (GT) approach was selected for this research as this qualitative method is most explicitly oriented to understanding process and change (Willig, 2010). First introduced by Glaser & Strauss, (1967), GT was heavily influenced by symbolic interactionism (Blumer, 1969). According to this perspective, social realities are a product of a dynamic process of human participation and negotiation, which is itself shaped by individual's interpretations of events. Reflecting this, GT has been explicitly developed to be sensitive to the dynamic properties of situations. Unique among qualitative methodologies, GT provides a set of procedures which promote the development of a theory about the process under investigation (Chamberlain, Camic, & Yardley, 2003). The method includes analytical coding paradigms that consistently sensitise the researcher to underlying processes. The output of GT extends beyond a thematic categorisation of data to deliver a theoretical model which attempts to best show the key dynamic processes. Grounded in the data, the output of a GT study should be relevant to its participants and fit the context in which it is researched (Chamberlain et al., 2003). The aim of the study was to create a theoretical framework for thinking about the problem of therapeutic engagement, with clear, practical relevance for practitioners working in this area.

7.2.3   Ontological and epistemological assumptions.

This research has embraced a realist constructionist stance (Elder-Vass, 2012), marrying a mild social constructivist epistemology (Berger & Luckmann, 1966) with a critical realist ontology (Bhaskar, 1998, 1975). The a-priori assumption was that there is a "truth" to be known (that engagement is a "thing" to be studied). However, it was acknowledged that this truth can only be partially known, being inevitably influenced by the lens through which it is examined. Critical realism proposes that social events are caused by multiple interacting causal powers, including the power of individuals as well as social structures (Bhaskar, 1998, 1975). Realist constructionism is sympathetic to the social constructionist view that knowledge is created through language, discourse and culture, however it also departs from this in viewing the latter as products of interacting causal powers, and also potentially as causal forces themselves (Elder-Vass, 2012). In embracing a mild social constructionist epistemology, it is acknowledged that all perspectives are to some degree biased and fallible. From this perspective, it is optimal to seek multiple data sources and perspectives and to use *triangulation* (Patton, 1999) across these to identify (as far as is possible) the truth, accepting that this is always provisional. In line with the spirit of GT, analyses have been assiduously grounded in the data supplied by participants. "Objectivity" was pursued in the sense of privileging participants' accounts (Strauss & Corbin, 1998), whilst also acknowledging the inevitable shaping influence of the researcher's own pre-existing perspectives.

7.2.4   Choice of grounded theory paradigm.

In this section, the choice of GT paradigm is considered. The proliferation of numerous competing GT approaches makes this a daunting method for a naïve grounded theorist. Mills, Bonner, & Francis (2006) recommend that grounded theorists select from the variety of procedures documented, to match their own preferences and positioning. As a committed methodological pluralist (Howard, 1983), this resonated with the author's own inclinations. Prior to conducting the research, the author read key texts in classic GT (Glaser, 1978; Glaser & Strauss, 1967) and constructivist revisions (Charmaz, 2006; Corbin & Strauss, 2015; Strauss & Corbin, 1990, 1998) in order to try to grasp the essential principles of the process. Although there are clearly differences between the different variants of the method, significant overlaps were also apparent.

Although the author was attracted to certain qualities of classic GT, Glaser's emphasis on "discovery" has strong positivistic connotations (Willig, 2010) and was incompatible with the author's own constructivist epistemological position. In addition, Glaser's texts seemed rather vague in terms of specifying how to follow the method (Bluff, 2005). Finally, Glaser strongly advocates postponing the literature review on the basis the preconceptions will inhibit the discovery process (Glaser, 1978, 1992, 1998). The notion that avoiding a literature review will eliminate preconceptions has been disputed, especially if a study is being conducted in the researcher's own professional domain (Bluff, 2005). The author agrees with the constructivist position the researcher's professional discipline, theoretical proclivities, and familiarity with the literature can enhance theoretical sensitivity. As noted by Dey, "*there is a difference between an open mind and an empty head*" (Dey, 1999, p. 251). In a similar vein, Strauss argues that pre-existing knowledge can facilitate data collection (Strauss, 1987), which is why he advocates semi-structured interviews over unstructured interviews (Bluff, 2005).

In choosing a constructivist approach the author had a number of options. Although, Charmaz is viewed as the "champion" of constructivist GT, as noted by Mills, Bonner & Francis (2006), there is a "*discernible thread of constructivism*" in Strauss & Corbin's approach (p. 1). Reflecting this position, Corbin states that researchers construct concepts and theories based on stories constructed by participants to make sense of their own experience (Corbin & Strauss, 2015). In the end, the specific constructivist approach chosen was based on the author's own personal analytical style and how well the different texts resonated with this. Strauss & Corbin (1990, 1998) purposefully set out to provide more detailed explication of the procedures involved in GT. Their approach has been criticised by some for being overly structured (Pidgeon, 1996), however, the author was attracted to the clarity of their guidance and their helpful analytic procedures. For example, *axial coding* helps the researcher to attend to context,

process and change (see 7.6.3), and the *conditional/consequential matrix* helps to orientate the researcher to the macro and micro level conditions that influence actions and interactions (Strauss & Corbin, 1998). Finally, the author found that Strauss & Corbin provided the clearest guidance for theoretical integration through their selective coding procedure (see 7.6.4), a process which seemed to be only vaguely articulated in Glaser's account of theoretical coding (Glaser, 2005). Strauss & Corbin's emphasis on constructing a core category appealed to the author's desire to generate a clear and parsimonious explanatory framework (Strauss & Corbin, 1998). Some argue that identifying a core category is essential to move from description to theory (Hutchinson & Wilson, 2001).

Charmaz has criticised Strauss & Corbin's analytical tools as being constraining and cumbersome (Charmaz, 2000, 2006, 2008a), however the author perceived these as useful tools to support the theory construction process. In any case, it was Strauss & Corbin's intent that their tools be used flexibly and creatively rather than a dogmatic and rigid way (Mills, Bonner, & Francis, 2006). As Charmaz herself states, GT offers flexible guidelines, not rigid rules or prescription (Charmaz, 2006). In applying Strauss & Corbin's ideas, the researcher has very much embraced this spirit.

7.3 Conceptual frameworks

This research has been shaped by several conceptual and theoretical frameworks. Firstly, it is underpinned by the biopsychosocial model of health and illness (Engel, 1977, 1982). Engel introduced the biopsychosocial model as an alternative to the biomedical model which he criticised as mechanistic, reductionist, and dualistic. Engel advocated a more holistic and integrated approach in which health and illness are seen to reflect the dynamic interaction between biological, psychological and socio-cultural factors. Drawing on systems theory (Schwartz, 1982), he asserted that all levels of the system are interlinked and will mutually influence one another. From this perspective, health reflects the level of harmony between and within systems. City & Hackney PCPCS could be considered to epitomise the principles of the biopsychosocial framework. Influenced by systemic principles, the service is embedded within the medical system (within GP surgeries) rather than in mental health services, and collaborates closely with other health and social care providers to promote an integrated and holistic approach to patient care. The research is also underpinned by a pluralistic framework with respect to treatment modalities (Cooper & McLeod, 2007; McAteer, 2010). Congruent with a post modern view that no one theory represents a singular truth, a pluralistic framework for psychotherapy respects multiple perspectives and eschews the idea of one optimal model (Cooper & McLeod, 2007). Reflecting the author's own pluralistic stance and the pluralistic orientation of the service hosting the study, the research is influenced by a range of

contemporary relational psychodynamic theories (see Borden, 2009), including object relations theory (Klein, Winnicott and Bion, etc.), attachment theory and mentalisation. In conducting the research, the author has also drawn on her theoretical knowledge from the cognitive behavioural paradigm, where relevant.

7.4   Research design

7.4.1   Overview of the design.

As this study has been conducted as part of a doctoral training program, an abbreviated version of the GT method was used (Willig, 2001). Depth interviews lasting approximately one-and-a-half hours were conducted with nine clinicians from the service who have worked with patients with MUS. In alignment with general GT principles, data collection and analysis were conducted in parallel and interwoven with one another throughout the process. Interviewing was conducted in two stages, between August and September, 2013 and between September, 2015 and January, 2016. The long gap between stages occurred because the researcher intermitted from training between the second and third year, and was unable to continue with research during this period.

All interviews were audio-recorded with participants consent and transcribed verbatim by the researcher to promote data familiarisation (See Appendix 3, p. 137). Data were analysed using the procedures outlined by Strauss and Corbin (Corbin & Strauss, 2015; Strauss & Corbin, 1990, 1998). The technique of *constant comparative analysis* (Glaser & Strauss, 1967) was pursued throughout the process to compare data within and between participants and across incidents, to try to elucidate the key processes involved in engagement. All data analysis was conducted using NVivo 10 qualitative analysis software from QSR International, to facilitate convenient and efficient data management.

In full GT, data collection and analysis proceeds until *theoretical saturation* is reached, that is, nothing new is being contributed to the theory (Glaser & Strauss, 1967). The notion of theoretical saturation has been contested by some qualitative researchers (e.g. Dey, 1999) who argue that *theoretical sufficiency* is a more appropriate aim. This goal seemed more appropriate for this study, given its necessarily limited scope.

7.4.2   Participant recruitment.

A short summary of the proposed study was emailed to all clinical staff in the service (see Appendix 4, p. 142), followed by an informal presentation at a team meeting. Clinicians who expressed an interest in the study were re-contacted to schedule an interview at the PCPCS offices. Written informed consent was obtained before the interview using a structured consent

protocol (see Appendix 5, p. 144). Permission was explicitly requested for the interviews to be audio recorded and transcribed verbatim, and for selected anonymised verbatim comments to be used in the thesis and any further publications, for illustrative purposes. After providing informed consent, clinicians took part in a semi-structured interview (See Appendix 6, p. 145).

7.4.3   Participant sample.

The sample of clinicians interviewed for this study was relatively heterogeneous. Although all participants expressed a preference for psychodynamic ways of working, they represented a variety of different backgrounds, and included a mix of psychologists and psychoanalytic psychotherapists. This was partly pragmatic, as all participants who were willing to engage with the study were interviewed. However, GT has traditionally encouraged solicitation of multiple different perspectives (Glaser & Strauss, 1967), and it was hoped that the heterogeneous sample would help to shed light on variations in practice that were relevant in terms of engagement. Theoretical sampling (Charmaz, 2006; Strauss & Corbin, 1998) was used to guide second stage interviews. At this point the aim was to locate participants who could help to flesh out under-developed categories and further explore the links between categories where necessary. The sample of participants who contributed to the research is summarised in table 1[3].

Table 1:

Participant Summary Table

	Participants								
Gender	F	M	F	F	F	F	M	F	F
Core Training	MHN	CoP	ClinP	ClinP	MHN	CoP	SW	PC	ClinP
Years since qualification[1]	20	5	4	5	-	1	20	5	2
Additional significant training	PP	-	PP	PP	PP	-	PP	-	Sys
Years since qualification[1]	I/P	-	I/P	I/P	7	-	15	-	1
Years working in the service[1]	3	4	4	4	5	1	5.5	1	2

Note [1]: At the time the interview was conducted
Key: I/P: In progress; ClinP: Clinical Psychology; CoP: Counselling Psychology; MHN: Mental health nursing; PC: Psychodynamic counselling; PP: Psychoanalytic psychotherapy; SW: Social work.

7.4.4   Interview schedule.

As recommended by Strauss & Corbin (1998), a semi-structured interview schedule was created incorporating a series of open questions exploring issues considered relevant to the process of engagement (See Appendix 7, p. 146). The author tried to limit the number of questions in the interview schedule in order to ensure that her own ideas and preconceptions did not dominate the agenda. Holding in mind these topic areas, an attempt was made to take the lead from the

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[3] This table has been included to give the reader a sense of the sample composition. The participant identifiers have been removed to protect the confidentiality of the study's participants.

participants, as far as possible, in terms of what they considered relevant to this topic. As noted by Charmaz (2006), the researcher's interests, professional perspective, and sensitizing concepts (Blumer, 1969), provide only a point of departure for the research, not an end per se. In the spirit of taking the lead from her participants, the author invited participants to define central concepts, including their understanding of the term MUS and the concept of therapeutic engagement itself, and used their constructions to guide the research process. As recommended in GT, the interview schedule was revised iteratively as the data collection and analysis unfolded, especially during the second stage of interviews when the analysis was starting to take shape (see Appendix 8, p. 148). This allowed attention to refocus towards categories or concepts that required further exploration and elaboration, as the research proceeded.

7.5   Ethical considerations

No significant risks were anticipated with this study other than the possibility that clinicians could potentially worry about being evaluated. To mitigate this, the researcher worked collaboratively with clinicians to ensure that they were appropriately briefed and debriefed about the aims of the study, and of the provisions made to ensure their confidentiality (see Appendix 9, p. 150). Data management for this project was in full compliance with NHS data protection regulations and a trust confidentiality agreement was signed by the researcher (see Appendix 10, p. 152).

7.6   Analytical procedure

7.6.1   Open coding.

The analytical process began with a process of open coding (Strauss & Corbin, 1998), which commenced as soon as the first interview had been transcribed. After reading each transcript fully several times, the researcher worked through it in detail, reading line-by-line, and breaking the data down into individual meaning units. Segments of the text were labelled with initial codes, indicating the idea or concept referred to in that data fragment. Following universal grounded theory principles, an attempt was made, where possible, to embed action in the codes (Charmaz, 2006; Glaser, 1978). Through *microanalysis* of the data fragments, a flexible analytic stance to the material was pursued, for example, being mindful of "taken-for-granted" assumptions about the data, and asking questions to see what else it might be communicating (Strauss & Corbin, 1998).

7.6.2   Category and concept formation.

After completing open coding for the first five interviews (stage one), a detailed process of comparing codes was conducted. Initial codes with similar meaning were clustered to develop

lower-level theoretical concepts. This process was then repeated over and over to develop higher-level theoretical concepts. This process of constant comparison was conducted throughout the research until the highest level theoretical categories were constructed. As the analysis proceeded and higher-order concepts and categories were constructed, the lower-order concepts became the properties that defined each category and its dimensions (Strauss & Corbin, 1998).

7.6.3 Axial coding.

Once some initial concepts were constructed, axial coding (Strauss, 1987) was introduced in parallel with the above clustering process, to explore the links between different concepts. Following the spirit of the *paradigm* recommended by Corbin & Strauss (2015), the researcher engaged in constant questioning and thinking about potential linkages (explicit or implicit) between concepts and categories. This involved distinguishing between *conditions*, *actions/interactions* and *consequences* in order to sort and arrange the concepts during the process of analysis (pp. 158-159). These linkages were documented in memos throughout the research process. After the first stage of interviewing and analysis, the researcher took stock of the analysis status, and created an initial tentative model to capture the analysis so far. This exercise informed the second stage of the research, shaping both the theoretical sampling process and the emerging interview schedule. From that point onwards, the researcher then engaged in *focused coding* (Charmaz, 2006), selectively focusing subsequent coding activities on the concepts and categories constructed in the initial model, in order to further elaborate and saturate these categories.

7.6.4 Selective coding (theoretical integration).

In the final stage of analysis attention was focused on what Strauss & Corbin (1998) termed *selective coding*, which represents the process of integrating and refining the categories to construct the theory. According to Strauss & Corbin, a key step in integration is locate a super-ordinate core category which represents the major theme of the research and which can pull all the other categories together into a coherent framework. The core category should be abstract enough to integrate all the other categories and should capture what the research is all about (Bartlett & Payne, 1997). A range of approaches recommended by Strauss and Corbin were used to facilitate the process of integration, including; writing the storyline, re-writing the storyline in terms of categories, use of diagramming, and memo reviewing and sorting.

7.6.5 Memo writing.

As recommended by Charmaz (2006), throughout the study memos were written to capture the emerging analytical process (see Appendix 11, page 153). The nature and quality of the memos

evolved as the analysis proceeded. Earlier memos captured thoughts and reflections on codes which stood out and documented hypothesised links between lower-level concepts, and questions about these links, in order to shape the basic category formation process. As the study proceeded, the memos increased in their level of theoretical abstraction, documenting higher level linkages between categories and their properties. In addition to written memos, visual and diagrammatic memos were created to help capture the researcher's emerging understanding of the data.

7.7   Research rigour and credibility

A variety of measures were taken to evidence the rigour of this work.

7.7.1   Audit trail.

In addition to regular supervision meetings to discuss ongoing analytical ideas, an audit trail was developed to document the construction of one of the early categories of the initial model. This involved producing a summary of one category, including all its layers of sub-categories, down to the initial codes and the underlying data (see Appendix 12, p. 156). This was reviewed by the researchers' supervisor and a peer to ensure that the analytical codes made sense and were justifiable, in relation to the underlying data. Some qualitative authors (e.g. Lincoln & Guba, 1985) view auditing as the single most important approach to evaluate the trustworthiness of qualitative research.

7.7.2   Self-reflexivity and transparency.

Constructivist approaches emphasise reflexivity, so that researchers are transparent about their position and its potential influence on the analytical process (e.g. Charmaz, 2006). Throughout the research, the author has maintained a reflective journal to capture her own influence on the research process and to provide space for "*bracketing*" reactions to the data (Smith, Flowers & Larkin, 2009, p. 13). For the sake of transparency, key observations are documented in three reflexive statements (see sections 4, 6 and 11).

7.7.3   Peer supervision.

Alongside formal supervision, the researcher has engaged in informal supervision with peers who were also doing GT. This helped to clarify any areas of confusion and to redirect the research process at inevitable "stuck" points.

7.7.4   Member checking.

Some qualitative authors recommend *member checking* as a validation procedure (Creswell, 1998). This involves giving a copy of draft results to a participant to enquire if the analysis

captured their experience. Although this option was considered, in the end a decision was made not to do this by the researcher, with the help of supervision. The rationale for this decision was that the analysis was abstracted from multiple accounts and was not therefore expected to "give voice" to individual participant accounts. However, the author presented her results to the service in December, 2016 and in feedback elicited afterwards, one of the participants stated "*this absolutely reflects what we try to do*", illustrating that the research had resonance for the participants who contributed. In addition, selected quotations from the raw data have been included in the results section to illustrate the grounding of the analysis.

8   Results of analysis

This chapter outlines the results of the GT analysis. Session 8.1 introduces the conceptual model which is also depicted graphically in figure 1 (p. 53). It provides a summary of the major categories that constitute the model and their interrelationships. Section 8.2 illustrates the model's analytical foundations through a detailed explanation of its constituent sub-categories. Illustrative verbatim quotations are provided for each sub-category to demonstrate the grounded nature of the analysis. For clarity, a table of the major categories and sub-categories is included documenting the participants who contributed to each one (see table 2, pp. 55-56).

8.1   Introduction to the model

This model provides a framework for understanding the process of therapeutic engagement of patients with MUS, and how clinical practitioners seek to address this. As shown in figure 1, it contains seven high-order categories, four that specify the unique contextual factors underlying this process (categories 1-4) and three that address the stages of the engagement process (categories 5-7). Above these lies the core category "negotiating disconnection" which is the over-arching abstract category that was constructed through the analysis. As the core category, negotiating disconnection integrates the seven higher-order categories within the model. Considering the contextual categories firstly, category 1 "primary care system orientation to MUS" and category 2 "service orientation to MUS" represent the systemic conditions that seemed pertinent to the issue of therapeutic engagement. Category 3 "patient orientation to therapy for MUS" and category 4 "clinician orientation to therapy for MUS" represent the basic orientation of both participants within the therapeutic dyad towards therapy. Together, these four contextual categories formed a crucial part of the analysis to the extent that they provided the foundations for identifying, at the most abstract level, the core concern of clinicians who are working with these patients, namely the "dilemma of disconnection" (see section 8.1.1.5 below). The remaining three categories of the model (categories 5-7) focus on the process of therapeutic engagement. These categories, "drawing in" (category 5), "meeting patients where they're at" (category 6) and "nudging forward" (category 7), represent the core strategies that participants seem to use to engage these patients. These could loosely be considered as stages of the engagement process in that each is negotiated in sequence. However, the analysis suggested that this was not considered a linear process as the behavioural strategies associated with "meeting" and "nudging" are expressed throughout therapy, and could therefore also be considered as different modes of relating to the patient. The core category has been labelled negotiating disconnection because clinicians seem to be continually seeking to resolve different types of disconnection in order to engage these patients. Thus, negotiating disconnection might be considered the fundamental behavioural strategy, in abstract terms.

8.1.1 Exploring context (categories 1-4).

This section introduces the first four categories that define the unique and specific context of this research. In constructing these categories, attention was directed to the specific characteristics and differences that were considered most relevant to the process of engagement, for this specific patient group, and within this specific service context.

8.1.1.1 Category 1: "Primary care system orientation to MUS".

This category represents the conditions in primary care general practice that seemed to be most pertinent to therapeutic engagement. Participants perceived that GPs have a central role to play in managing patients with MUS in primary care. However, they had the perception that GPs can really struggle to manage these patients, and may, themselves, unwittingly contribute to engagement difficulties, because of difficulties that they experience managing their relationships with these patients (sub-category 1.1: "The central role of the GP-patient relationship"). For patients with severe and chronic MUS, there may be a long history of difficulties in the doctor-patient relationship, including problematic dynamics of collusion or conflict. This can negatively impact a patient's perspective on their problem and their attitude to seeking help through the health system. Within this service context, many referrals are made by GPs who struggle to manage difficult doctor-patient dynamics, frequent GP attendance, and repeated demands for medical tests. In other words, the impetus for the referral comes from the GPs and the problem foregrounded is often the patient's health-seeking behaviour. However, patients who feel physically ill may view their health seeking as a rational response to their situation. Linked to this, the referral process was also seen to be highly pertinent to engagement (sub-category 1.2: "GP management of the referral process"). Participants' accounts suggested that GPs vary in how well they handle the referral process in terms of sensitivity, transparency and clarity, and this was seen to be critical in terms of whether patients attend psychotherapy assessments, and how they present.

8.1.1.2 Category 2: "Service orientation to MUS".

"Service orientation to MUS" illustrates the characteristics of the service context that are most crucial with respect to engagement, including the service's specialist positioning focusing on "hard to engage" patients (sub-category 2.1), its accommodating policies and procedures (sub-category 2.2) and its psychoanalytic and systemic orientation (sub-category 2.3). Participants stressed that the service remit is to work with hard-to-engage patients and that engagement is, to a large degree, its raison-d'être. In line with this positioning, participants reported that most clinicians recruited to the service had significant prior experience working with other hard-to-engage groups. They also noted that the service has embraced a range of accommodating

Engaging patients with MUS through continual, genuine empathic orientation to understanding and resolving barriers to connection, including mind-body dualism in self and other

1) Primary care orientation to MUS

Central role of GP , MUS referral process

4) Clinician orientation to therapy for MUS

Engagement beliefs and orientation
Person/process led versus theory/task-led
Holism versus tacit dualism
Cultivated sensitivity to MUS

Theoretical guiding frameworks
Learning through experience

GP-clinician relationship

Negotiating disconnection

4.1.1 Initial attendance

4.1.2 Initial engagement

6) Meeting

5) Drawing in

7) Nudging

4.13 Real engagement

2) Service orientation to MUS

Remit, culture, policies

GP-patient relationship

3) Patient orientation to therapy for MUS

MUS embeddedness
Emotional reactions to referral
Complexity alongside MUS
Self-sabotaging behaviours
Psychological deficits
Signs of (dis)engagement

Patient developmental history
History of interactions with the health system
Socio-cultural factors

Figure 1: Negotiating disconnections: A grounded theory model of the process of therapeutic engagement of patient with "medically unexplained symptoms"

policies and procedures designed specifically to promote engagement, including flexible referral and discharge procedures, proactive engagement efforts, and a commitment to systemic and partnership working. Reflecting the service culture, the service attracts clinicians who are orientated to psychodynamic and systemic ways of working. This context is important as it means that clinicians gravitate more strongly to psychodynamic, emotional and relational understanding of patients' problems, which may be more or less helpful, depending on how sensitively these perspectives are negotiated with patients. The ways in which individual clinicians may differ in this respect is represented in category 4 (see section 8.1.1.4 below).

8.1.1.3   Category 3: "Patient orientation to therapy for MUS".

This category and its constituent sub-categories represent how patients' attitudes towards their symptoms and their emotional and relational functioning may create multiple interacting barriers to engagement. Analysis suggested that participants perceived a wide variation amongst patients presenting with severe and chronic MUS. For this patient group, the factors that were perceived to be most pertinent to engagement included the patients' beliefs about the nature of their symptoms and its possible relationship with psychological factors (sub-category 3.1), the valence and intensity of their emotional reaction to the referral and their willingness to be open about these feelings (sub-category 3.2), the presence and degree of underlying emotional and relational issues that may present barriers to the formation of a therapeutic relationship (sub-category 3.3), "self-sabotaging" therapy behaviours such as getting stuck in "body-talk" (sub-category 3.4), and psychological deficits thought to be related to MUS such as alexithymia and/or mentalising difficulties, especially among patients at the more severe end of the spectrum (sub-category 3.5). Reflecting the unique service context (category 2), all patients referred to the service were deemed hard-to-engage in one way or another. However, participants' accounts suggested that the engagement barriers encountered may be qualitatively different, and more or less challenging, depending on where patients are in relation to the above interacting issues.

8.1.1.4   Category 4: "Clinician orientation to therapy for MUS".

"Clinician orientation to therapy for MUS" explores clinician characteristics that are pertinent to engagement. Clinicians' capacity to engage patients seemed to reflect the interacting influences of their beliefs about engagement, theoretical guiding frameworks, and clinical maturation shaped by prior clinical experience with this patient group. Clinicians' beliefs about engagement played an important role in guiding the process (sub-category 4.1: "engagement beliefs"). Analysis suggested that participants seemed to construe this as a stage-like process involving three key stages each one associated with explicit goals. These stages include: "initial attendance" (sub-category 4.1.1, p. 70), "initial engagement" (sub-category 4.1.2, p. 70) and

Table 2

Summary of categories and sub-categories and contributing participants

CATEGORIES AND SUB-CATEGORIES	PART'S
1 "Primary care system orientation to MUS" (GPs struggle to manage patients with MUS in an over-burdened primary care system and may themselves contribute to engagement difficulties)	12345679
1.1 "Central role of GP-patient relationship" (GPs have a central role in managing patients with chronic MUS but often have a history of difficult dynamics with these patients)	12345679
1.2 "GP management of referral process" (GPs vary in how well they handle the referral process and this was seen to have a critical influence on whether patients attend assessments and how they present)	125679
2 "Service orientation to MUS" (The service has established policies orientated to promoting engaging "hard-to-engage" patients, however, it privileges psychoanalytic understandings of MUS which may be a barrier for some patients)	123456789
2.1 "Hard to engage patients" (The service remit is to work with hard-to-engage patients which creates both freedom and pressures for clinicians)	13456789
2.2 "Accommodating policies and procedures" (The service has embraced a ranged of accommodating policies and procedures designed specifically to facilitate engagement)	4679
2.3 "Psychoanalytic orientation" (The service attracts and recruits therapists who are strongly orientated towards psychoanalytic and psychodynamic ways of working)	123456789
3 "Patient orientation to therapy for MUS" (Patients present multiple interacting barriers to engagement relating to their understanding of their symptoms and to underlying difficulties with personal and relational functioning)	123456789
3.1 "MUS embeddedness" (Patients with MUS can be embedded in their MUS symptoms and fixated on locating their cause. While some may use their MUS as a "ticket to therapy", others may be dismissive or ambivalent about attending therapy)	12345689
3.2 "Emotional reactions to referral" (Patients may experience a variety of negative emotional reactions in response to the referral, especially anger, depending on how this was handled by the doctor, their prior healthcare experiences, and their own psychological vulnerabilities)	1234569
3.3 "Complexity alongside MUS" (Patients with chronic MUS can exhibit multiple facets of complexity alongside their MUS which compound engagement difficulties, including emotional and relational problems such as issues with trust and reluctance to face their past)	12345679
3.4 "Self-sabotaging behaviours" (Patients may engage in "self-sabotaging" therapy behaviours including excessive compliance, passivity, and/or getting stuck in body talk)	12345689
3.5 "Psychological deficits" (Some patients with MUS can exhibit psychological deficits (lack of skills or functions) which make it hard for them to use an open, reflective space)	234689
3.6 "Signs of (dis)engagement" (Patients show positive and negative signs of engagement throughout the therapy process, including red flags indicating that engagement may be under threat)	123456789
4 "Clinician orientation to therapy for MUS" (Clinicians' training, theoretical guiding frameworks, beliefs about MUS and clinical experience with this patient group influence their capacity to engage these patients)	123456789
4.1 "Engagement beliefs" (Therapeutic engagement was viewed as a multi-faceted concept (multi-level, fluid, relative), but was often characterised in terms of key stages, including "initial attendance", "initial engagement", and "real engagement")	123456789

Table 2 (cont.)

Summary of categories and sub-categories and contributing participants

CATEGORIES AND SUB-CATEGORIES	PART'S
4.2 "Engagement orientation" (Clinician's vary in their orientation towards the process of engagement in terms of their both their motivations, priorities and anxieties, which may affect how well they engage patients at different stages)	134589
4.3 "Person/process-led versus theory/task-led" (Participants described a trajectory in which they evolved from being more psychodynamically purist and theory-led to being more pragmatic, person and process-led, in order to engage patients)	12345679
4.4 "Willingness to use challenging formulations" (Clinicians vary in their willingness to use challenging formulations, some of which may be 'unpalatable' for some patients)	12345678
4.5 "Holism versus tacit dualism" (Participants try to embrace a holistic stance towards patients but tacit dualism can occasionally creep in, especially when patients are highly challenging)	13456789
4.6 "Cultivated sensitivity to MUS" (Clinicians who have significant clinical experience with MUS tend to cultivate sensitivity to MUS-related experiential phenomena which helps them engage patients)	123468
5 "Drawing-in" (Drawing patients in by engaging the system)	1245679
5.1 "GP-clinician relationship" (Clinicians strive to develop strong GP-clinician relationships to tackle systemic disconnection although this is not always easy to achieve)	124679
5.2 "Collaboration about referrals" (Clinicians try to proactively find ways to collaborate effectively with GPs regarding referrals)	125679
5.3 "Supporting GPs" (Clinicians proactively support GPs to help build their confidence in managing patients with MUS, which also strengthens the GP-clinician relationship)	14679
6 "Meeting" (Meeting patients where they are at)	123456789
6.1 "Engaging with patients' experience" (Engaging with the patient's subjective experience, including bodily preoccupation)	123456789
6.2 "Establishing emotional connection" (Using strategies to establish and maintain an emotional connection especially when affect is difficult to access)	123456789
6.3 "Noticing hidden communications" (Being openly receptive to all communications to "see" what is hidden or out of awareness)	1234567
6.4 "Adapting flexibly" (Adapting flexibly to meet the patient and work out what they can make use of)	123456789
6.5 "Addressing initial barriers" (Empathically addressing initial engagement barriers)	123456789
6.6 "Sensitive formulation" (Being highly sensitive about sharing the initial formulation)	23456789
7 "Nudging forward" (Nudging patients towards thinking about both the mind and the body and the links between them)	123456789
7.1 "Fostering body-mind links" (Employing active strategies to foster body-mind links)	135689
7.2 "Digging deeper" (Digging deeper to cultivate connections between MUS and unconscious influences)	23456789
7.3 "Balancing and pacing" (Balancing and pacing therapeutic behaviours to hold an optimal degree of tension)	12356789
7.4 "Addressing process issues" (Managing process issues and self-sabotaging behaviours, including repetitive body-talk)	1234568
7.5 "Managing therapeutic impasse" (Dealing constructively with therapeutic impasse through therapist self restraint and managing negative countertransference)	12345678

"real engagement" (sub-category 4.1.3, p. 71). These stages framed the structure of the model and its conceptual core. In addition, analysis showed that clinicians varied in their orientation to the process of engagement (and its different stages) in terms of their motivations, priorities and their own anxieties, which may affect how effective they are at negotiating the different stages (sub-category 4.2: "engagement orientation"). In addition to engagement beliefs and orientation, category 4 highlights dimensions of difference which appeared to be most relevant to the process of engagement, based on clinicians' accounts of their behaviours in therapy, and the ensuing reactions of their patients. These are represented by the sub-categories "person/process-led versus theory/task-led" (sub-category 4.3), "holism versus tacit dualism" (sub-category 4.5) and "cultivated sensitivity to MUS" (sub-category 4.6). Although all participants espoused a preference for psychodynamic ways of working, analysis suggested that clinicians perceived greater success in engaging patients when they were more pragmatic and person-centred in their approach. Learning from their mistakes, clinicians often recalled "negative engagement events" associated with earlier attempts to work in a more psychodynamically purist or theory-led way. Clinicians mostly embraced a holistic understanding of their patients' difficulties, conveying acceptance that their patients were suffering distress both psychologically and physiologically. However, it was apparent that "tacit dualism" can occasionally creep in, especially when clinicians are feeling highly challenged by their patients. In these conditions, clinicians may be temporarily more inclined to "psychologise" their patients' symptoms and lose sight of their physical suffering, leading to therapeutic ruptures. If these are not detected early enough and proactively addressed, there is a risk that patients will disengage. Finally, more experienced MUS clinicians showed a cultivated sensitivity to MUS related experiential phenomena which seemed helpful in terms of developing and maintaining a strong therapeutic alliance.

8.1.1.5   *Analysis of context: The dilemma of disconnection.*

In GT it is necessary to identify the "core concern" of participants (Glaser, 1998), that is, their central challenge. In this study, the analytic process of constant comparison (across categories 1-4) gradually seemed to point towards the notion of disconnection as a permeating theme, which eventually became central to the model. The disconnections were broad-ranging and operated at organisational, interpersonal and intrapersonal levels, constituting multiple interacting barriers to engagement. Specifically, the research highlighted three types of disconnection: structural disconnections reflecting the dualistic structure of the health system (the separation of physical and mental health services), relational disconnections (between patients and GPs, patients and clinicians, and clinicians and GPs), and intra-psychic disconnections (for example, patients who are disconnected from their emotions, or who fail to link somatic sensations with emotional experience, or emotions with behaviours). These disconnections are represented visually in the layout of the model.

Although issues of disconnection are multi-faceted and interacting, a fundamental aspect of disconnection related to discrepant beliefs regarding the nature and causes of MUS symptoms. Whilst acknowledging great variation, the patients with MUS seen in this service context are typically not seeking help for psychological issues and may have strong beliefs that they are physically ill (category 3). In contrast, when formulating these patients, participants predominantly rely on psychoanalytic frameworks that seek to explain MUS in terms of its causal origins, rooted in emotional or relational disturbances (category 4). The essential dilemma to be resolved is disconnection, born out of the fact that therapy is bringing together two parties who may view a problem from very different perspectives, and have diverging concerns and priorities. The quality and magnitude of the disconnection dilemma that clinicians encounter may vary across individual patient-clinician dyads, reflecting the initial orientation of both parties to therapy, and the quality of the relationships between both the patient and the clinician and the referring GP. The disconnections discussed above interact to create significant barriers to engagement in each of these stages.

8.1.2 Exploring process.

8.1.2.1 The core category: "Negotiating disconnection".

Following the theme of disconnection, the model contributes to understanding therapeutic engagement of patients with MUS by conceptualising this as a process of "negotiating disconnection". As an abstract theoretical construct this core category has the power to integrate all the seven categories of the model, and provides a framework for understanding why and how clinicians approach the task of engagement the way they do. The remaining categories of the model outline the core behavioural strategies employed by clinicians to negotiate disconnections through each of three stages respectively: "drawing in" (category 5), "meeting patients where they're at" (category 6) and "nudging forward" (category 7). How successful this might be may depend on the initial orientation to therapy of both the patient and the clinician (categories 3 & 4), and the actions and interactions that are guided by this. To engage patients, clinicians need to successfully navigate the different stages of the process, applying the skills and knowledge gained from their prior work with MUS patients, and from clinical work with other hard-to-engage patient groups. However, success also depends on how patients respond to clinician's interventions, which will be influenced by their own initial orientation to therapy (as depicted in category 3), which in turn, may be influenced by systemic issues. Categories 5-7 are summarised briefly below.

8.1.2.2   Category 5: "Drawing in patients by engaging the system".

"Drawing in" highlights the activities described by participants that are oriented towards the goal of getting MUS patients through the door and into an assessment (see sub-category 4.1.1: "initial attendance", see p. 74). Reflecting the ethos and principles of the service, participants emphasised the importance of thinking about therapeutic engagement in a systemic way. The category suggests that clinicians try to negotiate disconnections within the health system by making proactive efforts to "engage the system" through striving to form strong, collaborative working relationships with GPs (sub-category 5.1: "GP-clinician relationship"), and in particular, by working with GPs to help to improve the referral process (sub-category 5.2: "collaborating about referrals"). Clinicians proactively support GPs to help them cope with their most complex patients with MUS, by providing emotional support, case consultation, and formal training (sub-category 5.3: "supporting GPs"). The category suggests that clinicians may have to be proactive in nurturing relationships with GPs to support this kind of collaborative working. Although clinicians can work hard to connect with GPs, GPs are not always able to respond to this due to the pressures of the primary care context. However, their clinical experience working this way suggests that this can positively impact patient engagement by promoting initial attendance and completion of a psychological assessment.

8.1.2.3   Category 6: "Meeting patients where they're at".

The category "meeting patients where they're at" incorporates all the behavioural strategies that participants described using to negotiate "initial engagement" (sub-category 4.1.2, see p. 74). Meeting behaviours seemed to be orientated towards creating the foundations for exploratory therapeutic work. Key goals were to establish a positive therapeutic alliance and to build the patient's motivation for engaging in therapy. They aim to create an atmosphere of safety and curiosity in which the patient can begin to explore their experience, and be receptive to input from the clinician. However, clinicians perceive multiple barriers to doing this when working with patients with MUS. Through "meeting", participants aimed to establish a good understanding of the patient's initial orientation to therapy for MUS, enabling them to address any initial engagement barriers that become apparent at this stage. Participants believe that they can promote initial engagement if they are willing to engage with the subjective experience of their patients and be open to whatever they bring to therapy, including preoccupation and distress related to their physical symptoms (sub-category 6.1: "engaging with patients' experience"). Clinicians strive hard to form an emotional connection with patients, and use specific strategies to do this if patients seem disconnected from their own emotions (sub-category 6.2: "establishing emotional connection"). However, to engage patients effectively they also believe that it's crucial to tap into hidden communications to begin constructing

hypotheses about unconscious emotional or relational factors that may be connected with the patients' difficulties (sub-category 6.3: "noticing hidden communications"). For this reason, clinicians emphasised tuning into transference and countertransference phenomena to identify problematic relational patterns which may relate to patient's MUS experience. Most importantly, participants acknowledge how important it was to adapt flexibly to meet the individual patient in order to find a helpful and workable focus for the work, which may not always be about insight (sub-category 6.4: "adapting flexibly"). Reflecting the unique context of the service and it emphasis on engaging hard-to-engage patients, clinicians attend carefully to initial engagement barriers, especially relational barriers, and try to address these barriers with great sensitivity and empathy (sub-category 6.5: "addressing initial barriers"). Perhaps most crucially, clinicians emphasised the need to be exceptionally sensitive when sharing formulation ideas, especially initial formulations (sub-category 6.6: "sensitive formulation"). Holding in mind multiple levels of formulation, clinicians consider digestibility at all times in choosing whether, how, and when to share these ideas with patients.

In summary, where both clinician and patient exhibit sufficient flexibility, patient engagement is more likely to occur. However, difficulties may arise if clinicians are unable or unwilling to be sufficiently flexible to "*meet*" their patients, or if there is empathic failure which is detected by the patient, precipitating disengagement. Initial engagement may also be jeopardized if patients remain rigid in their position, which may be more likely if they feel that they have not been heard or understood, or feel blamed or criticised.

8.1.2.4 *Category 7: "Nudging forward".*

Category 7 ("nudging forward") illustrates how therapists work to engage patients in the process of therapy itself (see sub-category 4.1.3: "real engagement", p. 71). In this final stage of negotiating disconnection clinicians focus on helping the patient to cultivate connections in a myriad of ways, tailored to the individual patient's needs. This may include connections between their MUS symptoms (or related behaviours) and past experiences. Alternatively they may help the patient to cultivate better intra-psychic connections, for example, helping the patient to connect with emotions that are out of awareness (hidden, suppressed, dissociated, not recognised or symbolised), and/or connecting their MUS difficulties with these emotional experiences. Clinicians employ a range of strategies to try to help patients address disconnections that may be relevant to their MUS, including emotional or relational disconnections, or intra-psychic body-mind splits.

They employ active strategies to foster body-mind links through psycho-education and exploring the context of somatic symptoms in and outside the therapy session (sub-category 7.1: "fostering body-mind links"). As therapy proceeds, clinicians use simple, tentative

interpretations to help patients cultivate connections between their MUS symptoms and unprocessed emotional or relational experiences (sub-category 7.2: "digging deeper"). In managing these interactions, they constantly pay attention to pacing the work and balancing the expression of empathy and validation with confrontations to hold an optimal degree of tension (sub-category 7.3: "balancing and pacing"). Clinicians acknowledge that problems can arise if clinicians push patients too far in their nudging efforts, triggering strong negative emotional reactions which are uncontained, or uncontainable. This may occur when patients are so fixed in their position that they are unable to respond constructively to the clinician's nudging efforts, but instead experience intense distress, precipitating disengagement.

Participants emphasised the need to pay constant attention to process issues and self-sabotaging behaviours that may impede therapy, especially repetitive body talk which can lead to therapy getting stuck (sub-category 7.4: "addressing process issues"). However, they also warned of the need to recognise the limits, and to accept that not all complex patients with MUS will be able to engage in exploratory work. Engagement outcomes are likely to be more positive if clinicians manage therapeutic impasse constructively and flexibly, and are willing to adjust their approach by working differently, for example, introducing more active behavioural interventions to help patients improve self-management of their symptoms, or systemic interventions to help patients function better in their family, social and healthcare settings (sub-category 7.5: "managing therapeutic impasse").

8.2 The analytical foundations of the model

Grounded theory is based on a bottom-up, inductive process of analysis. Each of the major categories of the model was constructed through an iterative clustering process starting with the initial codes and continuing until the higher order categories were constructed. This section illustrates the grounded nature of the analysis. It provides a detailed explanation of all the constituent sub-categories of each of the major categories of the model, as depicted in figure 2 (p. 62). In addition to textual description, each sub-category includes an illustrative verbatim quotation drawn from the interview transcripts. Due to space limitations, the lower-level concepts underlying the sub-categories of the model are not described in detail, except for sub-category 4.1 ("engagement beliefs"), due to its centrality to the model's structure.

Analytical process: Bottom-up / inductive
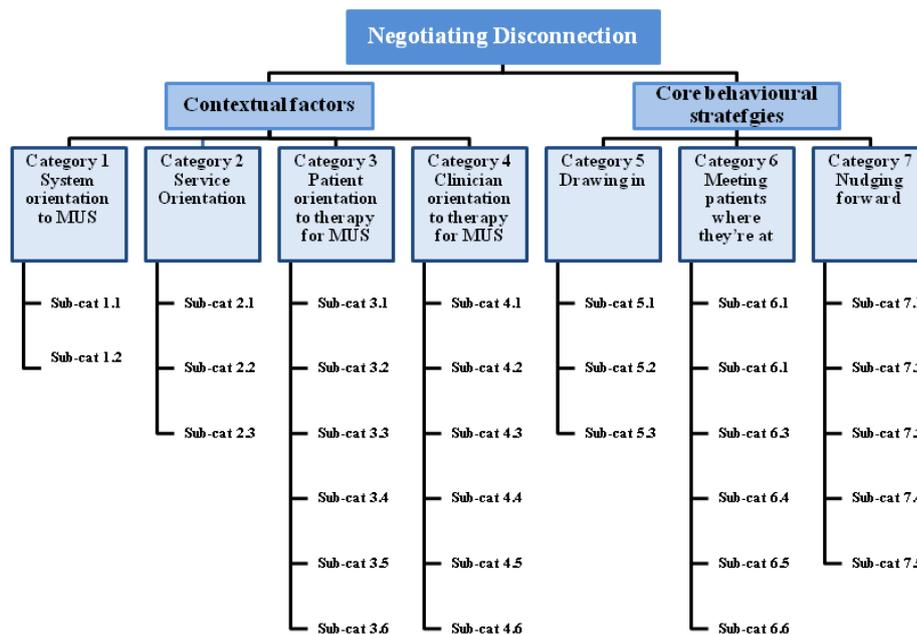
Figure 2: Visual representation of the hierarchical structure of the analysis illustrating the categories and their constituent sub-categories

Category 1: "Primary care system orientation to MUS" (GPs struggle to manage patients with MUS in an over-burdened primary care system and may themselves contribute to engagement difficulties).

CATEGORIES AND SUB-CATEGORIES	PART'S
1.1 "Central role of GP-patient relationship" (GPs have a central role in managing patients with chronic MUS but often have a history of difficult dynamics with these patients)	12345679
1.2 "GP management of referral process" (GPs vary in how well they handle the referral process and this was seen to have a critical influence on whether patients attend assessments and how they present)	125679

Sub-category 1.1 "Central role of GP-patient relationship" (GPs have a central role in managing patients with chronic MUS but often have a history of difficult dynamics with these patients).

Imbued with the authority of their caretaker role, participants felt that GPs can potentially exert a considerable influence over patients with MUS. However, they also had the impression that GPs often feel ill-equipped to deal with patient's emotional and psychological problems, due to lack of training and lack of time. They reported that some GPs may struggle to maintain boundaries, and give in to patients' demands for repeated referrals for invasive medical investigations. Patients were often referred for therapy in the context of a longstanding, mutually frustrating dynamic involving growing anger and resentment on both sides. Through

joint consultations, some participants described witnessing first-hand how fraught these relationships can become, and how, at their wits end, GPs sometimes behave in a rejecting or dismissing way towards their MUS patients.

"*I had a patient who was very skilled at, eh, getting the GP to refer her for multiple investigations,…, the GP, who was intensely frustrated with her, …,she felt impotent,…The impotence led to her feeling angry with the patient, who she felt was almost obstructive.*" (P7, 318-322)

Sub-category 1.2 "GP management of referral process" (***GPs vary in how well they handle the referral process and this was seen to be critical in terms of whether patients attend assessments and how they present).***

Because many patients with MUS referred to the service are most often not explicitly seeking help for psychological issues, how GPs position the MUS referral was considered critical. Participants felt that GPs should discuss the referral properly with the patient while validating the distressing impact of their symptoms, be honest and transparent about what they are suggesting, and position their referral as a way of providing more help and support for the patient. When handled well, participants felt that GPs can play an instrumental role in getting patients in the door and into an assessment. In practice, participants felt that there was great variation in how GPs handle referrals, in terms of sensitivity, transparency and clarity. In particular, GPs who are frustrated or overwhelmed by their MUS patients may handle referrals insensitively, eliciting negative emotional reactions in patients. However, participants felt that referral effectiveness had improved over time, as the service has matured.

"*Sometimes there can be a challenge where there is a GP who has tried everything, who feels frustrated with the patient,….,and then you get a referral for someone who isn't expecting to see a psychologist, and doesn't know why they have been referred.*" (P2, 224-226)

Category 2 "Service orientation to MUS" (The service has established policies orientated to promoting engaging "hard-to-engage" patients, however it privileges psychoanalytic understandings of MUS which may be a barrier for some patients).

SUB-CATEGORIES	PART'S
2.1 "Hard to engage patients" (The service remit is to work with "hard-to-engage" patients which creates both freedom and pressures for clinicians)	13456789
2.2 "Accommodating policies and procedures" (The service has embraced a ranged of accommodating policies and procedures designed specifically to facilitate engagement)	4679
2.3 "Psychoanalytic orientation" (The service attracts and recruits therapists who are strongly orientated towards psychoanalytic and psychodynamic ways of working)	123456789

Sub-category 2.1 "Hard to engage patients" (***The service remit is to work with "hard-to-engage" patients which creates both freedom and pressures for clinicians***).

The service was seen by participants to hold a unique positioning in the mental health landscape in being set up to work with hard-to-engage patients in primary care. Targeting patients who have struggled to engage with existing mental health services, it often sees patients who would normally be considered "unsuitable" for psychoanalytic therapy. Participants felt that complex patients with MUS exemplify a hard-to-engage group as they are often not seeking therapy and because tend to be referred when their difficulties have become chronic and entrenched. At the same time they felt a pressure to deliver change-promoting interventions to these patients within a relatively brief service context, reflecting the service's target to reduce healthcare utilisation costs such as GP and A&E attendance.

"*Engagement is quite an important part of the reason we exist as a service,….,the service was commissioned because GPs were feeling very frustrated that there was this group of patients that they felt would really benefit from a psychological intervention … who kept coming back to them and were not really engaging with the services that were available.*" (P1, 279-283)

Sub-category 2.2 "Accommodating policies and procedures" (***The service has embraced a ranged of accommodating policies and procedures designed specifically to facilitate engagement***).

Participants pointed out that the service has adopted accommodating policies, in order to circumvent common engagement barriers associated with other services. For example, it has flexible referral and discharge criteria relative to other services. Participants appreciated not being strait-jacketed into delivering strict, protocol-based interventions but instead being free to tailor their work to accommodate individual patient needs. Being permitted to undertake longer assessments of patients, when needed, was also considered helpful for engagement. The service has introduced a variety of initiatives to improve engagement, including proactive phone contact, patient leaflets, and a patient opt-in system.

"*They're a lot more flexible than other services in terms of discharge and referrals, eh, acceptance thresholds, which is necessary because MUS patients don't think they have a problem. So they're not going to come in, they're not going to be compliant, …, having that extra bit of flexibility and liaison with the GPs enables us to get a lot more in.*" (P6, 465-469)

Sub-category 2.3 "Psychoanalytic orientation" (***The service attracts and recruits therapists who are strongly orientated towards psychoanalytic and psychodynamic ways of working***).

Embracing a psychoanalytic service culture, the service seems to attract clinicians who are strongly oriented towards psychoanalytic and psychodynamic ideas and ways of working. Many have expertise in specific brief psychodynamic models which they draw on in their work. All participants reported having significant prior experience with other hard-to-engage groups (e.g. forensic, adolescents, personality disorder, etc.). Few reported prior experience working with patients with MUS although many had accumulated significant experience within the service. Whilst acknowledging the unclear aetiology of MUS, participants expressed the opinion that most patients with MUS seen in the service have pre-existing psychological issues which may have contributed to their condition and/or to the way that they have dealt with it.

"I would say that my current practice is primarily psychoanalytic or psychodynamic, …, it's a fairly exploratory process, you know, I'm quite open to whatever the patient is going to bring that day, …, and am interested in sort of seeing what sort of comes up, you know, in the room." (P3, 65-69)

Category 3 "Patient orientation to therapy for MUS" (Patients present multiple interacting barriers to engagement relating to their understanding of their symptoms and to underlying difficulties with personal and relational functioning).

SUB-CATEGORIES	PART'S
3.1 "MUS embeddedness" (Patients with MUS can be embedded in their MUS symptoms and fixated on locating their cause. While some may use their MUS as a "ticket to therapy", others may be dismissive or ambivalent about attending therapy)	12345689
3.2 "Emotional reactions to referral" (Patients may experience a variety of negative emotional reactions in response to the referral, especially anger, depending on how this was handled by the doctor, their prior healthcare experiences, and their own psychological vulnerabilities)	1234569
3.3 "Complexity alongside MUS" (Patients with chronic MUS can exhibit multiple facets of complexity alongside their MUS which compound engagement difficulties, including emotional and relational problems such as issues with trust and reluctance to face their past)	12345679
3.4 "Self-sabotaging behaviours" (Patients may engage in "self-sabotaging" therapy behaviours including excessive compliance, passivity, and/or getting stuck in body talk	12345689
3.5 "Psychological deficits" (Some patients with MUS can exhibit psychological deficits (lack of skills or functions) which make it hard for them to use an open, reflective space)	234689
3.6 "Signs of (dis)engagement" (Patients show positive and negative signs of engagement throughout the therapy process, including red flags indicating that engagement may be under threat)	123456789

Sub-category 3.1 "MUS embeddedness" (***Patients with MUS can be embedded in their MUS symptoms and fixated on locating their cause. While some may use their MUS as a "ticket to therapy", others may be dismissive or ambivalent about attending therapy***).

Participants' comments suggested that patients varied greatly in their relationship to their physical symptoms. At one end of the spectrum are patients who are seen to be fixated on their physical symptoms and on a quest to find the assumed medical cause. Participants felt that these patients were often highly reluctant to attend therapy. They may be highly dismissive about therapy and of the idea that talking, being listened to and understood can be helpful. Some may "rubbish therapy", eliciting negative emotional reactions in their therapists. At the other end of the spectrum are patients who acknowledge both physical and psychological difficulties, and who may be open to thinking about the role that psychological issues might play in contributing their symptoms. The latter were seen to present fewer challenges to engagement. Indeed, some were seen to use their MUS as a "*ticket to therapy*." Participants stated that many patients were ambivalent, however. They may accept the rationale to see a psychologist because they can acknowledge that they are experiencing psychological difficulties alongside their MUS symptoms. However, they may not necessarily accept that their physical and psychological symptoms are connected, hence their ambivalence.

"*It's kind of like a spectrum. At one end you have people who are, who are very fixated on a particular kind of physical symptom,…, and those are the people who will be more likely to be reluctant to come to our service because they say, well why should I see a psychologist, you know, this is a problem in my body.*" (P3,158-166)

Sub-category 3.2 "Emotional reactions to referral" (***Patients may experience a variety of negative emotional reactions in response to the referral, especially anger, depending on how this was handled by the doctor, their prior healthcare experiences, and their own psychological vulnerabilities***).

Participants stated that patients may experience a variety of different emotional reactions (e.g. shame, anger, distress, anxiety) in response to their referral for therapy. Depending on the meaning elicited (e.g. "*the doctor thinks I'm mad*")*,* patients may feel stigmatised, invalidated, or even medically abandoned. However, the meaning elicited may in turn be influenced by the way that the doctor handled the referral, the patient's history of interactions with the doctor or their prior experience in the health system, and their own psychological vulnerabilities. Participants noted that the emotional reaction to the referral influences how patients "arrive" at therapy and how they engage with the initial assessment. Participants also perceived variation between patients in their degree of openness about their negative emotions. Those who were

more open were considered easier to engage because their emotions are easier to grasp hold of. However, participants noted that patients who are highly embedded in their MUS can often bring strong feelings of anger and frustration to their initial appointment, or else latent feelings of anger may be easily triggered in the assessment process.

"*She was furious when she came to see me, understandably. And a lot of the work was sort of also, sort of, you know, repairing the relationship with the GP as well …. She was so relieved to know that actually her GP was worried about her.*" (P1, 183-188)

Sub-category 3.3 "Complexity alongside MUS" (*Patients with chronic MUS can exhibit multiple facets of complexity alongside their MUS which compound engagement difficulties, including emotional and relational problems, such as issues with trust and reluctance to face their past).*

Alongside their difficulties with MUS, many patients seen in the service were seen to exhibit additional complexity (to varying degrees) relating to chronic, co-morbid mental health problems, personality issues, relational difficulties, and/or diagnosed physical health problems, often associated with a high level of functional impairment. These problems were seen to complicate the process of engagement because the difficulties that patients experience with MUS are then compounded by the coping strategies reflecting their underlying personality issues. Participants noted that patients who exhibit high levels of complexity were often very reluctant to attend therapy due to their anxieties about people and relationships, reflecting prior maltreatment or trauma. Some really struggle to trust the clinician and/or the process in which they are engaging. They may be extremely reluctant to tell their story or talk about their past, which they feel unable or unwilling to face. At the extreme end of the spectrum, participants had encountered patients who were so distrustful that they seemed to actively resist building a positive therapeutic relationship.

"*Some patients I'm convinced, have never been in the room with another human being who has benign intentions towards them, so they don't know what to do with it. And you may get a perverse patient who actually wants to trash that and actively sabotage it.*" (P4, 126-128).

Sub-category 3.4 "Self-sabotaging behaviours" (*Patients may engage in "self-sabotaging" therapy behaviours including excessive compliance, passivity, and/or getting stuck in "body talk").*

Participants reported that patients with MUS can be prone to self-sabotaging behaviours, where they themselves get in the way of change by failing to engage in the process of therapy. The range of self-sabotaging behaviours cited was broad ranging, but included frequent

cancellations, failure to bring relevant material sessions, actively concealing true feelings, ranting, complaining and blaming others while failing to reflect on their contribution to difficult or upsetting situations, and "acting out" unexpressed anger. Patient compliance and passivity were identified as common problems by all participants. Compliant patients may attend therapy in order to avoid upsetting others who are putting pressure on them to attend (their GP, family members, etc.). Participants viewed passivity as a deeper problem and a more challenging barrier to engagement. Passive patients may struggle to take up an active role in making any beneficial changes, including thinking about the symptoms that they are experiencing. A common dilemma reported was that patients repeatedly return to focus on their bodily symptoms and to details of medical investigations, which was viewed as counterproductive, and possibly defensive. They experienced this relentless body talk as a dilemma because it can create a "pull to collusion" and/or may elicit strong negative reactions in clinicians, including feelings of boredom and disengagement, irritation or frustration, or feelings of hopelessness.

"I think that can be some of the more frustrating aspects of this work, where you feel you're just being engaged in a conversation that's about a long list of physical problems, and if I'm honest with you, sometimes it can make you feel a little bit overwhelmed actually." (P5, 387-390)

Sub-category 3.5 "Psychological deficits" (*Some patients with MUS can exhibit psychological deficits (lack of skills or functions) which make it hard for them to use an open, reflective space).*

Many participants cited difficulties relating to psychological deficits of various kinds with patients at the more challenging end of the MUS spectrum. Seen to lack psychological skills and functions, these patients were seen to struggle with the type of thinking required in dynamic therapy, even if they see the point of having therapy. The way these psychological deficits were conceptualised varied across participants, reflecting their differing theoretical proclivities. In the broadest terms, patients were described as lacking psychological mindedness, or more theoretically specific, reflective capacity. Other related constructs invoked included difficulties with mentalising, alexithymia, and being concrete. Clarifying the meaning of the latter, one participant explained that a patient who is "concrete" is unable to think about their pain, but is only able to experience it as a bodily symptom. Participants reported finding it more difficult to work in an exploratory way with these patients and considered these deficits to be poor prognostic indicators for engagement in insight-oriented therapy.

"Often, not invariably, but often, the patients with medically unexplained physical symptoms are the ones who find it more difficult to mentalise, you know, to reflect on experiences psychologically, so that experiences are more likely to be expressed or discharged through the body." (P3, 357-359)

Sub-category 3.6 "Signs of (dis)engagement"** (**Patients show positive and negative signs of engagement throughout the therapy process, including red flags indicating that engagement may be under threat).

Participants stated that patients communicate their engagement or disengagement both explicitly and implicitly. They made a distinction between obvious concrete signs of engagement, for example, whether patients attend their appointments (on time), and more subtle but important process signs (how they turn up). Positive signs of engagement cited included patients' open acknowledgement of difficult feelings and/or painful realities, active reflection on session material in and between sessions, and positive changes in behavioural patterns within therapy. Participants felt that highly engaged patients often show great curiosity to explore and understand their psychological experiences, so therapy becomes a highly creative and generative process. Beyond the obvious signs of cancellation, DNAs and actual dropout, clinicians also identified multiple engagement red flags indicating less than optimal engagement, such as the *"heart sink moment"* when patients attend their session with no recollection of the previous session.

"Sometimes people can be quire anorexic in engagement. Everything looks and sounds as though it's happening but nothing is going in. And there's a real resentment or hostility, or an envy that stops anything from going in. Maybe one thing might be where, between sessions, it's as though each session is starting again." (P4, 421-424)

Category 4 "Clinician orientation to therapy for MUS" (Clinicians' training, beliefs about engagement, theoretical guiding frameworks, and clinical experience with this patient group, all influence their capacity to engage these patients).

SUB-CATEGORIES	PART'S
4.1: "Engagement beliefs" (Therapeutic engagement was viewed as a multi-faceted concept (multi-level, fluid, relative), but was often characterised in terms of key stages, including "initial attendance", "initial engagement", and "real engagement")	123456789
4.2 "Engagement orientation" (Clinician's vary in their orientation towards the process of engagement in terms of their both their motivations, priorities and anxieties, which may affect how well they engage patients at different stages)	134589
4.3 "Person/process-led versus theory/task-led" (Participants described a trajectory in which they evolved from being more psychodynamically purist and theory-led to being more pragmatic, person and process-led, in order to engage patients)	12345679

4.4 "Willingness to use challenging formulations" (Clinicians vary in their willingness to use challenging formulations, some of which may be unpalatable for some patients)	12345678
4.5 "Holism versus tacit dualism" (Participants try to embrace a holistic stance towards patients but tacit dualism can occasionally creep in, especially when patients are highly challenging)	13456789
4.6 "Cultivated sensitivity to MUS" (Clinicians who have significant clinical experience with MUS tend to cultivate sensitivity to MUS-related experiential phenomena which helps them engage patients)	123468

Sub-category 4.1 "Engagement beliefs" (*Therapeutic engagement was viewed as a multi-faceted concept (multi-level, fluid, relative), but was often characterised in terms of key stages, including "initial attendance", "initial engagement", and "real engagement").*

Participants talked about therapeutic engagement as a complex, multi-dimensional and somewhat fluid construct. Some viewed it as a "state of mind" or "motivational state" which may shift back and forth between and across sessions. However, many described it as a stage-like process that unfolds over time. A distinction was often made between "initial attendance" (sub-category 4.1.1), "initial engagement" (sub-category 4.1.2), and "real engagement" (sub-category 4.1.3). Analysis suggested that these perceived stages tend to guide the core behavioural strategies that participants employ to engage patients in therapy (see Categories 5-7). For this reason, these lower level categories are explicated in detail below.

Sub-category 4.1.1 "Initial attendance" (*getting patients through the door).*

Many participants talked about the initial challenge of getting patients through the door to attend their initial assessment appointment (and the subsequent session), where the risk of DNAs was considered the highest. Although attendance was seen as a rather crude and minimalistic definition of engagement, in practice, it was also recognised as a significant challenge within this MUS-focused service context.

"*I think the first challenge is to get them through the door. Um, for some of them to even consider the idea that they would see a psychologist or a psychotherapist because for them, they have something very physically wrong with them, and it can be very offensive to them actually to be told that it's something in their head.*" (P5, 202-204)

Sub-category 4.1.2 "Initial engagement" (establishing the foundations).

Once initial attendance barriers have been addressed, participants describe orientating themselves to "initial engagement" which is seen to involve multiple, simultaneous goals, including; making psychological contact with the patient, building the therapeutic relationship, evaluating what psychological help the patient may be able to make use of, and promoting ongoing attendance. Participants considered a therapeutic relationship characterised by trust and

openness as an essential foundation for "real engagement", to create a safe space where the patient feels able to talk about difficult or personal things. While respecting the distinct roles of the therapist and the patient, clinicians emphasised the need to get alongside the patient and foster an atmosphere of equality, mutuality and authenticity, noting that patients can easily pick up when they are playing a role.

"*Well, you know, on the blunt surface level I think, you know, engagement means getting them to come back! ..... If you can convey that you understand at least something about the patient's feelings or predicament then I think that increases the likelihood, on the whole, that they'll come back.*" (P3, 249-157)

Sub-category 4.1.3 "Real engagement" (promoting engagement in the process).

Real engagement was seen to represent patients' engagement in the process of therapy itself. Participants stated that a big part of the work that is done in the service with this patient group is to try to encourage patients to explore the emotional meaning of their symptoms. In therapy, participants aim to help patients develop an emotionally-grounded account of their experience of "illness", their relationship to it, its implications, and their response to coping with it. However, the degree to which patients can engage in this process was seen to vary significantly. In the best case scenario, patients can be actively engaged in reflecting about their psychological experiences, and taking responsibility for using therapy to achieve new insights and foster positive changes. To do this, participants felt that patients need to be receptive to the therapist's input, and willing to think about difficult things. Some felt it should perhaps be a bit uncomfortable for both patient and therapist, but not so uncomfortable that it alienates the patient, precipitating disengagement or drop-out.

"*I think in order to be effective therapeutically, um, you do have to give the patient a taste of something that's not too comfortable. You know, they have to be comfortable enough to feel that it's bearable to come and to feel understood,....,but you're not really going to be able to help a patient without causing them some pain and some anxiety.*" (P3, 607-612)

Sub-category 4.2 "Engagement orientation" (Clinician's vary in their orientation towards the process of engagement in terms of their both their motivations, priorities and anxieties, which may affect how well they engage patients at different stages).

Participants varied in their orientation to the tasks associated with different stages of engagement. While some clinicians expressed comfort and confidence liaising and collaborating with medical professionals (see Category 5), others showed a preference for more traditional direct clinical work with patients. In direct work, to engage a patient successfully participants

felt that it was important to establish and maintain a good enough therapeutic relationship, while also being willing and able to find a way to challenge patients' (often very stuck) positions. Participants felt that some clinicians may err towards maintaining the relationship (promoting ongoing attendance) and fail to challenge patients sufficiently, whereas others may err towards being more challenging (to promote real engagement). Analysis of the transcripts confirmed this. For example, the excerpt below reveals one participant's willingness to have difficult conversations with patients about perceived self-defeating behaviour. However, this also seemed to vary for the same clinician across different patients, illustrating the importance of the developing relationship in this dynamic. Participants felt that therapists' willingness to confront patients is influenced by a complex array of factors, including temperament, training, experience, personal robustness, etc. To challenge patients the clinician must be able to tolerate the discomfort of occasionally eliciting their patient's anger. Orientation to engagement was also seen to be influenced by service pressures around engagement and individual clinician's concerns about how they are evaluated in relation to this.

"*You are committing to no bullshit and not putting up with things for the sake of being nice. Because you are also committing as a therapist to saying, look I think that you are doing something here that is destructive, that is against getting better.*" (P1, 424-426).

Sub-category 4.3 "Person/process-led versus theory/task-led" (*Participants described a trajectory in which they evolved from being more psychodynamically purist and theory-led to being more pragmatic, person and process-led, in order to engage patients*).

Although all participants expressed a strong belief in the psychoanalytic model as an effective way of working with patients with MUS, they also acknowledged that this was not necessarily appropriate for all MUS patients referred to the service. Learning from prior mistakes, most emphasised the need to be pragmatic, adaptable and flexible when working with these patients and reported being willing to deviate from psychoanalytic conventions if this is not working for the patient. They warned of the risk of being too psychoanalytic, and of being too pushy or bold with interpretations, particularly with patients who are highly sensitive and vulnerable. For example, one participant described their early practice with MUS patients as "*rather intellectual*", reflecting their stage of development as a psychologist with a very keen interest in psychoanalytic ideas, but with relative lack of experience in this way of working. Reflecting back, this participant recalled several some instances of losing patients by being somewhat over-zealous in offering psychoanalytic formulations, "*too analytic*" for the patient, and a bit out of tune with what they were ready to hear. Learning from this, their practice had evolved into being more relational and process-focused, and more sensitively attuned to what patients can digest. Being more person and process-led seemed to be facilitated by theoretical pluralism

(which helped participants to hold theory more lightly) and by experience working with MUS patients (which promoted openness, as experience often challenged stereotypes or theory-based preconceptions).

"I can think of one case in particular of a girl with a mysterious (physical symptom) ….She'd had a psychotic mother and I think I talked about, sort of, the bit of her body that had gone mad, like this sort of mum who was inside her. And I think it was a bit over-zealous. It wasn't so much that it upset her but she just didn't get it…. It didn't make sense to her." (P2, 362-365)

Sub-category 4.4 "Willingness to use challenging formulations" (*Participants vary in their willingness to use challenging formulations, some of which may be unpalatable for some patients*).

In conceptualising MUS related difficulties, participants made reference to a wide range of psychoanalytic theories, including classic Freudian concepts and object relations theories as well as drawing on contemporary developments in attachment theory, mentalisation and trauma. Some theories used were inherently more challenging for patients than others. For example, some participants cited examples of Kleinian formulations that they had used in their work, linking their patients MUS symptoms or their MUS-related behaviour (e.g. frequent attendance or medical test seeking) to the influence of unconscious negative emotions and impulses, including anger, hostility and envy. Many participants reported that secondary gains were sometimes in evidence among MUS patients seen in the service, noting that this idea was often helpful for understanding problematic health-seeking behaviours. For example, patients may relate to their GP as a parent figure, feel looked after, or gratified by "special treatment" that they may receive. The analysis suggested that some participants may draw on challenging formulations more frequently than others, which may affect engagement, depending on if, how and when these ideas are introduced.

"And um, a physical symptom does because, you know, it doesn't mean that's why, you know they started to have physical symptoms so they could, not in that sense, but once the physical symptom is there, whatever brought it on, it can become a way of getting care, you know, care that was always felt denied, deprived of before." (P3, 499-502).

Sub-category 4.5 "Holism versus tacit dualism" (*Participants try to embrace a holistic stance towards patients but tacit dualism can occasionally creep in, especially when patients are highly challenging*).

Most participants demonstrated a holistic attitude towards body-mind relations, stemming from engagement with literature on this topic and clinical experience working with MUS. Several

mentioned evidence linking psychological processes (attachment, chronic stress, etc.) with real physiological effects. However, although participants expressed belief in the subjective reality of the physical symptom experience (for the patient), at times scepticism or ambiguity about the precise status of these physical symptoms was communicated. One participant who admitted feeling sceptical occasionally said that she once witnessed a patient who always attended sessions on crutches, walking unaided. Tacit dualistic beliefs were also sometimes evident in participants' accounts of their behaviour with patients. For example, one participant described how she failed to engage a MUS patient who walked with a stick after she had offered her first floor appointment in a GP surgery. The participant's actions and her appraisal of the situation (outlined in the excerpt below) indicated that she perhaps struggled to accept the reality of her patient's physical symptoms and disabilities.

"Quite a lot of our patients have difficulties with their mobility,…. and quite a lot of them are on crutches…. there's something about that encounter that still hasn't, you know, drilled into me, if they're on crutches you must offer a ground room,….. of that really wasn't about the physical disability. It was more about not feeling um taken care of." (P6, 724-733)

Sub-category 4.6 "Cultivated sensitivity to MUS" (Participant who have significant experience working with MUS patients cultivate a sensitivity to MUS-related experiential phenomena which they can bring to bear on their practice to promote engagement).

Reflecting variations in exposure to MUS, participants revealed more or less appreciation of common MUS-related experiential phenomena. More seasoned MUS clinicians exhibited cultivated sensitivity in many ways, especially regarding the uniquely differentiating aspects of the MUS experience. For example, sensitised participants showed a great deal of empathy towards the terrible uncertainty that such patients endure in relation to their MUS, when they are unable to locate a cause, diagnosis, or cure, despite their ongoing efforts. They accepted that some patients with MUS may experience psychological problems as a consequence of their MUS and retreat into their illness, indicating a genuine belief in the reality of the symptoms. Clinicians who are highly sensitised to the lived experience of MUS patients may be better able to feel and sustain their empathy for patients with MUS, or to restore this when therapy becomes challenging.

"When people do have these symptoms that they haven't been able to find any cause or diagnosis for, or cure, they can end up feeling not only very stuck. There is this ongoing question that never gets answered 'what's wrong with me?' And I think as a therapist we have to be very sensitive to the impact of that and engage with it." (P3, 235-237).

Categories 5-7: Core behavioural strategies in therapy.

Categories 5-7 represent the core activities and behavioural strategies that participants described using to engage patients with MUS in brief psychodynamically informed therapy.

Category 5: "Drawing in" (drawing-in patients by engaging the system).

SUB-CATEGORIES	PART'S
5.1 "GP-clinician relationship" (Clinicians strive to develop strong GP-clinician relationships to tackle systemic disconnection although this is not always easy to achieve)	124679
5.2 "Collaboration about referrals" (Clinicians try to proactively find ways to collaborate effectively with GPs regarding referrals)	125679
5.3 "Supporting GPs" (Clinicians proactively support GPs to help build their confidence in managing patients with MUS, which also helps to strengthen the GP-clinician relationship)	14679

Sub-category 5.1 "GP-clinician relationship" (Clinicians strive to develop strong GP-clinician relationships to tackle systemic disconnection although this is not always easy to achieve).

Many participants felt that it was vital to cultivate strong working relationships with GPs to promote patient's attendance. When these relationships are strong, participants felt that GPs gain a better understanding of the types of patients to refer to the service and how to position referrals effectively for these patients. Some participants reported strong working relationships with GPs. However, others pointed to barriers that they had encountered trying to build these relationships. Limited GP availability was seen to reduce clinicians' opportunities to cultivate strong relationships. For example, one participant said that she mainly had to rely on snatched "*corridor conversations*" and "*kitchen conversations*" in the absence of more formalised contact. A senior manager interviewed contextualised this, noting that the strength of relationships developed with GPs tends to vary by practice, as some practices are too stretched to make time for this. Some participants also described making use of their relationship with GPs (and GP's relationship with patients) during therapy itself, for example, by bringing the GP into the room metaphorically, if engagement appears to be under threat.

"*The alliance with the GP, that's really important, … it's probably as important to getting people in as anything else we do because if we have a good alliance with the GP …. We're singing from the same hymn sheet.*" (P7, 371-375)

Sub-category 5.2 "Collaboration about referrals" (*Clinicians try to proactively find ways to collaborate effectively with GPs regarding referrals*).

Participants felt that it was important for them to collaborate with GPs (and sometimes other practice staff) regarding referrals. This enables them to explore how the referral was positioned, what discussion took place, and how the patient reacted. Participants found that this helps them to flag potential engagement barriers before they make contact with the patient. Many also described collaborating with GPs in a more formal way, for example, by organising joint consultations with the patient to help them understand why it might be helpful for them to see a psychologist. They believed that the GP's direct involvement may be seen by patients as an endorsement of the service, thereby fostering trust in patients where this is fragile, especially those who have a history of repeatedly DNA-ing their appointments, despite repeated referrals. Although participants valued collaboration with GPs, the degree to which this occurs seemed to vary, depending on the strength of the pre-existing clinician-GP relationship, GP availability, and participants' motivation and confidence to pursue this.

"*Some GPs send very good referrals where they'll say I don't honestly know if this person will engage or not. I think they could benefit from it. I've talked about it with them but they never turn up when I send them to these kinds of things, you know, so they invite a discussion, they invite a conversation, they raise some of the issues.*" (P2, 234-236)

Sub-category 5.3 "Supporting GPs" (*Clinicians proactively support GPs to help build their confidence in managing patients with MUS, which also helps to strengthen the GP-clinician relationship*)

Reflecting the unique positioning of the service, many participants considered the provision of support to GPs (emotional support, education, training, case-based discussions, etc.) as an integral part of their role, alongside direct patient work. Support for GPs was considered especially important in cases where a challenging patient fails to engage in any kind of meaningful psychological work, or is deemed "untreatable" by a clinician. In such cases, participants said that they would share something of their formulation with the GP to help them gain a better understanding the patient, and to promote greater empathy. Where helpful, participants may also work with GPs to help them find ways to cope with their patient's challenging health-seeking behaviour, for example, by making changes in the system that could "force" change in the patient. The support provided to GPs seemed to help participants build stronger relationships with GPs, as well as increasing the GPs' valuation of the service. By investing in supporting GPs, it seems that clinicians can also indirectly promote future referral, thus drawing future patients into the service.

"GPs can be quite harsh in their burnt out states, saying that they're crazy. So you just have to validate that first of all, and then, um, be able to shift some of that, or give your thoughts about what might be going on and why they (the patient) are acting like that." (P6, 493-495)

Category 6: "Meeting" (Meeting patients where they're at).

SUB-CATEGORIES	PART'S
6.1 "Engaging with patients' experience" (Engaging with the patient's subjective experience, including bodily preoccupation)	123456789
6.2 "Establishing emotional connection" (Using strategies to establish and maintain an emotional connection especially when affect is difficult to access)	123456789
6.3 "Noticing hidden communications" (Being openly receptive to all communications to 'see' what is hidden or out of awareness)	1234567
6.4 "Adapting flexibly" (Adapting flexibly to meet the patient and work out what they can make use of)	123456789
6.5 "Addressing initial barriers" (Empathically addressing initial engagement barriers)	123456789
6.6 "Sensitive formulation" (Being highly sensitive about sharing the initial formulation)	23456789

Sub-category 6.1 "Engaging with patients' experience" (***Engaging with the subjective experience of the patient, including their bodily preoccupation).***

This sub-category reflects the openly receptive stance of meeting. Participants emphasised the need to be open to what the patient brings and to show curiosity about the patient's manifest subjective experience. By adopting this stance, they aimed to get alongside the patient to understand their experience from their own perspective, to evaluate what use a patient can make of an open, reflective space, and to adapt their way of working accordingly. To be open, participants felt that they needed to tolerate uncertainty and resist the temptation to "formulate it away" precipitously, thus allowing space for the patient's own narrative about their MUS to emerge. They also stated that it was often necessary to go with the patient's preoccupation about their presenting physical or "medical" problems, and described giving patients plenty of space to talk about these issues, if needed, especially during assessment and the early stages of therapy. When patients arrive at therapy feeling distressed, angry and misunderstood, participants considered it vital to genuinely validate their physical symptoms and not to question their legitimacy, even if they suspect contributing psychological influences.

"I think it's about being really understanding and making them understand that you're not saying you don't believe them,...,not making them feel that this is something, you know, that's all in their mind." (P5, 217-219).

Sub-category 6.2 "Establishing emotional connection" (***Using strategies to establish emotional connection, especially when affect is difficult to access).***

All participants stressed the crucial importance of establishing (and maintaining) an emotional connection with patients, acknowledging that this may be challenging when patients present with strong negative emotions. To do this they said they tried to provide an encounter where the patient feels validated and understood by someone who understands their distress. Tuning into any emotion that is "available" during the early stages of contact, they talked about conveying understanding and empathy for the patient's expressed distress. For example, they may acknowledge how frightening it must be for a patient to experience debilitating physical symptoms that no one can explain, or how frustrating it must be to undergo repeated, fruitless medical investigations. However, participants reported that establishing emotional contact is harder when emotions are hidden or out of awareness, for example, if patients lack emotional awareness or express little emotion, or when patients are highly defensive. Participants felt it was important to gently penetrate these defences to make emotional contact with the patient. Where patients' emotions are less accessible, participants described using a variety of strategies to establish an emotional connection. To tune into hidden emotion they said that they attended to non-verbal communications of emotional states and used their own countertransference experiences as a guide to understanding the patient's emotional experience. To encourage emotional expression they sometimes directly acknowledge the difficulty of talking about emotions, or shared their own emotional reactions to the patient's material.

"So these patients can be, forgive my language, pissed off about coming to see a psychologist ...you can say gosh I can see you were very angry ... these kinds of patients are a lot easier to engage because there is an emotional experience immediately which you can work with." (P1, 397-403)

Sub-category 6.3 "Noticing hidden communications" (***Being openly receptive to all communications to "see" what is hidden or out of awareness).***

Reflecting their guiding theoretical frameworks for understanding MUS, participants said that their aim was understand the assumed, potentially unconscious, emotional and relational factors that may be connected with the patient's MUS-related difficulties. However, because some patients with MUS are unwilling to be open or reveal much about their history, they often felt compromised in these efforts. For this reason, participants emphasised the need to be open to all channels of information that may provide clues about the nature of the patient's underlying difficulties. In the absence of rich verbal reflection, what is happening in the room was viewed as the most reliable source of information about the patient's emotional and relational

functioning. By attending to process in this way, participants negotiate potential disconnections by first identifying issues which are hidden, unacknowledged or suppressed. For example, they talked about tuning into the transference for clues about how the patient is relating to them, to try to identify underlying relational issues that may relate to patients' difficulties with MUS. They also reported attending carefully to their countertransference to guide therapy. By processing their own feelings, participants aimed to understand something of how the patient might be feeling, especially when the patient is unable or unwilling to express this directly.

"*A lot of these patients won't really elaborate a great deal on their relationships or on their emotional life, or at least won't in the early stages….you're very much thrown back on working with um what's in the room, so thinking about, well how do they seem to be relating to me at this point in time, and um what links might we make between that and what they're telling me about their physical symptoms.*" (P3, 642-646)

Sub-category 6.4 "Adapting flexibly" (*Adapting flexibly to meet the patient and work out what help they can make use of).*

Because many patients referred may be relatively naïve about therapy, not actively seeking therapy, and/or unsure why they have been referred, participants expressed a need to flexible when working with these patients, personalising the work to meet the individual their needs. They described ways in which they had learned to "tone down" their approach, deviating from psychoanalytic conventions, if necessary, to help patients feel comfortable enough to attend and to build an alliance with them. For example, a number of participants talked about accepting a bit less of a history in order not to alienate patients who are unwilling or unable to explore this straight away. To proactively managing patients' discomfort, some said that they would engage in a discussion about what therapy is, and attempt to communicate what is being offered in a non-threatening way. Others described actively promote therapy in a persuasive way, using scripts or metaphors that they felt patients would relate to. Many participants reported using a "trial and error" approach to engagement. If patients do not respond positively to trial interpretations, they may borrow techniques from other models. For example, one participant described using the systemic technique of circular questioning to help get the conversation going. If the patient is really struggling, most said they would consider other more structured ways of working, for example, using systemic or mentalising interventions.

"*It's very much … not a kind of purist way of working …. I am also quite integrative and draw upon other techniques …. to try to engage patients, and to try to get them to a place where they are ready to think about their relationships and about their emotional life, which a lot of them when they first come in, aren't so much.*" (P3, 76-81)

Sub-category 6.5 "Addressing initial barriers" (***Empathically addressing initial engagement barriers***).

Participants reported that many patients with MUS referred to the service are reluctant patients who may contest the legitimacy of their referral, attribute negative meaning to it, and/or resist engaging in the process either consciously or consciously (as highlighted in Category 3 "patient orientation to therapy"). In order to engage patients in the idea of having therapy and establish a positive therapeutic relationship, participants said that they tended to look out for these issues and find a way to address them openly with the patient. They noted that negative transference reactions can sometimes occur with MUS patients, for example, when the therapist is perceived as a critical or attacking figure. Though challenging for initial engagement, participants also viewed this a valuable opportunity for promoting insight into the patient's relational functioning. They emphasised the need for great sensitivity in managing this, because attempts to draw attention to unconscious processes can be extremely alienating for patients if they are poorly timed, or insensitively delivered. Negative transference was also used to guide the pace of therapy. For example, hypervigilance in the transference was seen to potentially indicate a level of patient vulnerability, indicating a need to tread gently, and to spend more time building the therapeutic relationship.

"*When I am trying to engage a patient and I am experiencing something like this, ... I would actually stop what I am doing and I would say,..., look I can see that this is actually really getting to you and I'm sorry,.... What was it that I did?*" (P1, 329-332)

Sub-category 6.6 "Sensitive formulation" (***Being highly sensitive about sharing initial formulation***).

Many participants highlighted the risk associated with formulation for patients with MUS because of the frequent disconnect between clinicians and patients regarding the aetiology of MUS. They therefore emphasised the need to position formulation ideas tentatively and to be highly sensitive about sharing formulations, including whether to share, how much to share and when to share. Crucially, they stressed the importance of not expressing certitude "*don't marry your hypothesis*", on the grounds that a definitive account may be alienating for the patient who may have their own, possibly conflicting, ideas. Holding in mind different levels of formulation, they described continually making judgments about what the patient might be ready to digest at any point in time. During assessment or early treatment, participants highlighted the important role of the initial formulation that is shared with the patient. When trying to establish a therapeutic relationship, the formulation that participants were most inclined to share was one that clearly speaks to the patient's experience and captures something that the patient can

readily relate to and is unlikely dispute. It is therefore more likely to capture the patient's conscious emotional experience. Participants warned that the initial formulation should not be too "sewn up" as this may be off-putting for patients and would not allow much scope for it to develop in an emergent fashion. Formulations hypothesising causes of MUS were considered very risky, whereas those highlighting the emotional impact of MUS and patients' coping mechanisms were considered safer territory. At some point, however, participants felts that it was very important to try to plant a seed about possible contributions of psychological factors to MUS. Paying careful attention to their use of language, using qualifying adjectives (possibly, maybe) they described presenting these ideas as a potential hypotheses to consider, to avoid alienating patients. Participants were particularly cautious in relation to written formulations. Some described agonising over formulations shared in assessment letters, reflecting their belief that written assessment reports sent to GPs could have a powerful impact on patients and could potentially precipitate disengagement. For this reason, some clinicians advocated active collaboration with patients in the preparation of assessment reports for GPs for example by eliciting their feedback directly before sending at letter, so that the patient feels directly involved in the process.

"If you can communicate something about yes, I understand what this experience of getting ill might have meant for the patient, then that's um, I think that's more likely to make them feel that you're getting alongside them somehow." (P3, 490-492)

Category 7 "Nudging forward" (nudging patients towards thinking about both the mind and the body and the links between them).

SUB-CATEGORIES	PART'S
7.1 "Fostering body-mind links" (Employing active strategies to foster body-mind links)	135689
7.2 "Digging deeper" (Digging deeper to cultivate connections between MUS and unconscious influences)	23456789
7.3 "Balancing and pacing" (Balancing and pacing therapeutic behaviours to hold an optimal degree of tension)	12356789
7.4 "Addressing process issues" (Managing process issues and self-sabotaging behaviours, including repetitive body-talk)	1234568
7.5 "Managing therapeutic impasse" (Dealing constructively with therapeutic impasse through therapist self restraint and managing negative countertransference)	12345678

Sub-category 7.1 "Fostering body-mind links" (Employing active strategies to foster body-mind links).

Participants viewed an essential task of therapy for MUS being to help patients to gradually accept the possibility of a relationship between their MUS symptoms and stress, emotional, or

relational functioning. Respecting the uncertain aetiology of MUS, they described gently encouraging patients to be curious about expanding their understanding to consider potential contributing psychological factors, while being careful not to dismiss potential biological factors. Many participants reported using mind-body psycho-education to help patients to accept body-mind linkages, especially when patients have fixed ideas about symptom causes. This was considered particularly useful for patients with unexplained chronic pain and/or trauma histories, as there is evidence associating these phenomena with neurobiological changes which may be related to MUS. Participants felt this could help patients to understand that overwhelming emotional experiences can have physical consequences, and that physical symptoms do not necessarily equate with organic pathology, and may not therefore warrant ongoing medical testing. Aside from using psycho-education, participants also reported working directly with patients to make body-mind links. Some reported using CBT techniques such as Socratic questioning to help patients to elaborate on their mental and somatic experiences, and behaviours. Others described taking opportunities to work with body-mind linkages during the session, attending to verbal or non-verbal signals of physical discomfort. Attuning to these cues was seen to give a "live opportunity" to help patients make meaningful connections between mental processes (thoughts, feelings, etc.) and physical sensations.

"When patients suddenly say that things feel worse, you know, oh my god, my head. I can't think anymore ...that can be a way of, sort of, beginning to demonstrate to a patient, that there might be a link between the kind of physical and the psychological experience." (P3, 677-685)

Sub-category 7.2 "Digging deeper" (*Digging deeper to cultivate connections between MUS and unconscious emotional and relational influences*).

As therapy unfolds, participants described trying to help patients to cultivate connections between their MUS symptom experiences and unprocessed emotional or relational experiences. Inviting patients to consider these links through interpretations, they described carefully titrating this process according to what they believe the patient is able to hear at any point in time, based on the patient's verbal and non-verbal responses to earlier interactions. Participants appreciated that some psychoanalytic formulations of MUS could be challenging for patients to hear (e.g. formulations linking MUS to unconscious anger or secondary gains). When making challenging interpretations of this kind, they advised waiting for the right moment to share simple, tentative interpretations in a highly compassionate way, to make sure that patients do not feel criticised, blamed or judged. They often tried to soften their delivery, for example, by first normalising essentially human needs and emotions such as anger. When interpreting secondary gains, participants felt that it was vital that patients understand the behaviour as an expression of unconscious unmet human needs, not a conscious manipulative process. If patients are

amenable to talking about their history, participants reported that they would try to move beyond considering the impact of MUS symptoms, towards understanding the meaning of the MUS symptoms for the patient, their relationship to their symptoms, and its possible links with early caregiver relationships or traumas.

"I suppose being able to say to her ... I think there's some anger there.....even though she pushed it a way, I think she was able to sort of, take it in....people are so afraid of anger, I suppose that's understandable. So it's making anger acceptable, I suppose...., reassuring people, her, that anger, envy, these difficult feelings are, sort of, in us all." (P8, 461-466)

Sub-category 7.3 "Balancing and pacing" (*Balancing and pacing therapeutic behaviours to hold an optimal degree of tension*).

In order to cultivate change-making connections for MUS patients, participants stressed the need to maintain a degree of tension in the therapeutic relationship. As a result, they described constantly striving to keep a balance between making the patient feel comfortable by validating their experience, and being able to push them to explore unconscious (unacknowledged, hidden) issues that may be contributing to their difficulties. Participants therefore continually monitor patients' responses as their interactions unfold, and adjust the balance of their actions to help modulate their patient's level of emotional arousal. However, when patients are highly embedded in their MUS, participants recognised that confrontations may easily kindle underlying feelings of self-blame and criticalness and trigger defensive justification of the patient's position (e.g. how long they have been suffering, etc.). Pacing was also considered important when working with patients who have a history of relational trauma or abuse. These patients may need more time for their story or their "*untold secrets*" to unfold. Although they would tentatively hypothesise links between these issues and the patient's MUS symptoms early in therapy, they did not advocate pushing the patient to delve into these issues before they feel ready, accepting that patients will generally get there in their own time.

"I think all therapeutic work is, but with these patients, it is about trying to move people forward but not being, you know, too much too soon. And you're somehow trying to negotiate this, kind of, middle position,... I mean you don't want to be so probing so soon that the patient will withdraw, but you have to be a bit probing in order to be effective." (P3, 550-558)

Sub-category 7.4 "Addressing process issues" (*Managing process issues and "self-sabotaging" behaviours, including repetitive body-talk*).

As noted in sub-category 3.4, many patients with MUS seen in the service engage in "self-sabotaging" behaviours which can undermine the therapeutic process. All participants talked

about the need to confront this in an honest and straightforward way, in order to be helpful to the patient. As patients are more likely to be receptive to challenges if they are not feeling attacked, criticised or bullied, therapists try to deliver confrontations with a high degree of warmth, in a friendly and non-threatening tone of voice, and with a plea to the patient to be curious to explore the patterns. Perhaps the most common and frustrating MUS-specific process difficulty reported by clinicians was relentless body talk. To confront this pattern, clinicians often simply remind the patient of the hypothesised body-mind link, and of the importance of thinking about their mind as well as their body, acknowledging that this may need to be repeated many times, with increasing directness. Some also reported actively coaxing patient into to a wider discussion, for example, by encouraging patients to "externalise" the problem (drawing on narrative therapy techniques). Challenging the patient's body focus was acknowledged to be a very delicate process, as this may be experienced as invalidating by the patient and could potentially precipitate a rupture or drop out. Participants believed that the outcome of this depends largely on when and how the confrontation is made, in terms of pacing, tone of voice, facial expression, etc.

"*If after a period of sessions it became very clear that that person was just talking about those things in a defensive way, and wasn't going on to talk about anything else, then just finding a way to talk about that really.*" (P2, 291-294)

Sub-category 7.5 *"Managing therapeutic impasse"* (*Dealing constructively with therapeutic impasse through therapist self-restraint and managing negative countertransference*).

Participants noted that not all patients with MUS seen in the service are able to engage in dynamic therapy. When patients are really struggling, some participants said that they introduced more active interventions to help patients improve self-management of their symptoms. Those who continue to work dynamically but are repeatedly thwarted in their efforts reported experiencing a variety of difficult feelings (boredom, disconnection, irritation, anger, hopelessness or helplessness). Although some advocated ongoing confrontation through carefully-crafted and well-timed interpretation, they emphasised the need to be careful not to push too hard or be too tenacious, as this may lead to "*getting into a battle*" with a patient, which may damage the therapeutic relationship and precipitate disengagement. As one participant acknowledged, unmanaged emotions can lead therapists to "act out", labelling patients "untreatable" when they are simply too difficult or too draining to be with, in which case clinicians themselves may unwittingly jeopardise engagement. Labelling a patient untreatable was considered over-generalised and unhelpful as it fails to consider goodness of fit between clinician and patient, or patients' readiness to change which may shift over time. In order to avoid these negative outcomes, participants felt that it was important to exercise an

appropriate level of self-restraint, and to hold back and wait for a good opportunity to challenge the patient's stuck position. As one therapist noted, sometimes she just needs to "*bear being the dustbin*" at times, even though this could elicit feelings of anger in her.

"Sometimes, I think with these patients um, there can be a sort of an invitation to some kind of confrontation or to some kind of ending up at loggerheads, and that can kind of come out for example, when a patient is really, really keen to convince you of just how disabled they are by their difficulties." (P3, 687-690)

9   Discussion

This section reviews the findings of this study from a Counselling Psychology perspective. Section 9.1 reviews the rationale for this study, its main aims, and contribution. Section 9.2 explores the key stages of engagement represented in the model illustrating how systemic, relational and intra-psychic disconnections interact to create barriers, and how these can be addressed. Section 9.3 examines the specificity and generalisability of the model. Section 9.4 discusses the core theme of disconnection and its relationship to integration, including systemic issues in delivering holistic, biopsychosocial care. In section 9.5, the implications for service development, clinical practice, and training are considered, as well as implications for Counselling Psychology. The discussion concludes with a critical evaluation of this research including its strengths and limitations, and suggestions for future research (9.6).

9.1   Core aims and contribution of this research

The impetus for this piece of research was a highly pertinent practice-related question. The research was developed in response to the widely reported observation that engaging patients with MUS in psychological therapy is very challenging, evidenced by high referral refusal and treatment drop-out rates (Schneider et al., 1990). Although prior research has explored how therapists conceptualise MUS and what interventions therapists use with these patients (Luca, 2010, 2011), to the author's knowledge no previous research has explored the issue of therapeutic engagement specifically for this patient group. This study builds on previous research by exploring this process, illustrating how clinicians adapt their practice to engage these reluctant patients. It is very timely given the current impetus to significantly expand psychotherapeutic services for patients with MUS. As this process has just begun, the research may be a valuable resource for those involved in developing and delivering these new services.

In line with the aims of practice-based research (McLeod, 2001), this research has synthesised the experience of clinicians who have significant expertise working with this patient group, to share their collective learning. Therefore, it inevitably draws on some collective, widely-accepted and influential psychotherapeutic concepts. Glaser (1998) observed that, in some domains, "conceptual data" dominates how everything is talked about. This certainly applies to the theory-rich field of psychotherapy. However, this research seeks to build on these ideas to offer some unique and practical insights. The central aim of GT is to create an abstract theoretical or conceptual framework representing a social-psychological process. As noted by Corbin and Strauss (2015), a theory is distinguished from mere description by its overarching framework. To achieve status as a theory, the framework should incorporate an abstract concept, the core category, which stands above the rest (Bartlett & Payne, 1997). The latter should capture in only a few words the essence of the research and provide the integrating framework for all the other categories. Glaser stated that a good model should have "*relevance*" and "*grab*"

(Glaser & Strauss, 1967). Indeed, many powerful theoretical concepts in psychotherapeutic practice can be simply referenced, such as the notion of alliance rupture and repair (Katzow & Safran, 2007), and empathic confrontation (Young, Klosko, & Weishaar, 2003).

With these aims in mind, the research has introduced a new theoretical framework - "negotiating disconnection" - that conceptualises the process of engagement in terms of a series of stages: "drawing in" (negotiating systemic disconnection), "meeting" (connecting in the disconnection), and "nudging forward" (cultivating connection), and illustrates how the different stages of engagement are negotiated by clinicians. As highlighted in the model summary (section 8.1), the notion of disconnection captures the dilemma faced by clinicians at the most abstract level. There is a fundamental disconnect between how patients and clinicians understand the patients' symptoms. However, the disconnections that clinicians are confronted with are much broader than this, as they also extend far beyond the therapeutic dyad. The disconnection experienced by clinicians is also mirrored in GP's relationships with patients which seem to be fraught with tension, miscommunication and misunderstanding. Clinicians also face challenges of disconnection from GPs due to structural issues in our health system. One reason why it is so difficult to engage patients with MUS in psychotherapy is that the disconnections operate across multi-layered relationships within the system and tend to interact in complex ways. The challenge for clinicians and services is to negotiate the layers of disconnection present in the system, the therapeutic process, and the client's presenting issues. However, powerful psychological, sociocultural, economic and political forces make it difficult to address all these disconnections simultaneously, explaining why this problem has been so intractable historically.

The model constructed is novel in that it provides a broad conceptualisation of the notion of therapeutic engagement. Consistent with her constructivist stance, the author sought to understand how participants themselves defined therapeutic engagement. In the model, Bordin's notion of the therapeutic alliance (Bordin, 1979) is reflected in practitioners' definitions of "initial engagement" as many of the behavioural strategies outlined in "meeting" are oriented towards establishing a positive therapeutic alliance with this highly reluctant patient group. This component of the model is extremely important because many patients with MUS drop out of therapy at this early stage (Schneider et al., 1990), so it is valuable to know what clinicians can do that works. However, this study expands beyond this narrow construct of engagement, and beyond the scope of the previous work of Luca (2010, 2011), by also conceptualising engagement as a systemic endeavour, involving proactively engaging professionals in the physical health system to encourage patients to attend therapy ("drawing in"). In addition, the framework also considers what clinicians do to help patients engage in the process of therapy itself. Although it is vital to build a strong therapeutic alliance with patients with MUS (as with all patients), successful outcomes depend on clinicians then being able to harness that

relationship and use it as a vehicle for facilitating psychological change. "Nudging forward" addresses how clinicians go about realizing this, for complex patients with MUS.

9.2   Model synthesis: Stages of engagement, barriers related to disconnection and how they are negotiated

This section examines the three stages of engagement in detail, highlighting how disconnections create barriers in each one, what contextual forces and influences play into them, and how these can be successfully negotiated. To help situate and contextualise this research, links are made with existing MUS literature and current practice trends, where relevant. Section 9.2.1 ("drawing in") shows how clinicians tackle the issue of systemic disconnection in the health system and the resulting relational disconnections between GPs and clinicians and GPs and patients respectively. Section 9.2.2 ("meeting") addresses the challenge of forging a positive therapeutic alliance with patients who have a negative orientation to therapy and who may exhibit relational, intra-psychic or emotional disconnections that impede this process. Finally, section 9.2.3 ("nudging forward") addresses the task of cultivating intra-psychic and relational connections in ways that are relevant to the individual patient's needs.

9.2.1   "Drawing in" (negotiating systemic disconnection).

The model indicates that systemic disconnections (structural and relational) may create barriers to addressing the first stage of engagement (initial attendance). Echoing previous research (Fischhoff & Wessely, 2003), it seems that GPs vary considerably in the degree to which they think in psychologically informed ways about their patients. Some may be sensitively attuned to their patients and competent and confident in supporting their patients' needs, whereas others may develop strained or problematic relationships with patients, involving excessive collusion or confrontation. The dualistic structure of the health system feeds into this (Salmon et al., 1999). As the model suggests, this concrete manifestation of disconnection does a disservice to patients with MUS as it directly feeds into the relational and intra-psychic disconnections associated with this problem, including unhelpful disconnection between GPs and mental health clinicians. This may contribute to under-referral of patients or referral failure. As a result many patients with MUS who could potentially benefit from psychotherapy may never reach the first step. Alternatively, poorly managed referrals may contribute to patients' angry and frustrated presentations at therapy, and challenging therapy dynamics. "Drawing in" suggests that clinicians try to negotiate these systemic disconnections by making proactive efforts to engage the system and forming strong, collaborative working relationships with GPs, in the belief that this helps patients to attend and complete a psychotherapy assessment. It has been previously suggested that MUS patient referrals may sometimes be unsuccessful due to medical professionals' lack of confidence in psychological treatments for this condition (Brown, 2007). Conversely, this study seems to indicate that GPs who develop close relationships with

psychological services may develop greater confidence in psychotherapy for MUS and promote it more effectively. This is important not only because it seems to promote initial attendance, but also because treatment outcomes tend to be better when doctors convey strong positive expectations (Di Blasi et al., 2001). Commentators have long argued for co-location of medical and psychological care for patients with MUS on the basis of patient acceptability (Looper & Kirmayer, 2002). However, although co-location may facilitate collaboration the model suggests that this does not necessarily address all the structural, psychological or cultural elements of disconnectedness. In recent years, economic pressures have precipitated a crisis in primary care leading to difficulties with GP recruitment, burnout and staff retention (Thompson & Walter, 2017). Notably, the model indicates that some GPs may be unwilling or unable to commit the time required for effective inter-professional working. This echoes findings of a recent pilot study of MUS treatments in IAPT (de Lusignan et al., 2013), although realistic time may not have been allocated to this, given IAPT's emphasis on efficiency (Rizq, 2012). Also notable, the model indicates that clinicians may vary in their interest, willingness and confidence to proactively identify and address any systemic disconnect from referring GPs. Aside from location therefore, it seems that a multitude of factors may contribute to disconnection between GPs and clinicians, including: health professionals' roles and expectations, cultural norms within work settings, training, and organisational targets.

9.2.2 "Meeting patients where they're at" (connecting in the disconnection).

The model indicates that initial engagement of patients with severe and chronic MUS can be fraught with challenges that may create disconnection between clinicians and patients. According to the model, patients can present as angry, dismissive or ambivalent about the referral, have rigid beliefs about being physically ill, and/or be fixated on locating medical causes. Those with a background of early relational trauma may have deeply embedded relational anxieties and use unconscious defence mechanisms, including defensive body-talk, to keep the therapist at a distance. Patients' intra-psychic disconnection creates further barriers. Participants noted that some MUS patients can be disconnected from their emotional experience, consistent with the literature suggesting that these patients tend to "stuff" their feelings (Bakal, Coll, & Schaefer, 2008). Others may be aware of their feelings but fail to link them with bodily sensations, reflecting highly specific embodied mentalising deficits (Luyten et al., 2012). In severe cases, emotional disconnection may be rooted in childhood neglect, which can undermine ability to symbolise emotional states (Allen, Fonagy & Bateman, 2008). In short, therapists may have to navigate a complex web of conscious and unconscious disconnections (intra-psychic and interpersonal) in order to form a positive therapeutic alliance with the patient. To do this effectively, clinicians must be highly attuned to patients' sensitivities, flexible and adaptable, and prepared to deal with challenging and potentially confusing dynamics.

"Meeting" emphasises the importance of putting the patient at the centre of therapy. Clinicians often deviate from a pure psychodynamic framework and integrate approaches from other models to engage patients, especially if patients are struggling to make use of an open, reflective space. Although psychodynamic therapy is oriented towards understanding relational and affective experience, the model suggests that clinicians facilitate initial engagement when they go with their patients' bodily preoccupation and validate their negative healthcare experiences. This sends the signal that patients symptoms are being taken seriously, addressing issues of illegitimacy (Nettleton, 2006), and reducing defensiveness (Kirmayer, Groleau, Looper, & Dao, 2004). Faced with a patient who is highly defensive, some clinicians position therapy as a treatment to help them cope with their MUS symptoms. In engagement terms, this might be considered the "low hanging fruit" given that many patients with MUS resist psychological framing of their condition (Chew-Graham, Brooks, Wearden, Dowrick, & Peters, 2011).

It seems that a strong focus on bodily symptoms may create tension for some therapists, who may feel frustrated or compromised by this. Enthusiastic, inexperienced psychodynamic practitioners may be over-zealous in encouraging patients to talk about their childhood or relational experiences before patients understand or accept the rationale for doing so. Despite increasing acceptance of the biopsychosocial nature of MUS (Luyten et al. 2013), the model suggests that clinicians may occasionally struggle to genuinely believe and empathise with patients with MUS, especially when fatigued or under pressure from a patient who is highly hostile and/or distressed. Mind-body dualism is powerful in Western society and may also be present in clinicians at times, if only tacitly. These lapses may help to explain clinicians' struggles with empathy given that psychological problems elicit less compassion than physical illness (Weiner, Perry & Magnusson, 1988). Disconnections can easily occur (i.e. therapeutic ruptures or premature drop-out) if patients detect dualistic beliefs in therapists (overt or tacit) and conclude that their symptoms are being "psychologised". Patients who have experienced repeated invalidation of their symptoms may be "re-traumatized" if they detect scepticism, even if erroneously. In line with the "alliance rupture and repair" literature (Katzow & Safran, 2007), clinicians must address these ruptures quickly and sensitively to avoid early disengagement.

Although hearing and responding empathically to patients' bodily concerns was considered vital for initial engagement, it does not get to the heart of the issues of relational and intra-psychic disconnections that may be central to the MUS experience. A common dilemma reported was the challenge of establishing a strong therapeutic relationship with patients who use unconscious defence mechanisms to maintain distance and who may devalue or dismiss therapy or possibly even the therapist. From an embodied mentalisation perspective (Luyten et al., 2012), some (possibly avoidantly attached) patients may experience a mind-body split in which the mind is "self" and the body is "other", disinvested of affective meaning. To connect with these patients in their state of disconnection, clinicians must work hard to pick up emotional undercurrents

that are not consciously experienced or expressed by the patient, by attending to transference and countertransference and processing non-verbal communications. By exploring these barriers openly with the patient, clinicians strive to pre-emptively address relational barriers that could undermine therapy, or trigger premature ending.

9.2.3 "Nudging forward" (Gradually cultivating connections).

"Nudging forward" illustrates how clinicians approach the task of helping patients to cultivate connections in whatever way is most relevant to individual patient's presenting issues. As participants spoke about their role in this stage of engagement, they tended to characterise it as a gentle process of nudging patients forwards bit by bit, offering them new ideas to consider, and gently pushing or supporting them if process difficulties or skills deficits prevent them from using the reflective space offered. Sometimes this means moving away from insight therapy towards skills building or helping the patient to cultivate better connections in their external world, within their family, the healthcare system, or their own communities. "Nudging forward" suggests that therapists are most effective in engaging patients if they strive to work at the edge of the patient's comfort zone, helping them to make connections that are digestible and within their grasp. A parallel could be drawn with the work of developmental psychologist, Vygotsky (1978), who generated the concept of the *zone of proximal development*. Central to this theory is the notion of *scaffolding* (Wood, Bruner & Ross, 1976), which recognises that although children can learn independently, they have the capacity to shift their learning to a different level with appropriate input from others. Similarly, helpful input introduced by the therapist at the right moment may be the catalyst needed to help patients with MUS who are stuck to cultivate new connections that can foster meaningful change. More complex patients who have mentalising impairments may need more active support as difficulties connecting to emotional states in self and others may contribute to relational disconnection in and outside therapy (Allen & Fonagy, 2006). To work "in the zone", clinicians must be attuned to their patient's psychological awareness and functioning, emotional arousal, and the moment-to-moment quality of the therapeutic relationship, and adjust their interventions accordingly.

Addressing the intra-psychic body-mind split was seen to be a central goal of therapy for many patients with MUS. Although clinicians reported many different strategies for approaching his, they often talked about the power of working "in the room" to help patients make links between bodily sensations reported by the patient (or observed by the therapist), and related emotional experience. Working directly with somatic experience is not traditional territory for psychotherapy, but is intuitively an obvious target for patients presenting with MUS. Complex patients with MUS are known for ignoring their body when not experiencing symptoms, thereby missing potential warning signs of emotional distress (Bakal et al., 2008). This "body avoidance" has been associated with emotional avoidance associated with early attachment difficulties. Some brief dynamic therapies focus quite explicitly on patient's somatic symptoms.

Applying the principles of ISTDP to MUS, Abbass (2005) suggests that MUS symptoms can be overcome if the patient can be encouraged to experience the emotions that are creating conflict, triggering defence mechanisms and anxiety (see section 5.3.2.4). This involves working directly in the room with physical sensations reported or observed, and noticing and addressing the defences used by the patient to avoid the underlying affect. Proponents of ISTDP for MUS suggest that this approach is very effective in reducing somatic symptoms (Russell, 2015), suggesting that this may warrant more attention as a potentially important treatment ingredient.

9.3   Model specificity and generalisability

This research was conducted in a specialist service that targets complex patients with MUS in primary care. A large array of diagnoses fall within the MUS spectrum and clinicians working in primary care must be ready to deal with this diversity. Based on their experience in the service, participants viewed MUS as a broad category with "fuzzy boundaries", incorporating a range of loosely related, overlapping conditions and presentations. Perceived classic features included preoccupation with (or anxiety relating to) one or more bodily symptoms, frequent GP or A&E attendance and ongoing pursuit of medical testing. However, participants also associated it with a variety of other presentations, including anxiety and depression with troubling somatic symptoms, long term medical conditions involving "*disproportionate disablement*" (according to the GP), and unexplained physical symptoms assumed to be related to prior trauma. Reflecting the specific research context, this study has focused on the commonalities observed in the clinical process across a broad range of different MUS presentations, rather than focusing on any individual specific diagnosis.

The theoretical framework has clear specificity to the MUS population (broadly defined) as the sub-categories of the model clearly articulate the issues that are most pertinent to MUS. For example, the category "patient orientation to therapy for MUS" represents highly specific MUS-related issues, including patients' acute sensitivity to how their symptoms are understood by others. According to clinicians, these subtle nuances really do matter, and whether and how doctors and clinicians respond to these sensitivities can significantly influence the ongoing dynamics in a positive or negative way. For example, the model highlights how doctors' referral style and competence can trigger strong emotional reactions in patients which are then brought to therapy. If patients have a long history of negative interactions with the health system, clinicians may be faced with a tidal wave of accumulated embitterment, which they then need to manage. The model is also specific to MUS in that it embodies a range of contemporary theoretical ideas about MUS spanning multiple disciplines (as synthesised in the literature review). Working with emotions, particularly those that are unrecognised or unacknowledged permeates throughout the model (e.g. sub-category 6.2: "establishing emotional connection" and sub-category 7.2: "digging deeper"). These strategies are congruent with contemporary thinking that severe MUS may be rooted in difficulties with emotional processing and emotional

regulation. Similarly, the model emphasises strategies aimed at cultivating body-mind connections, something that is fundamental to this patient population. One important caveat to bear in mind, however, is that although the model has been constructed around patients with MUS, it is also very much focused on complexity, as the population that the study's participants work with only includes patients at the most complex end of the MUS spectrum. Some features of the model may reflect aspects of complexity in general.

As is typical in GT, the model has been conducted in a particular substantive setting, and has focused on clinicians who work with a particular patient group. While the model is not generalisable per se, it is possible that the overarching framework could potentially be applied to related patient populations. The most closely related population is patients with LTC; however, arguably the model (at the most abstract level) could possibly even apply to other hard-to-engage or complex patient groups, such as adolescent populations. The pioneers of GT make a distinction between "substantive theory", that is developed in a highly specific context and "middle range theory", which results from studying a topic in multiple contexts (Glaser & Strass, 1967). Further research would be required to determine if this model could also apply to patients with LTC, and to explore how underlying sub-categories would need to be adapted to reflect the specific nuanced differences of these other populations. It is impossible to define any patient population in a very precise way, especially in relation to MUS with its "fuzzy boundaries". At the complex end of the MUS spectrum, patients may have co-morbid LTCs, mood disorders and/or personality disturbance (Kirmayer, Robbins, & Paris, 1994). Arguably, however, individuals who have a LTC diagnosis are in a different position to patients with MUS who do not have a diagnosed LTC ("pure MUS"), as the latter are essentially "placeless" in the physical health system (Seabrook, 2017). It is perhaps this "placelessness" that creates the unique challenges for this particular patient group. Supporting this assertion of difference, the recent evaluation of the IAPT LTC/MUS pilots concluded that patients with MUS and LTC should be considered as separate groups with distinctive needs (Kellett et al., 2016).

9.4   Core themes

9.4.1   Disconnection versus integration.

The central theme in this study is the notion of disconnection. It has been identified as the core dilemma faced by clinicians who work with patients with severe and chronic MUS. The dilemma is a complex one because the disconnections are multi-layered and each layer seems to feed into the other layers. Structural disconnection (the dualistic split of our health and diagnostic systems into 'physical' and 'mental' components) creates problematic relational disconnections between professionals and with patients, and perpetuates a culture of dualistic thinking that undermines a holistic approach to health. As the model indicates, the above disconnections all feed into the vulnerabilities of complex patients with MUS who may struggle

with significant psychosocial difficulties but who may not perceive (or want to perceive) any connection between their physical symptoms and emotional distress. The clinicians interviewed in this study aim to help patients cultivate a more holistic, biopsychosocial understanding of their illness. In this context, integration means expanding patients' understanding of their condition to incorporate psychosocial contributions, as failures to recognise these influences may underlie patient's inappropriate health-seeking behaviours. The above approach is consistent with a biopsychosocial approach which essentially seeks to understand health as the product of biological, psychological and social processes and to deliver holistic, integrated care that targets these interacting elements (Engel, 1977, 1982).

Disconnection and integration could therefore perhaps best be understood as two sides of the same coin, the former representing the "problem" and the latter representing the "solution" and/or desired outcome. Disconnection (the problem) can be present at many levels (structural, relational and intra-psychic). In the same way, integration (the solution or goal) can also be considered at each of these levels. At the level of the individual, a patient with MUS who has engaged in therapy will hopefully develop better intra-psychic integration, achieving a better understanding of the links between somatic symptoms and emotional or relational distress. Similarly, a health system that is integrated will have established structures that tie together its core operational components, especially the people participating within it. Negotiating disconnection as a process seems to be all about striving towards integration - intra-psychically, relationally and in terms of care delivery - in a disconnected system. The concept of negotiating has been invoked to reflect the fact that this is a very complex process bringing together multiple parties whose roles, needs, beliefs and motivations may not always be closely aligned. The behavioural strategies represented in the model have been finely honed through years of practice-based experience. To engage patients in therapy, clinicians must first address the systemic aspects of disconnection to ensure that patients attend therapy. Once patients do attend, clinicians must then negotiate the complex and sometimes hidden intra-psychic and relational disconnections that may relate to the patient's condition. Section 9.4.2 will explore the dilemma of disconnection versus integration at a systemic level. Section 9.4.3 will explore this same dilemma at the level of the therapy dyad, focusing on the aspects of clinical practice that seem to facilitate engagement (and integration).

9.4.2   Disconnection versus integration in the health system.

The biopsychosocial approach was introduced to challenge the pure biomedical model of health. Since its inception, it has been embraced enthusiastically in principle as a valuable concept, however, success implementing it in medical practice has been more limited (Stein, 2005). It is particularly challenging to implement in a primary care context characterised by brief consultations and high-volume caseloads (Scherger, 2005). Some doctors can be resistant to incorporating psychosocial elements into their care and may view this as a last resort (Masters,

2006). The medical education system itself has impeded proliferation of the approach by failing to introduce enough psychosocial material to the curricula (David & Holloway, 2005). Resistance has also been observed among medical students who may not view psychosocial interventions as "proper medicine" (Biderman, Yeheskel, & Herman, 2005). Because of the barriers to delivering holistic care in general practice, Herman (2005) advocated a *transitional split model* in which GPs draw flexibly on either biological or psychosocial elements, as appropriate. Others have suggested that is it unrealistic for GPs to do it all, advocating instead a collaborative care approach, where doctors share responsibility for care with patients, their families, mental health professionals and other professionals (Hepworth & Cushman, 2005).

GPs have frequently been criticised for inadequate management of MUS in primary care (Aiarzaguena, Grandes, Salazar, Gaminde, & Sánchez, 2008). However, the basic principles of the biopsychosocial approach are somewhat incongruent with a system that seeks to split and categorise health conditions into "physical" or "mental". Nowhere is this tension more pronounced than in relation to MUS, which lies so firmly at the intersection. Unfortunately, the increased acceptance of the mixed aetiology of MUS has not yet translated into effective, integrated treatment (Dimsdale & Dantzer, 2007), despite longstanding recognition that this is needed (Aiarzaguena et al., 2008). Pilot studies evaluating whether GPs could offer integrated medical and psychological care for patients with MUS produced disappointing outcomes (Morriss et al., 2006). Experts have concluded that successful treatment of MUS relies on providing psychological therapy alongside medical care delivered by therapists with specialist experience (Deary et al., 2007, Witthöft & Hiller, 2010).

Consistent with the collaborative care approach, some have argued that the biopsychosocial approach would be better defined as "relationship-centred care", emphasising all the relationships required to deliver holistic health care, including relationships between clinicians, with patients, and between the health system and the community (Suchman, 2005). The present model seems to support this relationship-centred notion of biopsychosocial care as it suggests that the bi-directional exchange between clinicians and GPs helps each support the other in adopting a more holistic approach to care. By working collaboratively with mental health clinicians in the service, GPs gain a more holistic understanding of their patients' needs, helping them to care more effectively for these patients in the long term. Arguably, delivering the vision of biopsychosocial care has been more successful in this particular service, quite simply, because the service has proactively challenged conventional ways of working to facilitate collaboration. Moreover, this endeavour is supported at the highest managerial level, including by service commissioners. As noted by Stein (2005), the delivery of biopsychosocial care relies critically on a supportive organisational and cultural environment.

While relationship-centred care, and the problems of process discontinuities between services, might be argued to affect the care and engagement of many client groups, not only those with

MUS difficulties, the present model strongly proposes that those relationships (or, rather, the discontinuities found in them) are both fundamental and central both to the nature of the dilemma experienced by the patient and to the nature of the treatment in this MUS service. The pattern or issue of negotiating disconnection and the need for relationship-centred care is certainly not unique to the MUS population and services. However, its *depth, extent, and centrality* arguably are. The present model goes further by articulating in detail how it is relevant and how closely it parallels the psychological dilemmas experienced by MUS patients, according to their therapists. In that sense, negotiating disconnection is a core thread linking together a paramount and central dilemma for the service managers, patients, clinicians and the whole referring/treating system.

The findings also highlight significant barriers to delivering a more integrated MUS referral and treatment system, including structural, cultural, and practical barriers. Integration seems to rely on the drive and determination of the management and frontline clinical staff, and this orientation may need to be proactively cultivated. However, it also depends on the ability and willingness of GP practices to accommodate such changes. Interdependencies mean that stresses or failures in one part of the system affect other parts. To deliver integrative, biopsychosocial care, all parts of the jigsaw need to fit together very well. Indeed, the model seems to suggest that, integrated care cannot be delivered by individual champions of the biopsychosocial model, but must be supported across all domains (biopsychosocial) and throughout all layers of the system, including by senior management and commissioners. For example, critics have argued that the social component of biopsychosocial assessment, formulation and treatment often gets lost (Barkley, 2009). In the UK at present, it is easy to see how this might happen given that the social care system is in a state of crisis due to chronic underfunding (Oliver, 2015).

Furthermore, there are theoretical and therapeutic practice barriers to consider. Given MUS is a complex biopsychosocial phenomenon, there may be a case to treat more complex patients using a multi-modal approach (Lazarus, 2003) rather than specific (psychodynamic) therapies. A multi-modal approach encourages assessment of all the factors which contribute to the individual's experience and consider a "broad spectrum" of helpful interventions. Lazarus advocates such an approach because many patients' problems are "*multi-faceted, multidetermined, and multi-layered*" (p. 1). This is especially valuable when empirically supported treatments are lacking or do not achieve the desired results (as is the case for MUS, at present). This would warrant involving multi-disciplinary teams (MDTs) in the assessment and treatment of these patients. This is perhaps easier to establish in acute hospital settings, however, MDTs can be established in the community too. Some innovative examples of this way of working have been developed in recent years (Naylor et al., 2016), and studies are emerging supporting interdisciplinary treatments for physical symptoms (e.g. Vowles,

Witkiewitz, Sowden, & Ashworth, 2014). In many ways, MDT-based assessment, formulation and treatment represent the "gold-standard" of biopsychosocial, holistic care.

In the acute setting, an MDT clinic for non-cardiac chest pain was successfully piloted at St Thomas's hospital (Chambers, Marks, Russell, & Hunter, 2015). The clinic offered joint biopsychosocial assessment of patients by a cardiologist and a psychologist and offered a range of treatment interventions tailored to the individual patient's needs, including physical and/or psychosocial interventions. In addition, cardiac nurses were trained to delivered specialist brief CBT interventions for non-cardiac chest pain. MDT teams in the community often focus on specific conditions (e.g. chronic pain), however, some innovative service models (e.g. multispecialty community providers) have been developed to target specific groups in the population, such as high cost patients with multiple health conditions (Naylor et al., 2016). Such approaches require effective partnership building with social care providers and community organisations to effectively address patients' social needs. In summary, even psychotherapists' theoretical preferences and having a service-driven model of therapy may generate subtle barriers to more thoroughly integrated and relational MUS care.

Integration of the health system is a complex task and political and economic factors clearly feed into this. High level policy directives shape service commissioning processes and historically this has worked against integration (Naylor et al., 2016). However, the tide has now clearly turned. Fuelled by tremendous pressures on our health and social care systems related to an aging population and a shift from acute to chronic illness, the government has recognised that disconnection in the health and social system is costly and unsustainable. The government's strategic objective at present is to transform healthcare delivery through "triple integration" (Stevens, 2015), that is, integrating primary and secondary care, health and social care, and physical and mental health care respectively. This study has focused a spotlight on just one dimension of this challenge, that is, the challenge of delivering integrated mental and physical health care in primary care for patients with severe and chronic MUS. Notably, the service that has pioneered this integration been demonstrated to reduce the cost of MUS across the healthcare system (Parsonage, Hard & Rock, 2014).

9.4.3   Disconnection versus integration in the therapy dyad.

This research suggests that effective engagement of patients with severe and chronic MUS requires highly experienced clinicians with specialist MUS experience. This is consistent with a meta-analysis of trials which showed better outcomes under these conditions (Witthöft & Hiller, 2010). For complex patients with MUS, it seems that tensions in the therapeutic relationship and process are quite likely, and careful attention to process can help clinicians pick up on these dynamics and address them. Faced with disconnection in the therapeutic relationship (e.g. patterns of distancing or conflict), therapists may experience negative emotional reactions, and

may need a raised tolerance for uncertainty and ambiguity to cope with the confusing dynamics. Mature clinicians who understand the sensitivities of this patient group, and who can embrace a stance of "safe uncertainty" (Mason, 1993) may be better positioned to manage this. Despite the psychodynamic orientation of this study's participants, the model has a clear person-centred underpinning and includes many examples of collaborative practice.

The model indicates that clinicians who can draw flexibly on multiple psychological frameworks, while also attending sensitively to process issues, may be better able to recognise and address the possible intra-psychic and relational disconnections that may relate to MUS. It seems, therefore, that engagement is promoted when clinicians themselves practice in an integrated way. Clinicians who practiced more integratively exhibited a balanced appreciation of how psychodynamic ideas might help patients with MUS, whilst also recognising that "insight is not everything" and may not be enough for some patients. A variety of different types of integration are evident in the model, including biopsychosocial integration and cross-modality integration (integration of theory and techniques from different psychotherapeutic modalities). Clinicians who can embrace these different dimensions of integration in their practice may be especially well positioned to constructively engage these patients.

Biopsychosocial integration: Clinicians seem to be more effective at engaging patients when they embrace a biopsychosocial approach that attends fully to all aspects of patients' experience, starting from the physical. For the most reluctant patients, joint consultations with GPs provide a very effective way of communicating this holistic approach. Having attended carefully to a patient's physical symptom experiences, clinicians can then gradually explore possible psychosocial influences. However, gentle pacing of therapy is critically important for complex patients with MUS, particularly those patients who have a history of chronic relational trauma. It has been suggested that what MUS should really stand for is "medically unexplained stories" (Launer, 2009, p. 504). Through gentle nudging, clinicians invite patients to construct their own personal "medically unexplained story" in dialog and negotiation with themselves (Kirmayer et al., 2004). Research shows that making sense of MUS symptoms in this way has beneficial therapeutic effects (Kirmayer et al., 2004).

Theoretical integration: A central aim of therapy for MUS is to help patients themselves to develop a more integrated understanding of their difficulties. To engage patients in this process, clinicians must embrace an attitude of openness and curiosity and resist being too hasty in offering their own theory-based formulations, in order to make space for the patient's own narrative. In this study assimilative integration (Norcross, 2005) was often apparent, meaning that clinicians tended to formulate using psychodynamic theories (plural), but integrate understandings from other models where helpful. Clinicians' bias towards psychodynamic formulation could perhaps be questioned given the evidence that multiple interacting factors may play a role in MUS (Deary et al., 2007). However, clinicians' pluralistic mindset was

evident in their multi-layered approach to formulation, which involved holding in mind multiple levels of understanding of patients' difficulties, and sharing these with patients in "*little snippets of formulation*", to ensure digestibility. Overall, the model suggests that theoretical pluralism and the ability to "hold theory lightly" may be important attributes of clinicians who work with these patients, as this promotes flexibility. Some clinicians exhibited a strong allegiance to specific psychoanalytic models, which may limit their flexibility (Hollanders, 2003).

Technical integration: The model illustrates that clinicians integrate a range of techniques from different modalities, including behavioural, mentalising and systemic interventions to engage patients. To address disconnections in the patient's body-mind system may require a combination of careful and sensitive questioning to actively tease out body-mind links, working in the room to draw attention to these splits through the psychotherapy process, and body-mind psycho-education. To practice in this eclectic way requires broad clinical skills (across different therapeutic modalities), and the confidence to apply them flexibly and creatively. Cooper & McLeod (2007) suggest that eclecticism of this kind improves a therapist's ability to meet individual patient's needs. The clear evidence of collaboration in the model was notable as a collaborative therapeutic style is most typically associated with CBT. Psychotherapy research in other populations has shown that collaboration promotes patient engagement generally (Van Audenhove & Vertommen, 2000). Having said that, many participants in this study eschewed goal-focused discussion as this was seen to be incompatible with the psychodynamic model. In terms of engagement, this conflicts with evidence that consensus about therapy goals promotes attendance, reduces drop out, and improves outcomes (Tryon & Winograd, 2002).

9.5   Implications for service development, clinical practice, training and Counselling Psychology

This research was conducted in an innovative specialist service that targets the most complex patients with MUS in primary care. The service model has already expanded to another London Borough. However, services for patients with MUS are needed nationally and whether this model is scalable on a national level remains to be seen. Since this study was originally conceived a transformation of the health system towards integration has begun. Over the next five years, this will bring a significant expansion in the provision of psychotherapeutic services for patients with MUS (NHS England, 2016a). This will be rolled out through "Integrated IAPT" and through expanding Liaison Psychiatry services in secondary care. The implications of this research will be considered in the light of these changes and will consider service development (9.5.1), psychological treatment provision (9.5.2), clinician recruitment, training and supervision (9.5.3) and implications for Counselling Psychology (9.5.4).

9.5.1 Implications for service development.

This research highlights how the current split between physical and mental health undermines the provision of holistic care for patients with MUS in primary care. More importantly, it illustrates how more integrated service models can potentially help to remedy this, by facilitating patient engagement in psychosocial assessment and treatment. However, the research shows that there is a chasm between the strategic vision of integration and the challenging reality of implementation. The model shows that professional relationships are the foundation of integrated, holistic care and that these relationships are cultivated through formal collaborative working practices (e.g. case discussion meetings, reviews, joint consultations, etc). Integration in primary care means that GPs, mental health clinicians and other practice staff need to work together as a team, engaging in genuine collaboration and reciprocal knowledge sharing. This requires that suitably qualified mental health practitioners who are experienced with MUS be embedded as an integral part of the primary care team. Staff charged with developing integrated IAPT services will need to think carefully about creating structures and working practices that facilitate genuine collaboration in order to promote holistic care.

Need for vision and leadership to drive cultural change: One clear implication of this research is that a strong culture of innovation is needed to deliver holistic care for patients with MUS in general practice. Service leads and senior staff will need to make a convincing business case to commissioners for new organisational structures and treatment approaches (drawing on academic, clinical and service-based research), as well as evaluating the outcomes of these efforts. Funding arrangements for this work will need to be carefully negotiated. Healthcare "Think Tanks" (such as The Kings Fund and The Health Foundation) fund and support initiatives promoting innovation in the NHS (The Health Foundation, 2015). Leaders who are driving integration can actively engage with these organisations, by joining and contributing to collaborative networks or taskforces. As this research shows, to embed a biopsychosocial approach in primary care may require a willingness to "rock the boat" and challenge traditional working practices, roles and responsibilities. The barriers that some clinicians experienced collaborating with GPs indicate that the split functions of physical and mental health are very strongly embedded in our system. Strong service leadership will be essential as it may take time, energy and determination to change cultural norms around working practices. Moreover, to promote MUS patient engagement, services targeting this patient group should embrace a patient-centred culture in all aspects of the organisation, with sensitivity to issues of stigma that create difficulties for these patients.

Training of physical health professionals: The model indicates that GPs play a critical role in helping patients with MUS to engage in psychosocial treatment interventions in primary care. GPs identify these patients in the first place, and, as gatekeepers, are uniquely positioned to facilitate a biopsychosocial approach, collaborating with mental health clinicians and other

health professionals. However, this study suggests that to do this effectively, more training is required to raise GPs' awareness and understanding of patients with MUS. At present, GPs work under tremendous time pressure, so training needs to be focused and practical. Training topics should address: the biopsychosocial model, screening for psychological issues, communicating sensitively and effectively with MUS patients, guidance for making successful referrals for psychological care (including patient targeting, referral timing and positioning), and understanding and managing challenging doctor-patient dynamics. Although this study has been located in primary care, by extension, similar training would also greatly benefit doctors and other health professionals (e.g. specialist nurses) in specialist acute settings who are in a position to refer patients for psychological therapy. The point of such training is not that all healthcare professionals become experts in everything, but that each learn enough about the others' roles and skills to help them work together constructively to provide holistic care.

Cultivating links with secondary care physical health services: This research has explored treatment of MUS in the specific context of primary care. However, patients with MUS are encountered throughout the health system across all specialist physical health settings and in Accident and Emergency (Stephenson & Price, 2006). In these settings it is equally crucial that the system can deliver holistic biopsychosocial care to patients with MUS. A study by Matzer et al. (2012) showed that effective screening of patients in A&E for "biopsychosocial complexity" can help to optimize resources in the system to deliver effective and appropriate care that is relevant to patient's individual needs. Although the expansion of Liaison Psychiatry services extends beyond the immediate scope of this study, one recommendation is that service leads and/or clinicians working with patients with MUS in primary care should establish a strong working partnership with colleagues in liaison psychiatry and clinical health psychology (and vice versa). As these new and transformed services mature there will be greater potential for cross referrals between services and collaborative working, as well as knowledge transfer, supervision, and training opportunities. For example, subject to funding availability, there is great potential for developing MDT approaches to the assessment and treatment of MUS in different specialist medical settings, similar to the non-cardiac pain clinic pilot at St Thomas's hospital. Psychologists are well placed to help develop such services.

9.5.2 Psychological treatment provision for MUS.

In the NHS, NICE guidelines strongly influence what kinds of therapies can be offered and nowhere is this more explicit than within IAPT. Although there is evidence supporting both CBT and brief dynamic approaches for MUS, currently there are no NICE guidelines for psychological treatments for MUS apart from specific syndromes such as CFS and IBS. In the absence of prescriptive NICE guidance and unequivocal evidence for specific modalities, there is room and a need for creativity and innovation, and an associated requirement to closely

evaluate outcomes of these efforts. The spirit of innovation has already begun with the proliferation of pilot sites across the country exploring new treatment approaches for MUS.

Initial treatments offered in Integrated IAPT will be CBT-based, reflecting the more robust evidence base of this approach (Witthöft & Hiller, 2010). From an engagement perspective, this research suggests that treatment models emphasising coping may be more palatable to MUS patients, especially in terms of initial engagement. Regardless of the ultimate cause, CBT models emphasise that MUS are precipitated and maintained by interacting biological, psychological and social processes. This can help to circumvent dualistic dialogue and facilitate a blame-free, collaborative approach to treatment (Brown, 2007). In this study, participants help patients make sense of their symptoms in an iterative way, sharing different levels of formulation with them, and allowing plenty of space for the patient's own narrative to feed into this. This approach is not, however, incompatible with a CBT framework. To promote engagement, clinicians can use a CBT framework flexibly to co-construct a shared understanding of the problem with their patients (de Lusignan et al., 2013).

It is notable that the recent call-to-bid for transformation funding for Integrated IAPT invited bids to offer treatments for MUS based on "*comprehensive assessment and formulation following by therapy broadly based on CBT principles*" (NHS England, 2016b). In the author's opinion this is a very welcome development, providing permission for case formulation-guided (rather than protocol-driven) therapy. However, this thesis highlights the additional benefits of psychodynamic thinking, particularly for patients at the more complex end of the spectrum. As this thesis shows, object relations theory and attachment theory offers a rich theoretical foundation for making sense of MUS patients' challenging health behaviours, and their potential unconscious emotional and relational influences. On the basis of this research, the author suggests that services should consider going a step further by offering integrative therapy guided by multi-theoretical formulation, allowing clinicians to incorporate insights from multiple therapeutic modalities. This will be especially important in secondary care acute settings where more complexity and comorbidity may be encountered, although this would also be beneficial in IAPT, for more complex patients with MUS.

The fact that flexibility and adaptability promote engagement suggests that transdiagnostic CBT approaches may also be promising for patients with MUS. Acceptance and Commitment Therapy (ACT) fluidly weaves together didactic, experiential, and metaphorical elements and is known for its flexibility (Hayes, 2004). Although it is not yet firmly established in terms of evidence, studies suggest that it can promote adjustment and improve quality of life for people struggling with physical symptoms (Brassington et al., 2016), and that it can be very helpful for working with challenging cases (Montgomery, Kim, & Franklin, 2011). A recent RCT found group ACT effective in treating severe health anxiety, even thought previous studies for this condition have showed problems with recruitment, dropout and recovery (Eilenberg, Fink,

Jensen, Rief, & Frostholm, 2016). Intuitively there are good reasons to believe that ACT may be a promising approach for patients with MUS. Integrating mindfulness concepts, it encourages individuals to notice their private experiences non-judgmentally instead of trying to control, avoid or minimise them (Springer, 2012). However, it is also a radical behavioural model that has the potential to bring about significant behavioural change within a brief therapy context (Strosahl, Robinson, & Gustavsson, 2012). Together these strategies may help to promote adjustment and improve quality of life for people who are struggling with chronic physical symptoms (explained or unexplained). ACT's emphasis on stopping unworkable behaviour in favour of committed, values-based actions may be helpful in targeting some of the problematic health-related behaviours that are encountered with these patients.

9.5.3   Implications for clinician recruitment, training and supervision.

This study indicates that engaging and working effectively with complex patients with MUS requires considerable specialist expertise, to address the specific sensitivities of this patient group and to navigate the complex dynamics that can occur. In this context, the clinician's ability to retain empathy is crucial. Granted that not all patients with MUS seen in primary care exhibit this complexity, however, clinicians who are prepared (and supported) to deal with a degree of complexity will be more likely to succeed in engaging these patients. Although the patients referred to Integrated IAPT are likely to be less complex than the patients referred to PCPCS, difficulties with engagement are likely to be an ongoing challenge, as was observed in the early IAPT MUS pilots (de Lusignan et al., 2013). Many of the clinicians that will be recruited to staff the new Integrated IAPT services will be High Intensity Therapists trained within the IAPT framework. A competency framework has been prepared for these staff (Roth & Pilling, 2015) and new recruits will be offered a two-week program of "top-up training" (NHS England, 2016a). According to the competency framework, all staff will be taught at least one biopsychosocial model of MUS (e.g. Deary et al., 2007). However, this thesis demonstrates that a pluralistic (cross modality) mindset is valuable for engaging these patients. Clinicians who work with MUS patients would benefit from additional training to expand their understanding of MUS from different theoretical perspectives, as this will enhance their clinical flexibility. The biopsychosocial framework is a helpful "meta-theoretical framework" that can unify and integrate this plural knowledge (Anchin, 2008). To enhance clinicians' sensitivity and empathy, training is also needed around the physiological dimension of MUS (e.g. mechanisms such as central sensitisation, etc.), the phenomenology of MUS, diagnosis and labelling, and the impact of socio-cultural factors (including doctors' behaviour) on patients. In the spirit of delivering a biopsychosocial approach, mental health clinicians should also be educated about the biologically-focused treatments that may help patients with MUS, including medications and psychobiological interventions, such as Autogenic Training (Luthe & Schultz, 1969). Clinicians may also need additional training to ensure that they are suitably prepared for collaborative,

inter-professional working. Careful attendance to process seems crucial for engaging patients with MUS. From a Counselling Psychology perspective, working in a person centred and process oriented way is something that can be embraced by clinicians working in multiple modalities, including CBT. To support a process-focused way of working, expert clinical supervision is vital, ideally delivered by a clinician with specialist MUS expertise. Psychologists (including Counselling Psychologists) are in an excellent position to take up these roles because they are trained in multiple therapeutic models.

9.5.4   Implications for Counselling Psychology.

The planned expansion of psychotherapeutic services for patients with MUS may offer many opportunities for Counselling Psychologists interested in body-mind issues and the physical-mental health intersection. With their pluralistic training (McAteer, 2010), Counselling Psychologists interested in this field are well placed to contribute to this. The approach needed to engage patients - a process-centred, flexible and relational approach - is very much in tune with the principles and philosophy of Counselling Psychology, which advocates a pluralistic approach to psychotherapy with a central focus on the therapeutic relationship (Woolfe, 1996). However, to contribute meaningfully in this area Counselling Psychologists will need to be familiar with the wide-ranging aetiological and treatment models of MUS and be proactively involved with developing and evaluating new services and treatments. As previously noted there is currently a shortage of clinicians with specialist MUS experience and knowledge. Counselling Psychologists with MUS expertise can help to rectify this by providing specialist MUS supervision and contributing to continuing professional development training initiatives for clinical staff (e.g. High Intensity Workers in IAPT). By engaging in practice-based-research (like this study), Counselling Psychologists can contribute to ongoing service development both in terms of treatments offered and by working constructively at the interface with the medical system to make a case for, and build an evidence base in support of what works from a systemic perspective. This could include leading training initiatives for GPs and other health professionals and involving service users more fully, drawing upon their experiences. Drawing on such research, they could also provide systemic consultation to clinicians in services that work with MUS patients. To influence the provision of psychological treatments for MUS in a strategic way, Counselling Psychologists would need to pursue management and leadership positions in services treating patients with MUS and get more actively involved in policy-influencing activities, such as research and dissemination.

Although Counselling Psychology training helps to equip trainees with many of the competencies needed to work effectively with patients with MUS, it is questionable whether the newly qualified are well prepared to make an active and meaningful contribution to this field as there is little explicit coverage of MUS in current training courses. Given the likely future expansion of this field, Counselling Psychology training programs could consider introducing

this subject to their syllabus, at least at a foundational level, for example, by introducing trainees to the different theoretical perspectives on MUS. As there is currently a dearth of MUS research within Counselling Psychology, this may also help more trainees to develop doctoral research ideas on this topic. Research on MUS could also be promoted through collaborative partnerships between Counselling Psychology training courses and clinical services that work with MUS patients. Finally, this research has highlighted the importance of collaborative and consultative relationships with medical professionals. Currently, Counselling Psychology training programs provide little preparation for trainees to "hit the ground running" in this area. As predominantly honorary posts, trainee placements are often only geared towards accruing clinical hours and trainees can struggle to find placements offering additional valuable learning experiences (e.g. MDT working). Training programs could help address this by developing stronger relationships with placement providers (e.g. in Clinical Health Psychology and Liaison Psychiatry) to ensure trainees are more fully integrated in service teams, and by introducing assessment components explicitly oriented towards evaluating inter-professional skills.

9.6 Critical evaluation of this research from a Counselling Psychology perspective, and suggestions for future research

9.6.1 Strengths of this research.

This qualitative study has responded to important and neglected practice-related research questions on the challenges of engaging patients with MUS in psychological therapy in a contemporary specialist NHS service context. The research has focused on understanding the process of engagement and has generated an abstract theoretical framework, "negotiating disconnection", to conceptualise this process. The tentative theoretical model derived from the analysis outlines three key stages of the engagement process (drawing-in, meeting and nudging). These constructs seem to meet Glaser's requirements of "relevance" and "grab" (Glaser & Strauss, 1967). They may be useful practice principles for practitioners in such services to hold in mind in their efforts to engage their patients. The model offers a broad conceptualisation of engagement reflecting how experienced clinicians thought about this topic. The research is both timely and relevant, given the emphasis on integration in healthcare and expansion of NHS funding for long-term conditions and somatic problems. Indeed, this research study was conducted in a "vanguard" service that is attempting to pioneer better integration of physical and mental health in primary care (Naylor et al., 2016). An important contribution of this study is that it seeks to capture and share the lessons that can be learnt from this service through qualitative analysis of therapists' thinking and practice in relation to MUS, and its associated clinical dilemmas. This research is clinician and practice-focused and was conducted in a setting strongly influenced by psychodynamic and systemic ideas. However, a key finding was that practicing in a pure psychoanalytic or psychodynamic way was generally not optimal for engaging patients. Although participants clearly relied on psychodynamic ideas to understand

and conceptualise challenging dynamics encountered with these patients, they most often pursued a person- and process-orientated, and more collaborative approach to promote engagement. The present model provides some precise and specific guidance for clinicians on what they can do both to promote engagement but also to negotiate with more awareness the identifiable pressures that seem to disconnect aspects of people, relationships, and parts of systems working with MUS. These can be argued to be "core business" rather than simply manifestations of ordinary failure or ineffectiveness. Seeing disconnection in the process as something that needs constructive ongoing attention may allow it to be worked with differently than if it is merely seen as a symptom of system or therapist failure or a reason to stop trying. In short, it may allow psychologists and others in the system to engage with disconnection itself, and in quite specific ways, when it might otherwise be problematised. Thus, this grounded theory model may be helpful both directly to therapists in clinical practice, and indirectly working collaboratively with and consulting to GPs and other medical professionals. The model may be helpful and informative for the many new clinicians who will begin working with these patients over the coming few years, including those working in the new Integrated IAPT services, and their supervisors. The model also provides some important insights into critical systemic issues that impact on engagement and, importantly, how these might be framed and approached. It might therefore also offer insights to managers and service leads that are charged to develop integrated services for MUS.

9.6.2   Limitations.

This study had a number of methodological limitations. Participants might have been inclined to talk about their practice in idealised terms. An attempt was made to mitigate this by emphasising the learning value of "negative engagement events". In a similar vein, the chosen method relied on clinicians' reports about their practice, not their actual behaviour. Clinicians often emphasised non-verbal aspects of interactions. Arguably, the finely tuned nuances of interaction cannot be well captured in an interview. From this standpoint, an observational approach might have been preferable. Audio- or video-recorded therapy sessions could potentially capture a much fuller and finely nuanced picture. However, such a study would pose significant ethical issues as well as practical and logistical barriers, and would not have been feasible for a doctoral project. The constructivist epistemological stance assumes that there is no direct correspondence between reality and our perceptions and understanding of it (Willig, 2010). As a result, the model constructed is considered just one possible construction of the process that was created by the author, based on her analysis and interpretation of the data. In addition, the researcher's capacity to engage in theoretical sampling (Strauss & Corbin, 1998) was constrained by the restricted pool of potential participants. For this reason, the output of this research is perhaps best viewed as a "best fit model" based on the available data. As this was a small-scale, abbreviated GT theory study conducted in a specific substantive area, the author

makes no claim that the findings are generalisable to other practitioners or other settings, although further research could be conducted to explore this, for example, for LTCs. From the author's perspective, a key weakness of this study is that is does not capture the patients' perspective on the issue of engagement, which may be very important. Historically, practice-based research has tended to prize the therapist's voice over the client's. However, many now argue that the clients' voice is vital for improving the quality of therapeutic work (e.g. Macran, Ross, Hardy & Shapiro, 1999), especially as there is often poor agreement between clinicians' and clients' appraisals (Elliott & James, 1989). Furthermore, the NHS patients' charter strongly emphasises patient-centred service provision (Department of Health, 2000). As noted by Elliott and James (1989), clients have their own hopes and expectations for therapy. From a phenomenological standpoint, it is important to solicit client feedback in an open ended fashion, thereby giving primacy to their personal experience (Hoshmand & Polkinghorne, 1992).

9.6.3   Suggestions for further research.

Exploratory patient research: Practice-based qualitative studies of clients' treatment experiences can make a valuable contribution to improving clinical practice (Hodgetts and Wright, 2007). However, very little qualitative research has explored patients' experience of therapy for MUS. A qualitative study exploring therapeutic engagement from the patient's perspective would be an obvious, natural progression from this research. In such a study it might be possible to sample participants according to their level of engagement in treatment. This would provide a powerful basis for comparison to really elucidate which factors promote or inhibit engagement. Perhaps most informative would be exploratory research among patients who disengage from therapy or fail to take it up. Recruitment of such participants could prove very challenging. However, GPs could be engaged in the research recruitment process, as they have ongoing relationships with patients after therapy finishes. In the light of this research, one issue which might warrant further exploration is the role of goal negotiation, as this was often eschewed by the clinicians who participated in this study. From a Counselling Psychology perspective, the pluralistic framework outlined by Cooper & McLeod (2007) recommends that therapists elicit patients' ideas about what they need, preserving patients' agency and autonomy. It puts collaborative and flexible negotiation of goals at the heart of the process, through "*an ongoing thread of goal-focused conversations*", or "*process contracting*" (Lee, 2006, p. 8). This is more compatible with Counselling Psychology which emphasises client's subjectivity as a guiding principle for therapy (Woolfe, 1996). Given the importance attached to goals in the working alliance construct (WAI-SR: Hatcher & Gillaspy, 2006), it would be helpful to understand how patients feel about goals, and how this might relate to engagement.

Referrer research: The research suggests that many GPs continue to experience difficulties referring patients with MUS. According to participants, patients were often referred to the

service after many years of problems, and referrals were not always well handled. Late/last resort referrals may contribute to difficulties becoming chronic and entrenched. Notably, the recent IAPT LTC/MUS pilot also found significantly lower referral of patients with MUS compared to LTC (Kellett et al. 2016). Thematic qualitative research (e.g. Braun & Clarke, 2006) could be conducted to explore the barriers that GPs face referring these patients, and used to inform the development of appropriate training. Although the study by Chianello (2010) reported that an enhanced consultation script for referral improved patient motivation to attend therapy, this was only a simulation study. Further research is needed to evaluate whether a brief training intervention for GPs will translate into more effective referrals in practice. A controlled study could be conducted to evaluate the efficacy of such an intervention.

Clinical effectiveness: The discrepancy between GPs' reasons for referring patients with MUS (problematic healthcare utilisation) and patients' own concerns (ameliorating their symptoms) suggests that there is a problem of goal or motivational conflict. This raises the question of what therapy for MUS is actually aiming to achieve, which is not always transparent. Intuitively one might imagine that engagement would be easier if patients had reasonable hope of symptom resolution or amelioration. Psychological treatments for MUS have been criticised for failing to alleviate somatic symptoms (Bakal et al., 2008). Indeed, most participants in this study viewed MUS as persistent symptoms requiring adjustment. However, it has been suggested that the somatic symptoms associated with MUS are reversible in some patients (Mayou & Farmer, 2002). In practice, this issue may be moot because of the impossibility of disentangling "objective" versus "subjective" symptom experience (Balabanovic et al., 2012, 2013). Whether physical symptoms can be reduced objectively may perhaps depend on symptom severity and chronicity, and the length of treatment. This research was conducted in a service that offers brief therapy, however, Houdenhove & Luyten (2007) suggest that long-term treatment may be needed to restore allostasis and alleviate MUS symptoms. Future clinical effectiveness studies could therefore be conducted to assess the impact of treatment length (and other variables) on somatic symptoms. The large sample-sizes of the clinical effectiveness studies means that they can address questions many RCTs cannot, including the impact of moderator variables such as treatment length (Parry, Castonguay, Borkovec & Wolf, 2010).

RCTs: This study indicates that psychodynamic, relational and emotion-focused approaches have much to contribute for this patient group, alongside CBT approaches. Although this has been criticised by the counselling and psychotherapy community, NICE guidelines in the UK are predominantly influenced by RCTs which establish the efficacy of treatment interventions (Pilling, 2008). Historically this led to a proliferation of CBT therapies (Westen, Novotny, & Thompson-Brenner, 2004) and a consequent reduction in patient choice (Bohart, 2005). To ensure their survival within the NHS, under-represented treatment models should be tested in more RCTs to demonstrate their efficacy (Cooper, 2011). For example, ISDTP has a developing

evidence base for MUS (e.g. Abbass et al., 2010; Abbass, Campbell, et al., 2009,) but more RCTs are needed to establish this approach in NICE guidance. The same is true for ACT for MUS (Gundy, Woidneck, Pratt, Christian & Twohig, 2011; Kellett et al., 2016; Montgomery et al., 2011). Furthermore, efficacy studies for MUS should incorporate a broad range of treatment outcomes beyond physical and psychological symptoms and healthcare utilisation, including illness adjustment, functioning, and quality of life measures.

Process research: RCTs are designed to evaluate "pure" treatment orientations. Therapy is manualised and high fidelity to the manual is required. However, this study highlights that engaging complex patients with MUS requires a great deal of flexibility, and that clinicians tend to practice integratively to achieve this. Some clinical researchers argue that clinical practice in real settings is always theoretically impure (Frank and Frank, 1991) and that common factors may be most importance in determining its effectiveness, such as the therapeutic relationship (Norcross & Wampold, 2011), or generic change processes (Beutler & Castonguay, 2005). In the context of integrative therapy, effectiveness studies exploring general processes and outcomes can be extremely informative for clinical practice (Borkovec & Castonguay, 1998). Such an approach would involve administering a variety of measures to patients (and therapists) including measures of the working alliance (WAI-SR: Hatcher & Gillaspy, 2006), generic change process measures, and batteries of different outcome measures. For example, therapy participants could be asked to complete the Helpful Aspects of Therapy scale (HAT Scale: Llewelyn, 1988), to elicit subjective, non-theory driven perceptions about their experience of therapy. A mixed method study such as the above could provide rich insights into the processes of change driving therapy outcomes for this patient group.

Alternative treatment modalities: This research was conducted among clinicians who offer talking therapy for MUS. However, the last few decades have seen a burgeoning interest in somatically based therapies for trauma (Scaer, 2014; Van der Kolk, 2014). This trend reflects the growing recognition of the neurophysiogical basis of PTSD and concerns that talking therapies do not effectively address the somatic dissociative symptoms experienced by many trauma patients (Scaer, 2014). Somatic therapies such as somatic experiencing (Levine, 1997) increase patients' capacity to attend to inner sensations, perceptions and feelings. Though not yet scientifically evaluated, Scaer reports that they tend to resolve trauma-related somatic symptoms more effectively than psychological techniques. Somatic therapies may have some clear advantages over talking therapies in avoiding the dualism inherent in psychological models, validating the patient's physical symptoms while also exploring related psychosocial issues (Bakal et al., 2008). The fact that they put somatic symptoms centre stage may be inherently more engaging for patients who see their problems as predominantly somatic. Future research is needed to establish if this is true, and if so, whether such approaches can deliver better outcomes than conventional talking therapies.

10 Conclusion

This research has explored the process of therapeutic engagement of patients with MUS from the perspective of clinicians working with these patients. The research has shown how various different types of disconnection (structural, interpersonal, intrapersonal) contribute to engagement difficulties. Using GT, a theoretical framework "negotiating disconnection" was constructed to show how clinicians can work through these disconnections to better engage these patients – that is, engage more successfully within any disconnection processes. The model offers a multi-stage process for therapeutic engagement: "drawing in" (initial attendance), "meeting" (initial engagement), and "nudging forward" (real engagement).

Getting patients to attend for psychological assessments was identified as a major engagement challenge. Perceived disconnections within the health system (both structural and relational) were seen to contribute to this problem. "Drawing in" illustrates how clinicians need to negotiate the systemic tendency for disconnection. It emphasises the importance of engaging with the system and persevering when the system may seem chronically or hopelessly disconnected. Clinicians who can continually work to generate stronger, more collaborative and supportive relationships with GPs and who can actively support them in managing these patients and making effective referrals, are likely to be directly influencing initial attendance by patients. They are also, arguably, likely to show greater resilience and persistence with such hard work and, with the help of an underpinning model, may be able to influence others' stances too.

"Meeting" highlights that a range of factors were considered important for initial engagement, including listening to the patient's illness story, legitimising MUS symptoms, and acknowledging their psychological impact. Rather than tolerating patient's body talk, clinicians can helpfully make use of patient's illness experiences as a route to accessing their psychological world. Clinicians should resist offering explanations of causes or making precipitous psychoanalytic interpretations, while also tentatively draw attention to possible psychological contributions (e.g. stress) in a timely way. Therapeutic engagement may be jeopardised if clinicians become too wedded to theory-based understandings of MUS which the patient cannot relate to or digest, or if clinicians struggle to adequately validate or legitimise the patient's suffering. In particular, clinicians are advised to be careful not to slip into tacit dualism and "over-psychologising" patients' symptoms, especially when they are feeling under pressure and experiencing negative emotional reactions to these patients (e.g. feeling overwhelmed themselves).

Overall, the research illustrates the importance of adopting a flexible, person and process oriented approach to engage patients with MUS in brief individual therapy. Although the

participants in this study are strongly informed by psychodynamic and psychoanalytic ideas in their work, in practice they embrace a person-centred and flexible stance to "meet patients where they are at" in order to work with patients in a way that that is helpful. Participants described working in the "here and now" attending assiduously to process to help understand relational and emotional factors that may relate to patient's MUS difficulties, whilst also attending carefully to patients' phenomenological experience and to careful management of the therapeutic relationship.

This research seems to suggest that integrative and pluralistic approaches to therapy are extremely helpful for engaging patients with MUS, allowing the clinician flexibility to focus attention on the patient's cognitive, behavioural, emotional and relational functioning, as needed. This allows the clinician to adapt their approach depending on how the patient presents, for example, becoming more active and supportive if patients have skills deficits. The research indicates that clinicians are best able to support their patients to engage in the process of therapy if they are able to work "in the zone", that is, where they are attuned to their patient's level of psychological awareness and functioning, emotional arousal, the moment to moment quality of the therapeutic relationship, and adjust their interventions accordingly.

The research highlights some exciting challenges ahead in this field. MUS service provision remains poor and underdeveloped relative to many other areas. There is increasing interest and commitment to change this, but many of the developments are in the early stages (e.g. the development of MUS service provision in IAPT). With the current emphasis on evidence-based practice within IAPT there is a danger CBT approaches will proliferate following the IAPT model. This would be a pity because, as this research illustrates, psychodynamic, relational and emotion-focused approaches also have a great deal to contribute. This research shows that a flexible, integrative and pluralistic approach is helpful for engagement. However, in order to influence service development and to satisfy service commissioners and attract funding, Counselling Psychologists may need to engage more in outcomes research (quantitative and qualitative) to generate convincing evidence that such an approach to therapy is effective and helpful for these patients.

11 Reflexive statement (part 3)

In this section I reflect on my experience of doing this research, the ways in which I may have influenced the process, and the impact that this research has had on me, in terms of my professional development. As a doctoral trainee embarking on a grounded theory project for the first time, I was very much in a position of learning through doing. Passionate about my topic and excited by GT's emphasis on eliciting multiple perspectives, I had initially aimed to explore the topic of engagement from the perspective of patients and therapists. Needless to say, I had a somewhat naïve appreciation of what my proposed research would entail in terms of time and resources; the project as originally conceived could not be implemented within the timeframe available and was scaled back to a clinician only study. With hindsight, it seems as if I was perhaps unconsciously attempting, but failing, to bridge elements of disconnection in my research, mirroring the problems in the system.

Perhaps not surprisingly, the analytical process was not quite as neat and straightforward as my method section might suggest. As discussed in supervision on many occasions, I struggled with the "negative capability" (Bion, 1978, pp. 8-9) that is perhaps fundamental to the grounded theory analytical process. My discomfort with uncertainty and desire to know the answer drove me to rush the process at times. I found the process of theoretical integration especially anxiety –provoking fuelled by a fear that the model might not come-together. Hammersley & Atkinson, (1983) describe integration as "*hard work*" and I would certainly agree with this. I had hoped or perhaps expected that I would "discover" a core category, yet in my research this did not seem to be happening. Confused and struggling, I re-read Strauss & Corbin's texts. They stated that, in some these situations, the researcher may need to be creative to generate a more abstract concept to subsume the other categories, which each tell part of the story but not the whole story. Finding this "permission" represented a breakthrough for me. I spent many hours generating, evaluating and discarding different abstract concepts. With the help of supervision I gradually settled on negotiating disconnection as my emergent core category. The sense of relief was enormous.

I tried to embrace the Grounded Theory spirit of emergence as best as I could. For example, my original interview schedule did not explore participants' interactions with primary care because I had been thinking about engagement more narrowly, in terms of the clinician-patient dyad. However, it became apparent that my participants considered this to be extremely important and this eventually became a category in the final model. Similarly, the concept of "meeting patient's where they're at" initially arose as an in-vivo code early in the study, but its centrality was not really established until the second stage. The phrase resonated with me powerfully because I had heard it used a lot when I was on placement in the service, although in the

language of Charmaz (2008a), its meaning was implicit and "taken-for-granted." In this research, I became curious to make sense of its meaning with my participants.

Going into this research, I had anticipated that collaborative formulation (during assessment) might be essential to patient engagement. This 'sensitizing concept' (Blumer, 1969) influenced some of my initial questioning. However, I eventually let go of this as my participants prioritised simply emotionally connecting with the patient over constructing a shared intellectual understanding of the problem. In retrospect, my initial assumptions reflected where I had been at the beginning of the research as a first year trainee who was, at that time, getting to grips with the CBT framework. Many participants talked about the importance of giving the patient space to build or reveal their own narrative about their symptoms, something which might be stifled if a detailed formulation was developed at the beginning of therapy. As a former MUS sufferer I could very much relate to this. Over time, I have gradually developed and elaborated my own narrative about my MUS experience. Had a therapist tried to engage me in an over-simplistic "sewn up" formulation of my experience I might have been inclined to reject it. I can see how encouraging a patient to construct their own story and meaning may be inherently more engaging. There is little doubt that my experiences as a former MUS sufferer have influenced this research in various ways. In this model, the need to acknowledge and legitimise physical symptoms and to be genuinely empathic to patients about their (physical) suffering is foregrounded, in line with my own preconceptions. I remember only too well that my subjective experience of MUS was one of feeling physically unwell, regardless of the aetiology. To have this questioned would have been extremely alienating. I felt encouraged, even relieved, to hear my participants express similar views to my own. With hindsight, I had perhaps expected more "psychologising" reflecting my initial awareness of outdated psychoanalytic perspectives on MUS, which do not necessarily reflect contemporary practice.

During the interviews, I noticed that some clinicians stood out as really "living the attitude" of curiosity and openness that they advocated as essential to engagement, whereas others positioned themselves more as the authority on MUS. In an interview situation some participants may have felt the need to communicate their professional knowledge, especially given the specialist nature of the service. Whatever the reason, I noticed that I myself felt much more engaged when my participants were more open and curious and this felt very relevant and important to my research topic. This is perhaps one reason why openness and tentativeness are repeatedly emphasised throughout my model. In my final year of training, I worked with a patient who had experienced chronic problems with MUS (mainly neurological symptoms) on and off for most of her adult life. Following a significant bereavement early in therapy, I noticed that the patient expressed no negative feelings or emotions about her loss, tending

instead to "look on the bright side" of the situation. Yet, in the weeks after the death the patient's unexplained symptoms (fatigue, pain, dizziness, parathesias, confusion, etc.) returned with full force. Witnessing "live" my patient's dramatic somatising response to her loss and her apparent disconnection from her feelings in relation to this event, I became more convinced by the postulated link between affect dissociation and MUS. This perhaps helped to cement my emerging construction of the process of engagement being one of negotiating disconnection.

Despite my initial scepticism, engaging in this study has helped me to genuinely appreciate the value of psychodynamic approaches in the treatment of MUS. In this respect, this research has been an important influence on my evolving professional identity as a Counselling Psychologist with a genuinely pluralistic and integrative orientation (Orlans, 2013). However, I remain unconvinced that insight is enough for many of these patients. My impression is that that active emotional regulation-oriented skills building (e.g. mindfulness, mentalisation etc) and experiential approaches (e.g. body work) may also be needed to address patient's actual somatic complaints. I find myself curious to learn more about ISTDP, a brief, emotion-focused dynamic approach which seems to show great promise for the treatment of MUS.

When I first started this research, I prevaricated for some time over use of terminology in my interviews. When I was planning to interview patients as well as clinicians I had intended to use the term "persistent physical symptoms" as I was worried that the term MUS would alienate patients who might participate in the study. However, once the scope of the study was reduced to clinicians only, I decided to revert to the more conventional term MUS. Reflecting back on my U-turn, I was concerned that introducing a new and less familiar term may create a barrier in my clinician interviews, potentially eliciting confusion or inviting controversy, and side-tracking the research away from its central focus. I was also worried that it would be imposing too much of me in the research rather than letting it be guided by my participants. I also had some personal ambivalence over the "correct" generic term. My own personal preferred terms were "functional somatic symptoms" or "somatic distress" because these terms acknowledge the disturbance in physiological functioning, however I was aware that these terms did not have universal appeal either. If I were to start the same project again now, I think I would be inclined to be bolder and try to challenge the current discourse by using a more patient-friendly generic term instead of MUS. Like any piece of research, this study was located in a specific time and context. Refreshingly, the discourse has shifted significantly even within the relatively brief lifetime of this research.

12 References

Abbass, A. (2005). Somatisation: Diagnosing it sooner through emotion-focused interviewing. *The Journal of Family Practice, 54*(3), 231-243.

Abbass, A., Campbell, S., Magee, K., Lenzer, I., Hann, G., & Tarzwell, R. (2010). Cost savings of treatment of medically unexplained symptoms using intensive short-term dynamic psychotherapy (ISTDP) by a hospital emergency department. *Archives of Medical Psychology, 2*(1), 34-44.

Abbass, A., Campbell, S., Magee, K., & Tarzwell, R. (2009). Intensive short-term dynamic psychotherapy to reduce rates of emergency department return visits for patients with medically unexplained symptoms: preliminary evidence from a pre–post intervention study. *CJEM, 11*(06), 529-534.

Abbass, A., Kisely, S., & Kroenke, K. (2009). Short-term psychodynamic psychotherapy for somatic disorders: Systematic review of meta-analysis of clinical trials. *Psychotherapy and Psychosomatics, 78*(5), 265-274. doi:10.1159/000228247

Abbass, A., Lovas, D., and Purdy, A. (2008). Direct diagnosis and management of emotional factors in chronic headache patients. *Cephalalgia, 28*, 1306-1314.

Aiarzaguena, J. M., Grandes, G., Salazar, A., Gaminde, I., & Sánchez, Á. (2008). The diagnostic challenges presented by patients with medically unexplained symptoms in general practice. *Scandinavian Journal of Primary Health Care, 26*(2), 99-105. doi:10.1080/02813430802048662

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Oxford: Lawrence Erlbaum.

Allen, J. G., & Fonagy, P. (2006). *The handbook of mentalization-based treatment*. Hoboken, NJ US: John Wiley & Sons Inc.

Allen, J. G., Fonagy, P., & Bateman, A. W. (2008). *Mentalizing in clinical practice*. Arlington, VA: American Psychiatric Publishing, Inc.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, Fourth Edition, Text Revision*. Washington DC: American Psychiatric Association. Task Force on DSM-IV.

American Psychiatric Association. (2013). *Highlights of changes from DSM-IV-TR to DSM-5*. Retrieved from http://www.dsm5.org/documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf Retrieved on 12th April, 2016.

Anchin, J. C. (2008). Pursuing a unifying paradigm for psychotherapy: Tasks, dialectical considerations, and biopsychosocial systems metatheory. *Journal of Psychotherapy Integration, 18*(3), 310-349. doi:10.1037/a0013557

Anderson, E. M., & Lambert, M. J. (1995). Short-term dynamically oriented psychotherapy: A review and meta-analysis. *Clinical Psychology Review, 15*(6), 503-514. doi:10.1016/0272-7358(95)00027-M

Ayers, B., Smith, M., Hellier, J., Mann, E., & Hunter, M. S. (2012). Effectiveness of group and self-help cognitive behavior therapy in reducing problematic menopausal hot flushes and night sweats (MENOS 2): a randomized controlled trial. *Menopause, 19*(7), 749-759.

Balabanovic, J., Ayers, B., & Hunter, M. S. (2012). Cognitive behaviour therapy to treat breast cancer treatment-related hot flushes and night sweats: An interpretative phenomenological analysis. *Maturitas, 72*(3), 236-242.

Bakal, D., Coll, P., & Schaefer, J. (2008). Somatic awareness in the clinical care of patients with body distress symptoms. *BioPsychoSocial Medicine, 2*. doi:10.1186/1751-0759-2-6

Balabanovic, J., Ayers, B., & Hunter, M. S. (2013). Cognitive behaviour therapy for menopausal hot flushes and night sweats: a qualitative analysis of women's experiences of group and Self-Help CBT. *Behavioural and Cognitive Psychotherapy, 41*(04), 441-457.

Barkham, M., & Mellor-Clark, J. (2000). Rigour and relevance: The role of practice-based evidence in the psychological therapies. In N. Rowland & S. Goss (Eds.), *Evidence-based counselling and psychological therapies: Research and applications.* (pp. 127-144). New York, NY, US: Routledge.

Barkham, M., & Mellor-Clark, J. (2003). Bridging evidence-based practice and practice-based evidence: Developing a rigorous and relevant knowledge for the psychological therapies. *Clinical Psychology & Psychotherapy, 10*(6), 319-327. doi:10.1002/cpp.379

Barkley, J. (2009). Biopsychosocial assessment: why the biopsycho and rarely the social? *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 18*(4), 344.

Barsky, A. J. (1992). Amplification, somatisation, and the somatoform disorders. *Psychosomatics: Journal of Consultation Liaison Psychiatry, 33*(1), 28-34.

Barsky, A. J., & Borus, J. F. (1999). Functional somatic syndromes. *Annals of Internal Medicine, 130*(11), 910-921.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*(2), 226-244. doi:10.1037/0022-3514.61.2.226

Bartlett, D., & Payne, S. (1997). 13 Grounded Theory—Its Basis, Rationale and Procedures. *Understanding social research: Perspectives on methodology and practice, 16*, 173.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. Oxford: International Universities Press.

Berger, P., & Luckmann, T. (1966). *The social construction of knowledge: A treatise in the sociology of knowledge.* Open Road Media: Soho, NY, USA

Beutler, L., & Castonguay, L. (Eds.). (2005). *What works in psychology, and why.* Oxford, UK: Oxford University Press.

Bhaskar, R. (1975). *A realist theory of science.* Leeds: Leeds Books.

Bhaskar, R. (1998). *The possibility of naturalism.* London: Routledge.

Biderman, A., Yeheskel, A., & Herman, J. (2005). The biopsychosocial model: have we made any progress since 1977? *Families, Systems, & Health, 23*(4), 379-386. doi:10.1037/1091-7527.23.4.379

Bion, W. (1978). *Four discussions with W. R. Bion.* Strath Tay: Clunie Press.

Blaustein, J. P., & Tuber, S. B. (1998). Knowing the unspeakable: Somatisation as an expression of disruptions in affective-relational functioning. *Bulletin of the Menninger Clinic, 62*(3), 351-365.

Blom, D., Thomaes, S., Kool, M. B., van Middendorp, H., Lumley, M. A., Bijlsma, J. W. J., & Geenen, R. (2012). A combination of illness invalidation from the work environment and helplessness is associated with embitterment in patients with FM. *Rheumatology, 51*(2), 347-353.

Bluff, R. (2005). Grounded theory: the methodology. In I. Holloway (Eds.) *Qualitative Research in Health Care*, (pp. 147-167). London: Open University Press.

Blumer, H. (1969). *Symbolic interactionism*. Englewood Cliffs, NJ: Prentice-Hall.

Bogaerts, K., Van Eylen, L., Li, W., Bresseleers, J., Van Diest, I., De Peuter, S., . . . Van den Bergh, O. (2010). Distorted symptom perception in patients with medically unexplained symptoms. *Journal of Abnormal Psychology, 119*(1), 226-234. doi:10.1037/a0017780

Bohart, A. C. (2005). Evidence-Based Psychotherapy Means Evidence-Informed, Not Evidence-Driven. *Journal of Contemporary Psychotherapy, 35*(1), 39-53. doi:10.1007/s10879-005-0802-8

Borden, W. (2009). *Contemporary psychodynamic theory and practice*. Chicago, IL: Lyceum Books.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252-260. doi:10.1037/h0085885

Borkovec, T. D., & Castonguay, L. G. (1998). What is the scientific meaning of empirically supported therapy? *Journal of Consulting and Clinical Psychology, 66*(1), 136.

Bowlby, J. (1977). The making and breaking of affectional bonds: I. Aetiology and psychopathology in the light of attachment theory. *British Journal of Psychiatry, 130*, 201-210.

Brassington, L., Ferreira, N. B., Yates, S., Fearn, J., Lanza, P., Kemp, K., & Gillanders, D. (2016). Better living with illness: A transdiagnostic acceptance and commitment therapy group intervention for chronic physical illness. *Journal of Contextual Behavioral Science*, *5*(4), 208-214. doi:10.1016/j.jcbs.2016.09.001

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Brennan, K. A., & Shaver, P. R. (1995). Dimensions of adult attachment, affect regulation, and romantic relationship functioning. *Personality and Social Psychology Bulletin, 21*(3), 267-283. doi:10.1177/0146167295213008

Brosschot, J. F., Pieper, S., & Thayer, J. F. (2005). Expanding stress theory: Prolonged activation and perseverative cognition. *Psychoneuroendocrinology, 30*(10), 1043-1049. doi:10.1016/j.psyneuen.2005.04.008

Brown, R. J. (2004). Psychological mechanisms of medically unexplained symptoms: An integrative conceptual model. *Psychological Bulletin, 130*(5), 793-812. doi:10.1037/0033-2909.130.5.793

Brown, R. J. (2006). Medically unexplained symptoms. In N. Tarrier (Ed.), *Case formulation in cognitive behaviour therapy: The treatment of challenging and complex cases.* (pp. 263-292). New York, NY: Routledge/Taylor & Francis Group.

Brown, R. J. (2007). Introduction to the special issue on medically unexplained symptoms: Background and future directions. *Clinical Psychology Review, 27*(7), 769-780. doi:10.1016/j.cpr.2007.07.003

Brown, R. J. (2016, October). *Looking ahead.* Paper presented at the Medically Unexplained Symptoms National Summit: Improving support for Somatic Symptom Disorder. De Vere W1 Conference Centre, London.

Burbaum, C., Stresing, A.-M., Fritzsche, K., Auer, P., Wirsching, M., & Lucius-Hoene, G. (2010). Medically unexplained symptoms as a threat to patients' identity?: A conversation analysis of patients' reactions to psychosomatic attributions. *Patient Education and Counseling, 79*(2), 207-217. doi:10.1016/j.pec.2009.09.043

Burton, C. (2003). Beyond somatisation: a review of the understanding and treatment of medically unexplained physical symptoms (MUPS). *The British Journal of General Practice, 53*, 231-239.

Butler, C. C., & Evans, M. (1999). The 'heartsink' patient revisited. The Welsh Philosophy And General Practice discussion Group. *The British Journal Of General Practice: The Journal Of The Royal College Of General Practitioners, 49*(440), 230-233.

Cannon, W. B. (1932). *The wisdom of the body*. USA: W. W. Norton & Company, Inc.

Carrington, A., Rock, B., & Stern, J. (2012). Psychoanalytic thinking in primary care: The Tavistock Psychotherapy Consultation model. *Psychoanalytic Psychotherapy, 26*(2), 102-120. doi:10.1080/02668734.2012.678636

Chamberlain, K., Camic, P., & Yardley, L. (2003). Qualitative analysis of experience: grounded theory and case studies. In D. F. Marks & L. Yardley (Eds.), *Research Methods for clinical and health psychology* (pp. 69-89). London: Sage.

Chambers, J. B., Marks, E. M., Russell, V., & Hunter, M. S. (2015). A multidisciplinary, biopsychosocial treatment for non-cardiac chest pain. *International journal of clinical practice, 69(*9), 922-927.

Charmaz, K. (1983). Loss of self: a fundamental form of suffering in the chronically ill. *Sociology of Health & Illness, 5*(2), 168-195. doi:10.1111/1467-9566.ep10491512

Charmaz, K. (1991). *Good days, bad days: The self in chronic illness and time*. New Brunswick, NJ: Rutgers University Press.

Charmaz, K. (2000). Constructivist and objectivist grounded theory. In N. K. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd edition ed.). Thousand Oaks, CA: Sage.

Charmaz, K. (2002a). Stories and Silences: Disclosures and Self in Chronic Illness. *Qualitative Inquiry, 8*(3), 302.

Charmaz, K. (2002b). The self as habit: The reconstruction of self in chronic illness. *Occupational Therapy Journal of Research, 22*(Suppl1), 31S-41S.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative research*. London: Sage.

Charmaz, K. (2008a). Grounded theory. In J. A. Smith (Ed.), *Qualitative Psychology: A practical guide to research methods*. London: Sage.

Charmaz, K. (2008b). Views from the margins: Voices, silences, and suffering. *Qualitative Research in Psychology, 5*(1), 7-18. doi:10.1080/14780880701863518

Chew-Graham, C., Brooks, J., Wearden, A., Dowrick, C., & Peters, S. (2011). Factors influencing engagement of patients in a novel intervention for CFS/ME: A qualitative study. *Primary Health Care Research and Development, 12*(2), 112-122. doi:10.1017/S146342361000037X

Chianello, T. (2010). Somatization and engagement in mental health treatment. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 71*(6-A), 2226.

Ciechanowski, P. S., Walker, E. A., Katon, W. J., & Russo, J. E. (2002). Attachment theory: A model for health care utilization and somatization. *Psychosomatic Medicine, 64*(4), 660-667. doi:10.1097/01.psy.0000021948.90613.76

Cooper, M. (2008). *Essential research findings in counselling and psychotherapy*. London: Sage Publications Ltd.

Cooper, M. (2011, May). Meeting the demand for evidence-based practice. *Therapy Today, 22*(4), 10-16.

Cooper, M., & McLeod, J. (2007). A pluralistic framework for counselling and psychotherapy: Implications for research. *Counselling & Psychotherapy Research, 7*(3), 135-143. doi:10.1080/14733140701566282

Corbin, J., & Strauss, A. (1985). Managing chronic illness at home: Three lines of work. *Qualitative Sociology, 8*(3), 224-247. doi:10.1007/BF00989485

Corbin, J., & Strauss, A. (2015). *Basics of Qualitative Research: Techniques and procedures for developing grounded theory* (Fourth Edition ed.). Los Angeles: Sage Publications, Inc.

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World psychiatry, 1*(1), 16-20.

Craig, T. K., Boardman, A. P., Mills, K., & Daly-Jones, O. (1993). The South London Somatisation Study: I. Longitudinal course and the influence of early life experiences. British Journal of Psychiatry, 163, 579-588. doi:10.1192/bjp.163.5.579

Creed, F., & Barsky, A. (2004). A systematic review of the epidemiology of somatisation disorder and hypochondriasis. *Journal of Psychosomatic Research, 56*(4), 391-408. doi:10.1016/s0022-3999(03)00622-6

Creed, F., Barksy, A., & Leiknes, K. A. (2011). Epidemiology: prevalence, causes and consequences. In F. Creed, P. Henningsen & P. Fink (Eds.), *Medically unexplained symptoms, somatisation and bodily distress.* (pp. 1-41). Cambridge: Cambridge University Press.

Creed, F., Fernandes, L., Guthrie, E., Palmer, S., Ratcliffe, J., Read, N., . . . Tomenson, B. (2003). The cost-effectiveness of psychotherapy and paroxetine for severe irritable bowel syndrome. *Gastroenterology, 124*(2), 303-317.

Creed, F., Guthrie, E., Fink, P., Henningsen, P., Rief, W., Sharpe, M., & White, P. (2010). Is there a better term than "medically unexplained symptoms"? *Journal of Psychosomatic Research, 68*(1), 5-8. doi:10.1016/j.jpsychores.2009.09.004

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA, US: Sage Publications, Inc.

Damasio, A. (1999). *The feeling of what happens: Body and emotion in the making of consciousness*. Fort Worth, TX US: Harcourt College Publishers.

Davanloo, H. (1980). *Short-term dynamic psychotherapy*. New York: Aronson.

David, A. K., & Holloway, R. L. (2005). The biopsychosocial model in medicine: Lost or reasserted? *Families, Systems, & Health, 23*(4), 422-425. doi:10.1037/1091-7527.23.4.422

De Gucht, V., & Heiser, W. (2003). Alexithymia and somatisation: A quantitative review of the literature. *Journal of Psychosomatic Research, 54*(5), 425-434. doi:10.1016/s0022-3999(02)00467-1

De Laplante, L. T. (2002). *Understanding somatization: A phenomenological-hermeneutic approach.* (64), ProQuest Information & Learning, US. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2003-95014-265&site=ehost-live Available from EBSCOhost psyh database.

De Lusignan, S., Jones, S., McCrae, N., Cookson, G., Correa, A., & Chan, T. (2013). *IAPT LTC/MUS Pathfinder Evaluation Project Phase 1 Final report*. Retrieved from http://www.iapt.nhs.uk/silo/files/ltcmus-pathfinder-evaluation--phase-1.pdf.

Deary, V., Chalder, T., & Sharpe, M. (2007). The cognitive behavioural model of medically unexplained symptoms: A theoretical and empirical review. *Clinical Psychology Review, 27*(7), 781-797. doi:10.1016/j.cpr.2007.07.002

Department of Health (2000). *The NHS Plan. A plan for investment, a plan for reform.* Retrieved from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAnd Guidance/DH_4002960.

Department of Health (2011). *No health without mental health.* Retrieved from www.doh.gov.uk.

Department of Health (2015). *Medically Unexplained Symptoms/Functional Symptoms: Positive Practice Guide.* Retrieved from http://www.iapt.nhs.uk/silo/files/medically-unexplained-symptoms-postive-practice-guide-2014.pdf.

Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative enquiry.* London: Academic Press.

Di Blasi, Z., Harkness, E., Ernst, E., Georgiou, A., & Kleijnen, J. (2001). Influence of context effects on health outcomes: a systematic review. *Lancet, 357*(9258), 757-762.

Dimsdale, J. E., & Dantzer, R. (2007). A biological substrate for somatoform disorders: Importance of pathophysiology. *Psychosomatic Medicine, 69*(9), 850-854. doi:10.1097/PSY.0b013e31815b00e7

Dowrick, C. F., Ring, A., Humphris, G. M., & Salmon, P. (2004). Normalisation of unexplained symptoms by general practitioners: a functional typology. *The British Journal Of General Practice: The Journal Of The Royal College Of General Practitioners, 54*(500), 165-170.

Edwards, T. M., Stern, A., Clarke, D. D., Ivbijaro, G., & Kasney, L. M. (2010). The treatment of patients with medically unexplained symptoms in primary care. A review of the literature. *Mental Health in Family Medicine, 7*(4), 209-221.

Eilenberg, T., Fink, P., Jensen, J. S., Rief, W., & Frostholm, L. (2016). Acceptance and commitment group therapy (ACT-G) for health anxiety: A randomized controlled trial. *Psychological Medicine*, *46*(1), 103-115. doi:10.1017/S0033291715001579

Elder-Vass, D. (2012). Towards a realist social constructionism. *Sociologia, Promblemas e Práticas,, 70*, 9-24.

Elliott, R., & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review, 9*(4), 443-467. doi:10.1016/0272-7358(89)90003-2

Engel, G. L. (1959). "Psychogenic" pain and the pain-prone patient. *The American journal of medicine, 26*(6), 899-918

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*(4286), 129-136. doi:10.1126/science.847460

Engel, G. L. (1982). The biopsychosocial model: Extending the scope of scientific medicine. In L. J. West & M. Stein (Eds.), *Critical issues in behavioural medicine.* (pp. 149-158). Toronto: J. B. Lippincott.

Epstein, R. M., Hadee, T., Carroll, J., Meldrum, S. C., Lardner, J., & Shields, C. G. (2007). "Could this be something serious?" Reassurance, uncertainty, and empathy in response to patients' expressions of worry. *Journal Of General Internal Medicine, 22*(12), 1731-1739.

Epstein, R. M., Shields, C. G., Meldrum, S. C., Fiscella, K., Carroll, J., Carney, P. A., & Duberstein, P. R. (2006). Physicians' responses to patients' medically unexplained symptoms. *Psychosomatic Medicine, 68*(2), 269-276. doi:10.1097/01.psy.0000204652.27246.5b

Fink, P., Burton, C., De Bie, J., Söllner, W., & Fritzsche, K. (2011). Current state of management and organisation of care. In F. Creed, P. Henningsen, & P. Fink (Eds.), *Medically unexplained symptoms, somatisation and bodily distress: Developing better clinical services.* (pp. 97-123). Cambridge: Cambridge University Press.

Fink, P., Rosendal, M., & Olesen, F. (2005). Classification of somatization and functional somatic symptoms in primary care. *Australian and New Zealand Journal of Psychiatry, 39*(9), 772-781. doi:10.1111/j.1440-1614.2005.01682.x

Fink, P., Toft, T., Hansen, M. S., Ørnbøl, E., & Olesen, F. (2007). Symptoms and syndromes of bodily distress: An exploratory study of 978 internal medical, neurological, and primary care patients. *Psychosomatic Medicine, 69*(1), 30-39. doi:10.1097/PSY.0b013e31802e46eb

Fischhoff, B., & Wessely, S. (2003). Managing patients with inexplicable health problems. *British Medical Journal, 326*(7389), 595.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press.

Fonagy, P., & Target, M. (2000). Playing with reality: III. The persistence of dual psychic reality in borderline patients. *The International Journal of Psychoanalysis, 81*(5), 853-873. doi:10.1516/0020757001600165

Ford, C. V. (1997). Somatic symptoms, somatization, and traumatic stress: An overview. *Nordic Journal of Psychiatry, 51*(1), 5-14. doi:10.3109/08039489709109078

Foucault, M. (1973). *The Birth of the Clinic: An archaeology of medical perception.* London: Tavistock Publications.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.

Freud, S. (1896). The Aetiology of Hysteria. (J. Strachey, Trans.). In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud (Vol 3)* (pp. 1-66). London: Hogarth Press (Originally published 1953).

Freud, S. (1923). The ego and the id. *Standard Edition, 19*, 1-66.

Gillock, K. L., Zayfert, C., Hegel, M. T., & Ferguson, R. J. (2005). Posttraumatic stress disorder in primary care: Prevalence and relationships with physical symptoms and medical utilization. *General Hospital Psychiatry, 27*(6), 392-399. doi:10.1016/j.genhosppsych.2005.06.004

Glaser, B. G. (1978). *Theoretical sensitivity*. Mill Valley, CA: The Sociology Press.

Glaser, B. G. (1992). *Basics of grounded theory analysis: Emergence vs forcing*: Sociology Press.

Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions.* Mill Valley, CA: The Sociology Press.

Glaser, B. G. (2005). *The grounded theory perspective III: Theoretical coding*. Sociology Press.

Glaser, B. G., & Strauss, S. A. (1967). *Discovery of grounded theory. Strategies for qualitative research.* New York: Aldine.

Glenton, C. (2003). Chronic back pain sufferers—striving for the sick role. *Social Science & Medicine, 57*(11), 2243-2252.

Goffman, E. (1968). *Stigma: Notes on the management of spoiled identity*. Harmondsworth: Penguin Books Ltd.

Goldberg, D., Gask, L., & O'Dowd, T. (1989). The treatment of somatization: Teaching techniques of reattribution. *Journal of Psychosomatic Research (Special Issue: Somatization: The somatic presentation of psychiatric illness), 33*(6), 689-695. doi:10.1016/0022-3999(89)90084-6

Gonzalez, J., Williams, J. W., Jr., Noël, P. H., & Lee, S. (2005). Adherence to mental health treatment in a primary care clinic. *The Journal Of The American Board Of Family Practice, 18*(2), 87-96.

Greenson, R. R. (1967). *The technique and practice of psychoanalysis.* New York: International Universities Press.

Grzesiak, R. C., Ury, G. M., & Dworkin, R. H. (1996). Psychodynamic psychotherapy with chronic pain patients. In R. J. Gathchel & D. C. Turk (Eds.), *Psychological approaches to pain management: A practitioner's handbook* (pp. 148-178). New York: Guildford Press.

Gundy, J. M., Woidneck, M. R., Pratt, K. M., Christian, A. W., & Twohig, M. P. (2011). Acceptance and commitment therapy: State of evidence in the field of health psychology. *The Scientific Review of Mental Health Practice: Objective Investigations of Controversial and Unorthodox Claims in Clinical Psychology, Psychiatry, and Social Work, 8*(2), 23-35.

Gunnar, M., & Quevedo, K. (2007). The Neurobiology of Stress and Development. *Annual Review of Psychology, 58*, 145-173. doi:10.1146/annurev.psych.58.110405.085605

Guthrie, E. (1999). Psychodynamic interpersonal therapy. *Advances in psychiatric treatment, 5*, 135-145. doi:10.1192/apt.5.2.135

Guthrie, E., Creed, F., Dawson, D., & Tomenson, B. (1991). A controlled trial of psychological treatment for the irritable bowel syndrome. *Gastroenterology, 100*(2), 450-457.

Hahn, S. R. (2001). Physical symptoms and the physician-experienced difficulty in the physician-patient relationship. *Annals of Internal Medicine, 134*, 894-904.

Hamilton, J., Guthrie, E., Creed, F., Thompson, D., Tomenson, B., Bennett, R., . . . Liston, R. (2000). A randomized controlled trial of psychotherapy in patients with chronic functional dyspepsia. *Gastroenterology, 119*(3), 661-669.

Hammersley, M., & Atkinson, P. (1983). *Ethnography: Principles in practice*, tavistock. London, England.

Hartz, A. J., Noyes, R., Bentler, S. E., Damiano, P. C., Willard, J. C., & Momany, E. T. (2000). Unexplained symptoms in primary care: Perspectives of doctors and patients. *General Hospital Psychiatry, 22*(3), 144-152. doi:10.1016/s0163-8343(00)00060-8

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research,* 16(1), 12-25

Hatcher, S., & House, A. (2003). Life events, difficulties and dilemmas in the onset of chronic fatigue syndrome: A case-control study. *Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences, 33*(7), 1185-1192. doi:10.1017/s0033291703008274

Hayes, S. C. (2004). Acceptance and Commitment Therapy and the New Behavior Therapies: Mindfulness, Acceptance, and Relationship. In S. C. Hayes, V. M. Follette, & M. M. Linehan (Eds.), *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition.* (pp. 1-29). New York, NY, US: Guilford Press.

Heijmans, M., Olde-Hartman, T. C., van Weel-Baumgarten, E., Dowrick, C., Lucassen, P. L. B. J., & van Weel, C. (2011). Experts' opinions on the management of medically unexplained symptoms in primary care. A qualitative analysis of narrative reviews and scientific editorials. *Family Practice, 28*(4), 444-455. doi:10.1093/fampra/cmr004

Heim, C., Nater, U. M., Maloney, E., Boneva, R., Jones, J. F., & Reeves, W. C. (2009). Childhood trauma and risk for chronic fatigue syndrome: Association with neuroendocrine dysfunction. *Archives of General Psychiatry, 66*(1), 72-80. doi:10.1001/archgenpsychiatry.2008.508

Henningsen, P., Fink, P., Hausteiner-Wiehle, C., & Rief, W. (2011). Terminology, classification and concepts. In F. Creed, P. Henningsen, & P. Fink (Eds.), *Medically unexplained symptoms, somatisation and bodily distress: Developing better clinical services.* (pp. 43-68). Cambridge: Cambridge University Press.

Henton, I. (2012). Counselling psychology and practice-based research: A critical review and proposal. *Counselling Psychology Review, 27*(3), 11-28.

Hepworth, J., & Cushman, R. A. (2005). 'Biopsychosocial'--Essential But Not Sufficient. *Families, Systems, & Health, 23*(4), 406-409. doi:10.1037/1091-7527.23.4.406

Herman, J. (2005). The need for a transitional model: A challenge for biopsychosocial medicine? *Families, Systems, & Health, 23*(4), 372-376. doi:10.1037/1091-7527.23.4.372

Hobson, R. F. (1985). *Forms of feeling.* London: Tavistock.

Hodgetts, A., & Wright, J. (2007). Researching clients' experiences: A review of qualitative studies. *Clinical Psychology & Psychotherapy, 14*(3), 157-163. doi:10.1002/cpp.527

Hofer, M. A. (1995). Hidden regulators: Implications for a new understanding of attachment, separation, and loss. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social, developmental, and clinical perspectives.* (pp. 203-230). Hillsdale, NJ England: Analytic Press, Inc.

Hollanders, H. (2003). The eclectic and integrative approach. In R. Woolfe, W. Dryden, & S. Strawbridge (Eds.), *Handbook of counselling psychology* (pp. 277-300). London: Sage.

Horvath, A. O. & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counselling Psychology*, *36*(2), 223-233.

Hoshmand, L. T., & Polkinghorne, D. E. (1992). Redefining the science-practice relationship and professional training. *American Psychologist, 47*(1), 55-66. doi:10.1037/0003-066x.47.1.55

Houdenhove, B. V., & Luyten, P. (2007). Fibromyalgia and related syndromes characterised by stress intolerance and pain hypersensitivity: do we need a new nosology? *Current Rheumatology Reviews, 3*(4), 304-308.

Howard, G. S. (1983). Toward methodological pluralism. *Journal of Counseling Psychology, 30*(1), 19-21. doi:10.1037/0022-0167.30.1.19

Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z., & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist, 51*(10), 1059-1064. doi:10.1037/0003-066x.51.10.1059

Hutchinson, S. A., & Wilson, H. S. (2001). Grounded theory: The method. *PL Munhall (Ed.), Nursing research: A qualitative perspective, 3*, 209-243.

Jones, E. E., Farina, A., Hastorf, A. H., Markus, H., Miller, D. T., & Scott, R. A. (1984). *Social stigma: The psychology of marked relationships.* New York: Freeman.

Jones Nielsen, J. D., & Nicholas, H. (2016). Counselling psychology in the United Kingdom. *Counselling Psychology Quarterly, 29*(2), 206-215. doi:10.1080/09515070.2015.1127210

Katon, W., Lin, E., von Korff, M., & Russo, J. (1991). Somatization: A spectrum of severity. *The American Journal of Psychiatry, 148*(1), 34-40.

Katsamanis, M., Lehrer, P. M., Escobar, J. I., Gara, M. A., Kotay, A., & Liu, R. (2011). Psychophysiologic treatment for patients with medically unexplained symptoms: A randomized controlled trial. *Psychosomatics: Journal of Consultation Liaison Psychiatry, 52*(3), 218-229.

Katzow, A. W., & Safran, J. D. (2007). Recognizing and resolving ruptures in the therapeutic alliance. In P. Gilbert & R. L. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioral psychotherapies* (pp. 90-105). East Sussex: Routledge.

Kellett, S., Webb, K., Wilkinson, N., Bliss, P., Ayers, T., & Hardy, G. (2016). Developing services for patients with depression or anxiety in the context of long-term physical health conditions and medically unexplained symptoms: Evaluation of an iapt pathfinder site. *Behavioural and Cognitive Psychotherapy, 44*(5), 553-567. doi:10.1017/S1352465816000114

Kindler, L. L., Bennett, R. M., & Jones, K. D. (2011). Central sensitivity syndromes: Mounting pathophysiologic evidence to link fibromyalgia with other common chronic pain disorders. *Pain Management Nursing, 12*(1), 15-24. doi:10.1016/j.pmn.2009.10.003

Kirmayer, L. J. (1994). Improvisation and authority in illness meaning. *Culture, Medicine And Psychiatry, 18*(2), 183-214.

Kirmayer, L. J. (2000). Broken narratives: Clinical encounters and the poetics of illness experience. In C. Mattingley & I. Garro (Eds.), *Narratives and the cultural construction of illness and healing* (pp. 153-180). Berkeley, California: University of California Press.

Kirmayer, L. J., Groleau, D., Looper, K. J., & Dao, M. D. (2004). Explaining medically unexplained symptoms. *Canadian Journal Of Psychiatry. Revue Canadienne De Psychiatrie, 49*(10), 663-672.

Kirmayer, L. J., & Robbins, J. M. (1991). *Current concepts of somatization: Research and clinical perspectives*. Washington, DC: American Psychiatric Association.

Kirmayer, L. J., Robbins, J. M., & Paris, J. (1994). Somatoform disorders: Personality and the social matrix of somatic distress. *Journal of Abnormal Psychology, 103*(1), 125-136. doi:10.1037/0021-843x.103.1.125

Kirmayer, L. J., & Taillefer, S. (1997). Somatoform disorders. In S. M. Turner & M. Hersen (Eds.), *Adult psychopathology and diagnosis (3rd edition)* (pp. 333-383). Hoboken, NJ: John Wiley & Sons, Inc.

Kleinstäuber, M., Witthöft, M., & Hiller, W. (2010). Efficacy of short-term psychotherapy for multiple medically unexplained physical symptoms: A meta-analysis. *Clinical Psychology Review, 31*, 146-160. doi:10.1016/j.cpr.2010.09.001

Kooiman, C. G. (1998). The status of alexithymia as a risk factor in medically unexplained physical symptoms. *Comprehensive Psychiatry, 39*(3), 152-159. doi:10.1016/s0010-440x(98)90075-x

Kreitler, S., & Niv, D. (2007). Psychological and psychopathalogical characteristics of patients with pain. In S. Kreitler, D. Beltrutti, A. Lamberto, & D. Niv (Eds.), *The Handbook of Chronic Pain* (pp. 115-133). USA: Nova Science Publishers, Inc.

Kroenke, K. (2007). Efficacy of treatment for somatoform disorders: A review of randomized controlled trials. *Psychosomatic Medicine, 69*(9), 881-888. doi:10.1097/PSY.0b013e31815b00c4

Kroenke, K., Spitzer, R. L., deGruy, F. V., Hahn, S. R., Linzer, M., Williams, J. B. W., . . . Davies, M. (1997). Multisomatoform disorder: An alternative to undifferentiated somatoform disorder for the somatizing patient in primary care. *Archives of General Psychiatry, 54*(4), 352-358.

Kroenke, K., Spitzer, R. L., Williams, J. B., Linzer, M., Hahn, S. R., deGruy, F. V. I., & Brody, D. (1994). Physical symptoms in primary care: Predictors of psychiatric disorders and functional impairment. *Archives of Family Medicine, 3*(9), 774-779.

Kroenke, K., & Swindle, R. (2000). Cognitive–behavioral therapy for somatization and symptom syndromes: A critical review of controlled clinical trials. *Psychotherapy and Psychosomatics, 69*(4), 205-215. doi:10.1159/000012395

Lane, R. D., & Schwartz, G. E. (1987). Levels of emotional awareness: A cognitive-developmental theory and its application to psychopathology. *The American Journal of Psychiatry, 144*(2), 133-143.

Launer, J. (2009). Medically unexplored stories. *Postgraduate Medical Journal,* 85(1007), 503-504.

Lazarus, A. A. (2003). *Multimodal Therapy: A Primer.* Retrieved online from the Zur Institute at http://www.zurinstitute.com/multimodaltherapy.html

LeDoux, J. E. (1995). Emotion: Clues from the brain. *Annual Review of Psychology, 46*, 209-235. doi:10.1146/annurev.ps.46.020195.001233

LeDoux, J. E. (1998). *The emotional brain: The mysterious underpinnings of emotional life.* New York: Simon and Schuster.

Lee, A. (2006). Process Contracts. In C. Sills (Ed.), *Contracts in counselling and psychotherapy (2nd ed.).* (pp. 74-86). Thousand Oaks, CA, US: Sage Publications, Inc.

Leichsenring, F., Rabung, S., & Leibing, E. (2004). The Efficacy of Short-term Psychodynamic Psychotherapy in Specific Psychiatric Disorders: A Meta-analysis. *Archives of General Psychiatry, 61*(12), 1208-1216. doi:10.1001/archpsyc.61.12.1208

Lemma, A. (2003). *Introduction to the practice of psychoanalytic psychotherapy.* Chichester: John Wiley & Sons Ltd.

Levine, P. (1997). *Walking the tiger: Healing trauma*. Berkeley, CA: North Atlantic Press.

Lidbeck, J. (1997). Group therapy for somatization disorders in general practice: Effectiveness of a short cognitive-behavioural treatment model. *Acta Psychiatrica Scandinavica, 96*(1), 14-24. doi:10.1111/j.1600-0447.1997.tb09899.x

Lidbeck, J. (2003). Group therapy for somatization disorders in primary care: Maintenance of treatment goals of short cognitive-behavioural treatment one-and-a-half-year follow-up. *Acta Psychiatrica Scandinavica, 107*(6), 449-456. doi:10.1034/j.1600-0447.2003.00048.x

Lin, E. H. B., Katon, W., Von Korff, M., Bush, T., Lipscomb, P., Russo, J., & Wagner, E. (1991). Frustrating patients. *Journal of General Internal Medicine, 6*(3), 241-246.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Enquiry*. Beverley Hills: Sage.

Link, B. G. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review*, 96-112.

Lipowski, Z. J. (1968). Review of Consultation Psychiatry and Psychosomatic Medicine: III. Theoretical Issues. *Psychosomatic Medicine, 30*(4), 395-422

Lipowski, Z. J. (1987). Somatization: the experience and communication of psychological distress as somatic symptoms. *Psychotherapy and Psychosomatics, 47*(3-4), 160-167.

Lipowski, Z. J. (1988). Somatization: The concept and its clinical application. *The American Journal of Psychiatry, 145*(11), 1358-1368.

Llewelyn, S. P. (1988). Psychological therapy as viewed by clients and therapists. *British Journal of Clinical Psychology, 27*, 223–237.

Looper, K. J., & Kirmayer, L. J. (2002). Behavioral medicine approaches to somatoform disorders. *Journal of Consulting and Clinical Psychology, 70*(3), 810-827. doi:10.1037/0022-006x.70.3.810

Luca, M. (2010). A qualitative study of psychodynamic and cognitive behavioural therapists' conceptualisations of medically unexplained symptoms in their clients. *Counselling & Psychotherapy Research, 11*(4), 291-299. doi:10.1080/14733145.2010.528007

Luca, M. (2011). Therapeutic activities and psychological interventions by cognitive behavioural and psychodynamic therapists working with medically unexplained symptoms: A qualitative study. *Counselling and Psychotherapy Research, 1-10*. doi:10.1080/14733145.2011.605455

Luthe, W., & Schultz, J. H. (1969). *Autogenic Therapy*. Grune and Stratton, Inc. New York.

Luyten, P. (2011, Oct). *An attachment and mentalization-based approach to the treatment of functional somatic complaints*. Paper presented at the Working with complexity: The psychotherapeutic challenges of working with people with persistent physical symptoms. The Tavistock and Portman Mental Health Trust. London.

Luyten, P., Kempke, S., Van Wambeke, P., Claes, S., Blatt, S. J., & Van Houdenhove, B. (2011). Self-critical perfectionism, stress generation, and stress sensitivity in patients with Chronic Fatigue Syndrome: Relationship with severity of depression. *Psychiatry: Interpersonal and Biological Processes, 74*(1), 21-30. doi:10.1521/psyc.2011.74.1.21

Luyten, P., van Houdenhove, B., Lemma, A., Target, M., & Fonagy, P. (2012). A mentalization-based approach to the understanding and treatment of functional somatic disorders. *Psychoanalytic Psychotherapy, 26*(2), 121-140. doi:10.1080/02668734.2012.678061

Luyten, P., Van Houdenhove, B., Lemma, A., Target, M., & Fonagy, P. (2013). Vulnerability for functional somatic disorders: A contemporary psychodynamic approach. *Journal of Psychotherapy Integration, 23*(3), 250-262. doi:10.1037/a0032360

Macran, S., Ross, H., Hardy, G. E., & Shapiro, D. A. (1999). The importance of considering clients' perspectives in psychotherapy research. *Journal of Mental Health, 8*(4), 325-337. doi:10.1080/09638239917256

Mahler, M. S. (1967). On human symbiosis and the vicissitudes of individuation. *Journal of the American Psychoanalytic Association, 15*(4), 740-763. doi:10.1177/000306516701500401

Malan, D. (1976). *The frontier of brief psychotherapy: An example of the convergence of research and clinical practice*. New York: Plenum Press.

Malan, D. (1995). *Individual psychotherapy and the science of psychodynamics* (S. edition Ed.). London: CRC Press.

Mann, E., Smith, M. J., Hellier, J., Balabanovic, J. A., Hamed, H., Grunfeld, B., & Hunter, M. S. (2012). Effectiveness of a cognitive behavioural intervention to treat menopausal symptoms following breast cancer treatment (MENOS 1): a randomised controlled trial. *Lancet Oncol, 13*, 309–318.

Marin, C., & Carron, R. (2002). The origin of the concept of somatization. *Psychosomatics: Journal of Consultation and Liaison Psychiatry, 43*(3), 249-250. doi:10.1176/appi.psy.43.3.249

Marks, E. M., & Hunter, M. S. (2015). Medically Unexplained Symptoms: an acceptable term? *British Journal of Pain, 9*(2), 109-114. doi:10.1177/2049463714535372

Martin, J., Slemon, A. G., Hiebert, B., Hallberg, E. T., & Cummings, A. L. (1989). Conceptualizations of novice and experienced counselors. *Journal of Counseling Psychology, 36*(4), 395-400. doi:10.1037/0022-0167.36.4.395

Mason, B. (2015). Towards positions of safe uncertainty. *InterAction-The Journal of Solution Focus in Organisations, 7*(1), 28-43.

Masters, K. S. (2006). Recurrent Abdominal Pain, Medical Intervention, and Biofeedback: What Happened to the Biopsychosocial Model? *Applied Psychophysiology and Biofeedback*, 31(2), 155-165. doi:10.1007/s10484-006-9016-4

Matzer, F., Wisiak, U. V., Graninger, M., Söllner, W., Stilling, H. P., Glawischnig-Goschnik, M., . . . Fazekas, C. (2012). *Biopsychosocial health care needs at the emergency room: Challenge of complexity.* PLoS ONE, 7(8). doi:10.1371/journal.pone.0041775

Maunder, R., & Hunter, J. (2004). An Integrated Approach to the Formulation and Psychotherapy of Medically Unexplained Symptoms: Meaning- and Attachment-based Intervention. *American Journal of Psychotherapy, 58*(1), 17-33.

May, C. R., Rose, M. J., & Johnstone, F. C. W. (2000). Dealing with doubt: How patients account for non-specific chronic low back pain. *Journal of Psychosomatic Research, 49*(4), 223-225. doi:10.1016/s0022-3999(00)00168-9

Mayou, R. (1993). Somatization. *Psychotherapy and Psychosomatics, 59*(2), 69-83.

Mayou, R. (2014). Is the DSM-5 chapter on somatic symptom disorder any better than DSM-IV somatoform disorder? The British Journal of Psychiatry, 204(6), 418-419. doi:10.1192/bjp.bp.113.134833

Mayou, R., Bass, C., & Sharpe, M. (1995). Treatment of functional somatic symptoms. In R. Mayou, C. Bass, & M. Sharpe (Eds.). *Treatment of functional somatic symptoms* Oxford: Oxford University Press.

Mayou, R., & Farmer, A. (2002). ABC of psychological medicine: Functional somatic symptoms and syndromes. BMJ: *British Medical Journal, 325*(7358), 265-268. doi:10.1136/bmj.325.7358.265

Mayou, R., Kirmayer, L. J., Simon, G., Kroenke, K., & Sharpe, M. (2005). Somatoform Disorders: Time for a New Approach in DSM-V. *The American Journal of Psychiatry, 162*(5), 847-855. doi:10.1176/appi.ajp.162.5.847

McAteer, D. (2010). Philosophical pluralism: Navigating the sea of diversity in psychotherapeutic and counselling psychology practice. In M. Milton (Ed.), *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues.* (pp. 5-19): Wiley-Blackwell.

McEwen, B. S., & Wingfield, J. C. (2003). The concept of allostasis in biology and biomedicine. *Hormones and behavior*, *43*(1), 2-15.

McFarlane, A. C., Ellis, N., Barton, C., Browne, D., & Van Hooff, M. (2008). The conundrum of medically unexplained symptoms: Questions to consider. *Psychosomatics: The Journal of Consultation and Liaison Psychiatry, 48*(5), 369-377. doi:10.1176/appi.psy.49.5.369

McLeod, J. (2001). Developing a research tradition consistent with the practices and values of counselling and psychotherapy: Why counselling and psychotherapy research is necessary. *Counselling & Psychotherapy Research, 1*(1), 3-11. doi:10.1080/14733140112331385188

Melzack, R. (2005). Evolution of the Neuromatrix Theory of Pain. The Prithvi Raj Lecture: Presented at the Third World Congress of World Institute of Pain, Barcelona 2004. *Pain Practice, 5*(2), 85-94. doi:10.1111/j.1533-2500.2005.05203.x

Mikulincer, M., Shaver, P. R., & Pereg, D. (2003). Attachment theory and affect regulation: The dynamics, development, and cognitive consequences of attachment-related strategies. *Motivation and Emotion, 27*(2), 77-102. doi:10.1023/A:1024515519160

Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods, 5*(1), 25-35.

Mintz, I. L. (1995) The psychosomatic patient. In H. J. Schwartz (Ed), *Psychodynamic concepts in general psychiatry* (pp 313-334). Washington: American Psychiatric Press.

Montgomery, K. L., Kim, J. S., & Franklin, C. (2011). Acceptance and commitment therapy for psychological and physiological illnesses: A systematic review for social workers. *Health & Social Work*, *36*(3), 169-179. doi:10.1093/hsw/36.3.169

Morriss, R., Dowrick, C., Salmon, P., Peters, S., Rogers, A., Dunn, G., . . . Gask, L. (2006). Turning theory into practice: Rationale, feasibility and external validity of an exploratory randomized controlled trial of training family practitioners in reattribution to manage patients with medically unexplained symptoms (the MUST). *General Hospital Psychiatry, 28*(4), 343-351. doi:10.1016/j.genhosppsych.2006.03.012

Morrow-Bradley, C., & Elliott, R. (1986). Utilization of psychotherapy research by practicing psychotherapists. *American Psychologist, 41*, 188-197.

Nathan, P. E., Stuart, S. P., & Dolan, S. L. (2003). Research on psychotherapy efficacy and effectiveness: Between Scylla and Charybdis? In A. E. Kazdin (Ed.), *Methodological issues & strategies in clinical research (3rd ed.).* (pp. 505-546). Washington, DC: American Psychological Association.

Naylor, C., Das, P., Ross, S., Honeyman, M., Thompson, J., & Gilburt, H. (2016). *Bringing together physical and mental health*: *A new frontier for integrated care.* The King's Fund. Retrieved from http://www.onewestminster.org.uk/files/onewestminster/bringing-together-kings-fund-march-2016_11.pdf

Neborksy, R. J. (2010). *The Collected Writings of Robert J. Neborsky, MD.* Chicago: Unlocking Press.

Nettleton, S. (2006). 'I just want permission to be ill': Towards a sociology of medically unexplained symptoms. *Social Science & Medicine, 62*(5), 1167-1178. doi:10.1016/j.socscimed.2005.07.030

Nezu, A. M., Maguth Nezu, C., & Lombardo, E. R. (2001). Cognitive-behavior therapy for medically unexplained symptoms: A critical review of the treatment literature. *Behavior Therapy, 32*(3), 537-583. doi:10.1016/s0005-7894(01)80035-6

NHS England (2016a) *Implementing the five year forward view for mental health*. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

NHS England (2016b). *Mental Health: Introduction to and supporting documentation for Value based transformation funding selection*. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2016/12/mental-health-call-to-bid.pdf

Norcross, J. C. (2005). A Primer on Psychotherapy Integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration (2nd ed.).* (pp. 3-23). New York, NY, US: Oxford University Press.

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy, 48*(1), 98-102.

Oakley, A., Strange, V., Bonell, C., Allen, E., & Stephenson, J. (2006). Health Services Research: Process evaluation in randomised controlled trials of complex interventions. *BMJ: British Medical Journal, 332*(7538), 413-416. doi:10.1135/bmj.332.7538.413

Oliver, D. (2015). We cannot keep ignoring the crisis in social care. *BMJ: British Medical Journal, 350,* h2684.

Orlans, V. (2013). The nature and scope of counselling psychology. In G. Davey (Ed.), *Applied psychologies.* Wiley-Blackwell.

Panksepp, J., & Biven, L. (2012). *The archaeology of mind: neuroevolutionary origins of human emotions (Norton series on interpersonal neurobiology). WW Norton & Company.* New York. London: WW Norton & Company.

Parry, G., Castonguay, L. G., Borkovec, T. D., & Wolf, A. W. (2010). Practice research networks and psychological services research in the UK and USA. In M. Barkham, G. E. Hardy & J. Mellor-Clark (Eds.), *Developing and delivering practice-based evidence: A guide for the psychological therapies* (pp. 311-325). Oxford: Wiley-Blackwell.

Parsonage, Hard & Rock. (2014) *Managing patients with complex needs: Evaluation of the City and Hackney Primary Care Psychotherapy Consultation Service.* Report from the Centre for Mental Health. Retrieved from http://repository.tavistockandportman.ac.uk/880/1/Managing_patients_complex_needs.pdf

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research, 34,* 1189-1208

Pennebaker, J. W. (1982). *The psychology of physical symptoms.* New York: Springer.

Pennebaker, J. W. (1989). Confession, inhibition, and disease. In L. Berkowitz (Ed.), *Advances in experimental social psychology, Vol. 22.* (pp. 211-244). San Diego, CA: Academic Press.

Pennebaker, J. W., Hughes, C. F., & O'Heeron, R. C. (1987). The psychophysiology of confession: Linking inhibitory and psychosomatic processes. *Journal of Personality and Social Psychology, 52*(4), 781-793. doi:10.1037/0022-3514.52.4.781

Persons, J. B., & Silberschatz, G. (1998). Are results of randomized controlled trials useful to psychotherapists? *Journal of Consulting and Clinical Psychology, 66*(1), 126-135. doi:10.1037/0022-006x.66.1.126

Peters, S., Stanley, I., Rose, M., & Salmon, P. (1998). Patients with medically unexplained symptoms: sources of patients' authority and implications for demands on medical care. *Social Science & Medicine, 46*(4-5), 559-565.

Peveler, R., Kilkenny, L., & Kinmonth, A.-L. (1997). Medically unexplained physical symptoms in primary care: A comparison of self-report screening questionnaires and clinical opinion. *Journal of Psychosomatic Research, 42*(3), 245-252. doi:10.1016/S0022-3999(96)00292-9

Picariello, F., Ali, S., Moss-Morris, R., & Chalder, T. (2015). The most popular terms for medically unexplained symptoms: The views of CFS patients. *Journal of Psychosomatic Research, 78*(5), 420-426. doi:10.1016/j.jpsychores.2015.02.013

Pidgeon, N. (1996). Grounded theory: theoretical background. In Richardson, JE (Ed.), *Handbook of qualitative research methods for psychology and the social sciences.* Leicester: British Psychological Society.

Pilling, S. (2008). History, context, process, and rationale for the development of clinical guidelines. *Psychology and Psychotherapy: Theory, Research and Practice, 81*(4), 331-350.

Porges, S. W. (2001). The polyvagal theory: Phylogenetic substrates of a social nervous system. *International Journal of Psychophysiology, 42*(2), 123-146. doi:10.1016/S0167-8760(01)00162-3

Rhodes, L. A., McPhillips-Tangum, C. A., Markham, C., & Klenk, R. (1999). The power of the visible: The meaning of diagnostic tests in chronic back pain. *Social Science & Medicine, 48*(9), 1189-1203. doi:10.1016/s0277-9536(98)00418-3

Rief, W., & Barsky, A. J. (2005). Psychobiological perspectives on somatoform disorders. *Psychoneuroendocrinology, 30*(10), 996-1002. doi:10.1016/j.psyneuen.2005.03.018

Rief, W., & Broadbent, E. (2007). Explaining medically unexplained symptoms-models and mechanisms. *Clinical Psychology Review, 27*(7), 821-841. doi:10.1016/j.cpr.2007.07.005

Rizq, R. (2012). The ghost in the machine: IAPT and organizational melancholia. *British Journal of Psychotherapy, 28*(3), 319-335. doi:10.1111/j.1752-0118.2012.01281.x

Roelofs, K., & Spinhoven, P. (2007). Trauma and medically unexplained symptoms: Towards an integration of cognitive and neuro-biological accounts. *Clinical Psychology Review, 27*(7), 798-820. doi:10.1016/j.cpr.2007.07.004

Rosenfeld, H. (2001). The relationship between psychosomatic symptoms and latent psychotic states. In de Masi, F. (Ed) *Herbert Rosenfeld at work: The Italian seminars* (pp. 24-44). London: Karnac.

Roth, A. D., & Pilling, S. (2015). *A competence framework for psychological interventions with people with persistent physical health conditions.* Retrieved from: https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/pdfs/Physical_Health_Problems/Physical_Background_Doc.pdf

Rubin, J., & Wessely, S. (2006). The role of stress in the etiology of medically unexplained syndromes. In B. B. Arnetz & R. Ekman (Eds.), *Stress in health and disease.* (pp. 292-306). Weinheim Germany: Wiley-VCH Verlag GmbH & Co KGaA.

Russell, L. (2015, July) *From attachment trauma to physical symptoms: The application of ISTDP to somatisation and functional neurological disorders.* Paper presented at an ISTDP evening seminar. John Adams Hall, London.

Russell, L., Abbass A. A., Allder, S. J., and Neborsky, R. J. (2016) *Applying intensive short-term dynamic psychotherapy to the treatment of medically unexplained symptoms: Integrating theories of cause and theories of change.* Manuscript submitted for publication.

Rygh, L. J., Svendsen, F., Fiskå, A., Haugan, F., Hole, K., & Tjølsen, A. (2005). Long-term potentiation in spinal nociceptive systems--how acute pain may become chronic. *Psychoneuroendocrinology, 30*(10), 959-964. doi:10.1016/j.psyneuen.2005.04.007

Sacks, H., Schegloff, E. A., & Jefferson, G. (1974). A simplest systematics for the organization of turn-taking for conversation. *Language, 50*, 696-735.

Salkovskis, P. M. (1989). Somatic problems. In K. Hawton, P. M. Salkovskis, J. Kirk, & D. M. Clark (Eds.), *Cognitive behaviour therapy for psychiatric problems: A practical guide.* (pp. 235-276). Oxford: Oxford University Press.

Salmon, P. (2007). Conflict, collusion or collaboration in consultations about medically unexplained symptoms: The need for a curriculum of medical explanation. *Patient Education and Counseling, 67*(3), 246-254. doi:10.1016/j.pec.2007.03.008

Salmon, P., Dowrick, C. F., Ring, A., & Humphris, G. M. (2004). Voiced but unheard agendas: qualitative analysis of the psychosocial cues that patients with unexplained symptoms present to general practitioners. *The British Journal Of General Practice: The Journal Of The Royal College Of General Practitioners, 54*(500), 171-176.

Salmon, P., Peters, S., & Stanley, I. (1999). Patients' perceptions of medical explanations for somatisation disorders: qualitative analysis. *BMJ (Clinical Research Ed.), 318*(7180), 372-376.

Salmon, P., Ring, A., Dowrick, C. F., & Humphris, G. M. (2005). What do general practice patients want when they present medically unexplained symptoms, and why do their doctors feel pressurized? *Journal of Psychosomatic Research, 59*(4), 255-262. doi:10.1016/j.jpsychores.2005.03.004

Sbarra, D. A., & Hazan, C. (2008). Coregulation, dysregulation, self-regulation: An integrative analysis and empirical agenda for understanding adult attachment, separation, loss, and recovery. *Personality and Social Psychology Review, 12*(2), 141-167. doi:10.1177/1088868308315702

Scaer, R. (2014). *The body bears the burden: Trauma, dissociation, and disease (3rd ed.)*. New York, NY, US: Routledge/Taylor & Francis Group.

Scherger, J. E. (2005). The biopsychosocial model is shrink wrapped, on the shelf, ready to be used, but waiting for a new process of care. *Families, Systems, & Health, 23*(4), 444-447. doi:10.1037/1091-7527.23.4.444

Schneider, W., Beisenherz, B., & Freyberger, H. J. (1990). Therapy expectation in different groups of patients with chronic diseases. *Psychotherapy and Psychosomatics, 54*(1), 1-7.

Schur, M. (1955). Comments on the metapsychology of somatisation. *The Psychoanalytic Study of the Child*, *10*(1), 119-164.

Schwartz, G. E. (1982). Testing the biopsychosocial model: The ultimate challenge facing behavioral medicine? *Journal of Consulting and Clinical Psychology, 50*(6), 1040-1053. doi:10.1037/0022-006x.50.6.1040

Seabrook (2017). *Exploring "medically unexplained symptoms" with GPs and counselling psychologists: A Foucauldian Discourse Analysis* (Unpublished doctoral dissertation). London Metropolitan University. London.

Sharpe, M., & Carson, A. (2001). "Unexplained" somatic symptoms, functional syndromes, and somatization: do we need a paradigm shift? *Annals of Internal Medicine, 134*(9_Part_2), 926-930.

Sharpe, M., Peveler, R., & Mayou, R. (1992). The psychological treatment of patients with functional somatic symptoms: A practical guide. *Journal of Psychosomatic Research, 36*(6), 515-529. doi:10.1016/0022-3999(92)90037-3

Shoenberg, P. J. (2001). Winnicott and the psyche-soma. In M. Bertolini, A. Giannakoulas, & M. Hernandez (Eds.), *Squiggles and spaces revisiting the work of D. W. Winnicott, (Vol. 2).* (pp. 147-154). Philadelphia, PA: Whurr Publishers.

Shoenberg, P. J. (2007). *Psychosomatics: The uses of psychotherapy*. London: Palgrave Macmillan.

Sifneos, P. E. (1973). The prevalence of 'alexithymic' characteristics in psychosomatic patients. *Psychotherapy and Psychosomatics, 22*(2-6), 255-262.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage.

Springer, J. M. (2012). Acceptance and commitment therapy: Part of the 'third wave' in the behavioral tradition. *Journal of Mental Health Counselling*, *34*(3), 205-212. doi:10.17744/mehc.34.3.9110205883653735

Strauss, A. (1987). *Qualitative analysis for social scientists*. New York, NY, US: Cambridge University Press.

Strauss, A. & Corbin, J. (1990). *Basics of qualitative research*: *Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications Inc.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory (2nd ed.)*. Thousand Oaks, CA, US: Sage Publications, Inc.

Stein, H. F. (2005). It ain't necessarily so: The many faces of the biopsychosocial model. *Families, Systems, & Health, 23*(4), 440-443. doi:10.1037/1091-7527.23.4.440

Stephenson, D. T., & Price, J. R. (2006). Medically unexplained physical symptoms in emergency medicine. *Emergency Medicine Journal, 23*(8), 595-600.

Stevens, S. (2015). *Simon Stevens on the NHS five year forward view.* Video clip. Available at: https://www.kingsfund.org.uk/audio-video/simon-stevens-nhs-five-year-forward-view (accessed on 10th February, 2017)

Stone, J., Colyer, M., Feltbower, S., Carson, A., & Sharpe, M. (2004). Psychosomatic': A Systematic Review of Its Meaning in Newspaper Articles. *Psychosomatics: Journal of Consultation and Liaison Psychiatry*, *45*(4), 287-290. doi:10.1176/appi.psy.45.4.287

Stone, J., Wojcik, W., Durrance, D., Carson, A., Lewis, S., MacKenzie, L., . . . Sharpe, M. (2002). What should we say to patients with symptoms unexplained by disease? The 'number needed to offend'. *BMJ: British Medical Journal, 325*(7378), 1449-1450. doi:10.1136/bmj.325.7378.1449

Strassnig, M., Stowell, K. R., First, M. B., & Pincus, H. A. (2006). General medical and psychiatric perspectives on somatoform disorders: Separated by an uncommon language. *Current Opinion in Psychiatry, 19*(2), 194-200. doi:10.1097/01.yco.0000214348.38787.d3

Strosahl, K., Robinson, P., & Gustavsson, T. (2012). *Brief interventions for radical change: Principles and practice of focused acceptance and commitment therapy*. Oakland, CA, US: New Harbinger Publications.

Stuart, S., & Noyes, R., Jr. (1999). Attachment and interpersonal communication in somatization. *Psychosomatics: The Journal of Consultation and Liaison Psychiatry, 40*(1), 34-43.

Stuart, S., & Noyes, R., Jr. (2006). Interpersonal psychotherapy for somatizing patients. *Psychotherapy and Psychosomatics, 75*(4), 209-219. doi:10.1159/000092891

Suchman, A. L. (2005). The current state of the biopsychosocial approach. *Families, Systems, & Health, 23*(4), 450-452. doi:10.1037/1091-7527.23.4.450

Tak, L. M., Bakker, S. J. L., & Rosmalen, J. G. M. (2009). Dysfunction of the hypothalamic-pituitary-adrenal axis and functional somatic symptoms: A longitudinal cohort study in the general population. *Psychoneuroendocrinology, 34*(6), 869-877. doi:10.1016/j.psyneuen.2008.12.017

Tak, L. M., & Rosmalen, J. G. M. (2010). Dysfunction of stress responsive systems as a risk factor for functional somatic syndromes. *Journal of Psychosomatic Research, 68*(5), 461-468. doi:10.1016/j.jpsychores.2009.12.004

Taylor, G. J., Bagby, R. M., & Parker, J. D. A. (1997). *Disorders of affect regulation: Alexithymia in medical and psychiatric illness*. Cambridge: Cambridge University Press.

Taylor, R. E., Mann, A. H., White, N. J., & Goldberg, D. P. (2000). Attachment style in patients with unexplained physical complaints. *Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences, 30*(4), 931-941. doi:10.1017/s0033291799002317

The Health Foundation (2015). *Better health and health care for the UK: Our strategic plan 2015-2018*. Retrieved from website: http://www.health.org.uk/sites/health/files/StrategicPlan_2015_2018.pdf

Thompson, M., & Walter, F. (2017). Increases in general practice workload in England. *The Lancet, 387*(10035), 2270-2272. doi:10.1016/S0140-6736(16)00743-1

Timmer, B., Bleichhardt, G., & Rief, W. (2006). Importance of Psychotherapy motivation in patients with somatization syndrome. *Psychotherapy Research, 16*(3), 348-356. doi:10.1080/10503300500485292

Tryon, G. S., & Winograd, G. (2002). Goal consensus and collaboration. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 109-125). Oxford: Oxford University Press.

Van Audenhove, C., & Vertommen, H. (2000). A negotiation approach to intake and treatment choice. *Journal of Psychotherapy Integration, 10*(3), 287-299. doi:10.1023/A:1009401129920

Van der Kolk, B. A. (2014). *The body keeps the score*. New York City: Viking.

Van Houdenhove, B., Luyten, P., & Egle, U. (2009a). Stress as a key concept in chronic widespread pain and fatigue disorders. *Journal of Musculoskeletal Pain, 17*(4), 390-399. doi:10.3109/10582450903284745

Van Houdenhove, B., Luyten, P., & Egle, U. T. (2009b). The role of childhood trauma in chronic pain and fatigue. In V. L. Banyard, V. J. Edwards, & K. A. Kendall Tackett (Eds.), *Trauma and physical health. Understanding the effects of extreme stress and of psychological harm* (pp. 37-64). Abingdon: Routledge

Van Ravenzwaaij, J., Olde Hartman, T. C., Van Ravesteijn, H., Eveleigh, R., Van Rijswijk, & Lucassen, P. L. B. J. (2010). Explanatory models of medically unexplained symptoms: A qualitative analysis of the literature. *Mental Health in Family Medicine, 7*, 223-231.

Van Ravesteijn, H., Lucassen, P., Bor, H., van Weel, C., & Speckens, A. (2013). Mindfulness-based cognitive therapy for patients with medically unexplained symptoms: A randomized controlled trial. *Psychotherapy and Psychosomatics, 82*(5), 299-310. doi:10.1159/000348588

Van Ravesteijn, H., van Dijk, I., & Lucassen, P. (2011). Commentary to: Medically unexplained symptoms as a threat to patients' identity? A conversation analysis of patients' reactions to psychosomatic attributions by Burbaum et al. [2010]. *Patient Education and Counseling, 84*(1), 137-138. doi:10.1016/j.pec.2010.12.030

Venable, V. L., Carlson, C. R., & Wilson, J. (2001). The role of anger and depression in recurrent headache. *Headache: The Journal of Head and Face Pain, 41*(1), 21-30. doi:10.1046/j.1526-4610.2001.111006021.x

Vowles, K. E., Witkiewitz, K., Sowden, G., & Ashworth, J. (2014). Acceptance and commitment therapy for chronic pain: Evidence of mediation and clinically significant change following an abbreviated interdisciplinary program of rehabilitation. *The Journal of Pain*, *15*(1), 101-113. doi:10.1016/j.jpain.2013.10.002

Vygotsky, L. S. (1978). *Mind in society: The development of higher mental process*. Cambridge, MA: Harvard University Press

Waller, E., & Scheidt, C. E. (2006). Somatoform disorders as disorders of affect regulation: A development perspective. *International Review of Psychiatry, 18*(1), 13-24. doi:10.1080/09540260500466774

Waller, E., Scheidt, C. E., & Hartmann, A. (2004). Attachment representation and illness behavior in somatoform disorders. *Journal of Nervous and Mental Disease, 192*(3), 200-209. doi:10.1097/01.nmd.0000116463.17588.07

Warwick, H. M., & Salkovskis, P. M. (1990). Hypochondriasis. *Behaviour Research and Therapy, 28*(2), 105-117. doi:10.1016/0005-7967(90)90023-c

Watkins, P. (2002). Medically unexplained symptoms. *Clinical Medicine, 2*(5), 389–390.

Webb, T. (2010). Medically unexplained symptoms. *Therapy Today, 21*(3), 10-14.

Weiner, B., Perry, R. P., & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology, 55*(5), 738.

Wessely, S. M. (2001). Discrepancies between diagnostic criteria and clinical practice. In P. W. Halligan, C. Bass, & J. Marshall (Eds.), *Contemporary approaches to the study of hysteria: Clinical and theoretical perspectives.* (pp. 63-72). Oxford: Oxford University Press.

Wessely, S., Nimnuan, C., & Sharpe, M. (1999). Functional somatic syndromes: one or many? *The Lancet, 354*(9182), 936-939.

Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The Empirical Status of Empirically Supported Psychotherapies: Assumptions, Findings, and Reporting in Controlled Clinical Trials. *Psychological Bulletin, 130*(4), 631-663. doi:10.1037/0033-2909.130.4.631

Willig, C. (2001) *Introducing qualitative research in psychology: adventures in theory and method* (1st Edition ed.). Buckingham: Open University Press.

Willig, C. (2010). *Introducing qualitative research in psychology: adventures in theory and method* (2nd ed.). Maidenhead: McGraw-Hill Open University Press.

Winnicott, D. W. (1958). *Collected papers: Through paediatrics to psycho-analysis*. Oxford: Basic Books.

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. Oxford England: International Universities Press.

Winnicott, D. W. (1989). On the basis for self in the body. In C. Winnicott, R. Shepherd, & M. Davis (Eds.), *Psychoanalytic Explorations* (pp. 261-283). Cambridge, MA: Harvard University Press.

Witthöft, M., & Hiller, W. (2010). Psychological approaches to origins and treatments of somatoform disorders. *Annual Review of Clinical Psychology, 6*, 257-283. doi:10.1146/annurev.clinpsy.121208.131505

Wood, D., Bruner, J. S., & Ross, G. (1976). The role of tutoring in problem solving. *Journal of Child Psychology and Psychiatry, 17*(2), 89-100.

Woolfe, R. (1996). Counselling psychology in Britain: past, present and future. *Counselling Psychology Review, 11*(4), 7-15.

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines.* Geneva, Switzerland: World-Health-Organization.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). Schema therapy: A practitioner's guide: Guilford Press.

Yunus, M. B. (2008). Central sensitivity syndromes: a new paradigm and group nosology for fibromyalgia and overlapping conditions, and the related issue of disease versus illness. *Seminars in Arthritis and Rheumatism, 37*(6), 339-352.

Yunus, M. B. (2009). Central sensitivity syndromes: An overview. *Journal of Musculoskeletal Pain, 17*(4), 400-408. doi:10.3109/10582450903284752

Appendix 1: Collaboration agreement with PCPCS

LONDON METROPOLITAN UNIVERSITY
Department of Psychology – Counselling Psychology
RESEARCH PROPOSAL

COLLABORATING ORGANISATION APPROVAL

(To be completed when the student's research involves the collaboration of another organisation)

Student Name	Janet Balabanovic
Student Number	07013607
Student Contact Tel. No	07970 453567
Collaborating Organisation (name)	City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS)
(address)	210 Kingsland Road, London E2 8EB
Contact/Liaison Person in Collaborating Organisation. Tel. No. Email:	Brian Rock 020 7683 4900 brock@tavi-port.nhs.uk

I, the undersigned, have given permission to the above named student to carry out fieldwork for their research. I have been fully briefed as to the nature of the project and the requirements for obtaining a suitable sample, administration of questionnaires, conducting interviews, or other appropriate means of data collection, and agree this can be undertaken in this organisation during the period specified and approved.

All ethical implications that might affect the organisation's reputation and commercial integrity, the well-being of it's employees, and significant third parties have been discussed and where necessary appropriate action taken. (Note, if this action includes the imposition of some form of restriction or limit on access to the final dissertation, please specify the extent of this restriction e.g. permanent or for a specified period.)

The student has been/will be briefed on company Health & Safety procedures as affects their planned data gathering activities.

Signed _Rock_
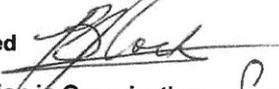
Position in Organisation _Service Lead, CH PCPCS_

Date _12/11/12_

Should the collaborating organization wish to discuss any aspect of the trainee researcher's activities please contact Dr. Elaine Kasket (e.kasket@londonmet.ac.uk), Advanced Psychological Research module leader.

Appendix 2: University ethics approval

London Metropolitan University,
School of Psychology,
Research Ethics Review Panel

I can confirm that the following project has received ethical approval to proceed:

Title: *An exploration of how engagement is promoted or hindered in brief psychotherapy among patients with chronic and severe 'medically unexplained' symptoms*

Student: **Janet Balabanovic**

Supervisors: Russel Ayling and Elaine Kasket

Ethical approval to proceed has been granted providing that the study follows the ethical guidelines used by the School of Psychology and British Psychological Society, and incorporates any relevant changes required by the Research Ethics Review Panel. All participating organisations should provide formal consent allowing the student to collect data from their staff.

The researcher is also responsible for conducting the research in an ethically acceptable way, and should inform the ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed:

Date: 06/02/13

Dr Chris Chandler
(Chair - School of Psychology Research Ethics Review Panel)
chandler@staff.londonmet.ac.uk

Appendix 3: Transcription rules and transcript excerpt

The interviews for this study were transcribed verbatim following the following transcription conventions.

1. All interviews were transcribed in verbatim by the researcher.

2. All pauses significant pauses were noted with dots, with one dot representing each second of the pause

3. If the participants and the interview are talking over one another, the comments that are overlapping are put in square brackets

4. Significant or potentially relevant non verbal communications are noted in parentheses, in italics (e.g. signs, irritated tone of voice, etc.).

5. Loud sections of speech are put in capitals.

6. Words or phrases that are specifically emphasised by participants are put in bold and underlined.

7. If participants say something that is grammatically incorrect, the word 'sic' is added after the phrase.

8. If a participant is mimicking someone else talking, then the sentence of phrase in question is put in speech quotations.

For illustrative purposes, a sample extract from one of my interview transcripts is included below.

369: Ok, so amongst all these challenges that you've talked about, the flipside of that is how to you then work to
370: kind of address these challenges to promote engagement. You know, what do you as a clinician do to sort of
371: fight this battle, or to try to overcome these barriers that you perceive?

372: Oh um, eh,....well. I think there's some things. If you start with the sort of challenge of the person who
373: doesn't see the point in coming to a psychologist at all. Um, I think that the way I would tend to work with
374: that, particularly in the early stages, is I would first of all kind of demonstrate that I understand their point of
375: view, so you know, not trying to argue with them or convince them, but to say something like perhaps
376: "Oh so you've been to your GP with these pains in your stomach and now you've been sent to a psychologist.
377: How confusing! Or how frustrating!" if that's what they're telling me, you know, their experience is. I think that
378: that starting point of empathy is quite important. Otherwise the patient can feel that they're not being
379: understood and they're being told what's what and that their own experience is being totally invalidated.
380: So that is a starting point. And then beyond that there are certain things I suppose that I will habitually say,
381: and then see, you know, whether they strike a chord with the patient or not. Sometimes, for example, it
382: would be about putting it to the patient, you know "well it seems like you have been having these difficulties
384: for a very long time and um, and the doctors haven't been able to solve this problem for you. And I can see
384: why that's hard." I will say to them sometimes, quite explicitly, when they say to me "well talking about
385: it won't change it will it?" I will say to them well we don't know what's going to happen in the future but it
386: does seem to me since this problem has been with you for a long time, it seems unlikely that coming here is
387: suddenly going to make a big difference, but I wonder whether, given that that is the situation, we need to give
388: more thought to how you manage these problems as long as they are with you. Also quite often,
389: particularly if a patient is very defensive about seeing a psychologist and what that means, you know,
390: "are you saying I'm mental" (laughs) you know, that kind of thing, um then um, I will tend to do a bit of very
391: basic psycho education, and say well actually, I think the body and mind are actually very closely linked and um,
392: and it strikes me that, you know, whatever the cause of these physical symptoms is, so acknowledging you know
393: that I don't know in some sort of omnipotent way, that whatever the cause of these physical symptoms is, it
394: strikes me that they are certainly having a psychological impact on you. Some patients are a bit more ready by
395: the time they come to you to think about the fact that something psychological might be causing the
396: physical symptom, but where they're not I will just put it to them the other way round, well perhaps not, but
397: certainly your physical symptoms are creating psychological problems for you because you're telling me

398: how depressed your pain makes you feel. So simple really, but I think sometimes that people need to hear these
399: things really. And then sometimes if people have it put to them that way, oh so, you know, here I am to see
400: someone about um the psychological impact of my physical problems rather than "Oh my GP tells me I
401: have psychological problems but I don't agree with him" and then are more able sometimes to work with
402: that.

403: So it might be more palatable for some patients, at least initially?

404: Yes. Sometimes that can be a way in. And then when it comes to the sort of issue of (laughs) which I think
405: does inevitably come up at some point, where people start to cancel sessions, or not turn up to sessions
406: because of the physical problem, then I think it's important to be quite, (laughs) I mean it may or it may not have the
407: desired effect, um but often I think it's important to be quite robust with patients. Um, in terms of,
408: you know, sympathizing with the illness and what's getting in the way, you know, not saying oh you must
409: come or you should have come, but actually to be quite robust in saying, you know, if someone phones in the
410: morning to say they can't come, then saying "oh well, so you're feeling physically bad today, that might be all the
411: more reasons to come!" Um, you know, whether they go for that are not, I mean they might not necessarily
412: come that day, but I think it's very important to have that idea put to them, which is so different from the idea
413: that is so often fixed in their mind which is "oh, when I feel this way I can't do anything" or...

414: So quite active encouragement there.

415: Yes, yes, I think that can be important to do that, rather than just let it.... particularly if absences happen
416: more than once, rather than just letting it go, you know, unaddressed. I think it's quite important to be quite
417: robust and to point out to them that you know, actually, part of why they're seeing you is because of these
418: physical symptoms, and you know, the more they see you, and that that kind of thing. And perhaps pointing
419: out to them how much, and it's rarely just about the sessions, it's often happening in all kinds of domains,
420: pointing out to them how much their symptoms are restricting their life. And seeing if they can get in touch
421: with some of the pain of that and that the loss of that. Because some of them have lost a great deal in terms of
422: how much this has affected their functioning, um, and, you know, not that that then makes it easier to
423: come to sessions when they're feeling like crap (laughs) but if they can feel that actually if I don't come to my
424: session or if I don't see my treatment through to its finish, you know, then I will lose out. Then that can, kind
425: of, give more of a motivation to come, even though they do um, feel awful. So I think that that's quite important.
426: I suppose the other thing I do, and this would be more as I've been working with, it could happen quite
427: early on but I think it's something that um
428: increasingly happens the longer that you've been working with someone rather
429: than right at the beginning, um but, I think there's really something about looking for parallels, that um, you, how
430: can I put that, I think there's always a question, whatever the symptom is, whatever is causing it or not
431: causing it, whatever is known about it, it's always ultimately well how does the person relate to their
432: symptom and what does it mean to them. I think over time, you try to think more and more with patients
433: about that. And so I think, just for an example, um, is one of the things the symptom means that "well is one
434: of the things it means to the person, well there is something terribly wrong and it's not being attended to".
435: because for some people they will get very worked up about the symptom and they will go repeatedly to GPs
436: and experience the GP as unhelpful and uncaring, or whatever it might be, because the GP is unable to effect a
437: fix as it were. And often that is a very very resonant experience for the patient. I think that the patients who are
438: more likely to experience their physical symptom in that way are the ones who are more likely to have had a
439: much earlier experience of being, you know, neglected or overlooked, or you know, short changed or
440: something like that, or not having something that was very well attended to. And then I think gradually
441: over time it becomes more and more possible to kind of think with patients, you know, not just what the
442: symptom is and how much it's hurting and upsetting them, or stopping them from doing things, but how
443: are they actually experiencing their symptom. What is their relationship to it. Is it, you know, a tyrant that's
444: keeping them down, or is it just a constant irritation that they can't quite let go of, or whatever you know, in
445: between it might be. And it you can get to the point with patients of thinking about that and about how that
446: might relate to other experiences in their life, and particularly early formative experiences, then I think that that's
447: a big part of the work. And you don't have to explicitly, you know, kind of say anything to the patient about,
448: I'm not sure how I'm putting this, but you don't have to then say you know some kind of neat, you know, some kind
449: of too neat way of trying to tie it all up, you know "oh well, this symptom does seem to have a psychological basis.
450: But again, you're keeping away from saying that you know what the symptom is about. You're just showing them
451: that you're very interested in their experience of it, and you think they're experience of it is very meaningful and
452: relates to other things, besides the body alone. And I think that that's probably quite a big part of the work that
453: we do really here.

454: **It's interesting there because you're talking a little bit about the meaning of the symptom for the person and**
455: **that makes me wonder about formulation and how you work with formulation with patients, how do you manage**
456: **that process to promote engagement?**

457: Um yeah, that's a good question. I think that um, I suppose that would be the area that I would tend to
458: focus on in formulating, not trying to tie it all together, but just trying to say something very simple and
459: fairly meaningful about what having this symptom means to the patient. So for example, we see a lot of people
460: where, well I certainly do, I've worked with quite a lot of people who, since I came to the service, where um,
461: their whole way of managing before they got ill was predicated on being very capable, and often very self sufficient
462: as well, and often it's people who needed to be very self sufficient as well, you know, because they were
463: neglected in their early years, you know, or something of that nature. But you see quite a lot of people I think who]
464: have really experienced getting ill as a sort of collapse, you know. Where even if they weren't psychologically
465: troubled before, or weren't manifestly psychologically troubled, the reason was that they kept all those feelings
466: of vulnerability at bay by just convincing themselves that they could just look after themselves because they
467: were very capable, or that they could sort of manage whatever was thrown at them. And then this experience
468: of not managing something is really really wounding to that person's sense of self. Yeah, so normally I think,
469: yeah, that's just an example, but it does tend to be the way I approach formulation, you know, rather than just
470: saying, especially in initial formulation because your formulation might then develop a lot through the course
471: of therapy with the patient, so rather than just saying, um, these symptoms have arisen from, it's more sort of
472: saying this patient has had these kinds of previous experiences or has developed these different ways of
473: managing, so therefore these symptoms mean for them.... whatever it is that they might mean, whether it's,
474: you know, that suddenly they're completely capable or there's no one they can trust to look after them because
475: that's the experience they had with their GPs if they can't get a diagnosis or a cure. I think that's the way I
476: would approach it.

477: **So in formulating with these patients, you might formulate with a focus on how the symptoms**
478: **affect the person and what that might mean, rather than necessarily digging into causes,**
479: **as a way of promoting engaging.**

480: Yeah, I think not only as a way of promoting engagement, but I think the hope is that that would um, if you
481: could say yes, I think on the whole, but not always, some patients might have their own quite strong causal ideas
482: that might come out sooner or later. So they will say, oh well actually, I think it was because this happened when
483: I was small, that I think this is now happening. Patients may not come in immediately and say that but you can
484: get to that point. Um, but um, but I think on the whole, if you make some kind of causal statement, because
485: most patients read our reports and things, then that's probably less likely to engage a patient, because they can
486: always say well I don't agree with that at all, I think it's this that causing.... You know, I think I've got cancer
487: and the GPs haven't found it yet because they've been negligent. Or they can just say quite legitimately,
488: well how do you know? I mean you can always speculate, and you shouldn't be completely put off from
489: speculating because you can always be, you know, too cautious with a patient. But I don't think that,
490: you know, that we can sort of, necessarily claim to know. Um, so yes, if you can communicate something
491: about yes, I understand what this experience of getting ill might have meant for the patient, then that's em,
492: I think that's more likely to make them feel that you're getting alongside them somehow, and um, and then I
493: suppose the other thing is you can, which I might focus on in the formulation depending on the patient, is
494: something about what the symptom does for them. Um, and, there, I think you can get into an area of something
495: that might be quite challenging for the patient to hear, but which might also be important. Because for example,
496: em, I think we do see a lot of patients, we do see a lot of patients who perhaps had to take, particularly in the
497: Turkish population, we do see patients who bring stories where they had to take on a lot of responsibility when
498: they were very young, and they had to care perhaps for other people, for younger siblings and things like that
499: from a terribly young age. And they never perhaps felt cared for or attended to themselves. And em, a
500: physical symptom does because, you know, it doesn't mean that's why, you know they started to have
501: physical symptoms so they could, not in that sense, but once the physical symptom is there, whatever brought it on,
502: it can become a way of getting care, you know, care that was always felt denied, deprived of before. Or it can
503: become a way of um expressing the feeling that something is terribly wrong without talking about other
504: things that are distressing that might feel much more personal, and much more traumatic. And this is often seen in
505: how patients are with their GPs. A lot of patients who go repeatedly to their GPs, although they perhaps know by
506: now, that well actually, going to my GP isn't going to lead to something that's going to give me a change in
507: how I actually feel in my body, but what they do get from their GP is actually care, and actually for some people
508: it's hard to feel that their more sort of psychological difficulties are, you know, legitimate. And find it really
509: difficult to ask for care and concern.

510: So you're talking here about the, you know, secondary gain, type of idea. And I wonder how you manage
511: how you manage that in a way that can promote engagement?

512: Um, well, this is not necessarily something that would, I think, you know, you have to be a bit um, you
513: have to be a bit judicious about what you, what you share of the formulation at what point. I mean it's always a
514: kind of emerging thing anyway. Um, but um, there might be times when you think that something like that is
515: going on, but you would choose not to say it at the start because you think, well that might provoke a very
516: defensive reaction or something like that. Some you might choose not to say it to promote engagement,
517: typically. But I think that there are ways of talking about things like that, that can actually promote engagement.
518: For example, um, if you talk to people, rather than you know saying, you can always ask people what does
519: something do for them but they might not understand the question but I think that that's not too loaded.
520: But if you were to say, you know, what does a particular behaviour or a particular situation set up in the
521: family or whatever, and if they say nothing, it doesn't do anything, it's just awful (laughs). But if you were to say,
522: you know, well what do you get out of being ill (laughs) you would imagine that would in many cases be
523: quite an upsetting, you know with all the implications that someone might read into that. So obviously you
524: wouldn't say that, but what you can look at with them is well, how, you know, now that you have this illness,
525: how do you cope with the illness? And I think, you know, one phrase I probably end up using with patients quite
526: often is something about the zone of comfort or the zone of safety, you know. You know, we do see quite a
527: lot of patients who have these kind of dependency issues whose way of coping with illness is to be
528: increasingly withdrawn and/or increasingly dependent on a small number of people in the household.
529: And you can certainly formulate that as an issue of secondary gain, so you might say there is something about
530: getting ill, they might get attention from their husband that they never got before, or something like that.
531: But you know, that might be a bit of a controversial idea to explore with a patient who is, you know, at the end
532: of the day, suffering. But if you talk about it, if you talk to them instead about "I think it's very hard for you,
533: since you have become ill it has become terribly important for you to have someone at home with you at
534: all times in order to feel safe for example." And "I think it's very hard for you to imagine letting go of that or
535: managing without that." So again, it's about sort of, looking at the flip side of the idea of secondary gain.
536: And that can actually actively promote engagement because one of the things that might actually be quite hard
537: to do is to just leave their home to come to the session with you. Um, and if you can get past the sort of
538: manifest reason given for missing the session which is something about the backache or whatever, to the fact
539: that it does feel very hard to, to leave the house at all, partly to leave the house, and partly to come and
540: talk to someone who is still a relative stranger, who brings up whatever the issues may be, whether it's over
541: scrutiny or whatever else it is that's frightening for the patients about seeing you. I think if you can show them
542: that you understand that it's very hard and why it might be very hard for them to come and see you, and
543:..it's not just that it's really hard because your back hurts but it's also about something more emotional and
544: relational, then that can actually promote engagement.

545: There's some really interesting things there. You're talking a bit about timing but also just perhaps about
546: the subtlety of positioning of your understanding of the problem, just moving the patient slightly forward, but
557: not too far. Does that kind of sum up what you're saying?

548: No, I think that's a good way of putting it. I mean I think i might have (laughs) I fed quite a lot, not
549: necessarily coherently, but you know, it's very much about, and I think all therapeutic work is, but with these
550: patients, it is about trying to move people forward but not being, you know, too much too soon. And you're
551: somehow trying to negotiate this, kind of, middle position, between becoming the person who does something
552: rather rough and intrusive, and I think in particular sometimes patient with physical symptoms will bring
553: material around, you know, having to go for some kind of scan or investigation or physiotherapy where they
554: feel that someone was very rough and intrusive with them, and they didn't understand that it hurt, and they
555: pulled their body around and now it hurts even more (laughs), which has quite a clear transference implication
556: for how they might experience a therapist poking around in their mind, touching on the sore spots. So your
557: trying to find a middle position between being, I mean you don't want to be so probing so soon that the
558: patient will withdraw, but you have to be a bit probing in order to be effective, and what you don't want to get
559: into is, is the, which will certainly come up for quite a lot of patients who have dependent personality traits,
560: where the invitation is to sort of accept whatever the patients is saying about "no, I couldn't possibly do that.
561: I couldn't possibly go there, I couldn't possibly manage that". And a lot of these people are living in a set
562: up where they've managed to convince quite a lot of people of that, and they get family members running
563: after them in various different ways.

564: So there's a danger of collusion almost between the therapist and the patient?

565: Yes, because it's obviously uncomfortable too for the therapist to say something that the patient
566: might take in the wrong way. And a big part of engagement is, you know, saying things that the patient
567: will find, you know, palatable, so that they don't just leave and never come back. But at the same time,
568: you do have to say something, you know, with a bit of potency, which has the potential, you know,
569: to sort of penetrate. So when you do talk to people about, that's why I do find the sort of comfort
570: zone or the safety zone quite a good phrase to use with some of these patients. When you're talking about
571: that, you're acknowledging how hard it is to leave that zone, but you're not saying therefore, let's never
572: leave it, you're actually saying, but I think there might be a reason why the health support group or a course
573: of therapy sessions or whatever it might be, might be a good idea for you, because at the moment you're
574: very stuck and nothings actually changing.

575: That's really interesting. How do you know when you're getting that right? How do you gauge when you're
576: doing that effectively? What do you rely on to guide you?

577: BQN: Oh, that's a really good question. Um, (long pause), I think that you, um, I suppose signs that you
578: might be doing it more effectively might be (pause) I mean (pause), one would be (pause), part of one
579: would be the sorts of things that apply in all therapies (um), when the patients agrees with something
580: you said interpreting their feelings and behaviour, and really seems to mean it. That's a big caveat
581: because patients will often (laughs) appear to agree with you, whether they really do is another matter
582: (laughs), you know that there's a lot of compliance and stuff, um, inevitably. But I guess you would look
583: for certain things to go along with that agreement. Was it an agreement and then a complete silence, or an
584: agreement and then they go on to talk about something completely different. Or was it just a token, yes of course,
585: but anyway, or whatever. Or does there seem to be something that has really resonated for the patient. Do you
586: have more of a sense of emotional contact with the patient in the room, a bit more of a feeling that they're
587: really feeling something in response to what you've said, and do they then bring something that might not me,
588: might not be completely following on but is associated. You know, what you've just said sparks off some
589: memory of some other situation in their life where a similar kind of theme is perhaps playing out.

590: So there's some continuity in the dialog, sort of being fluid and moving, but not just stopping a conversation
591: if you like. You have a sense that it's continuing into something.

592: Yeah, I think, if they're able, and different patients will have different ways of doing it, but are they're
593: able to think about and somehow expand on what you've said in a way that suggests, well actually, yes it is this
594: idea of a safety zone say, if that's one you've used, or whatever it is, that it actually means something to them,
595: and then they go, oh yes, and sometimes I do this as well when guests come to the house, that after a certain
596: amount of time I'll go to my bedroom, or whatever it might be. So I guess that that would be a bit of a sign, and
597: um, I mean sometimes I think that, and then obviously there's all the usual, between sessions there's all the
598: usual things you would look for, about people coming back, and coming on time, and cancelling or not showing up
599: and not cancelling. Um, but I think that probably the danger more often is that, in my experience and this
600: might be more about my temperament, but I think the danger seems to be more of too much collusion than too
601: much confrontation actually. And supervision is often very important to be, to have the person who can think
602: about what's going on between you and the patient and take a bit of an outside perspective, just as you're
603: aiming to do when you think about what goes on between the patient and their family, for example. And
604: supervision can be quite important in helping you pick up on whatever.

605: It was interesting what you were saying there about the difference between collusion and confrontation
606: and that perhaps being something about the therapist too, can you just elaborate a bit more on that.

607: Well I guess I just mean that it can be uncomfortable to make your patients uncomfortable. But I think
608: in order to be effective therapeutically, um you do have to give the patient a taste of something that's
609: not too comfortable. You know, they have to be comfortable enough to feel that it's bearable to come
610: and to feel understood and held enough when they do come, but a lot of therapeutic work involves thinking
611: about and talking about very difficult things and so, you're not really going to be able to help a patient
612: without causing them some pain and some anxiety, you know. Perhaps they will be angry with you at times,
613: but I think that for many of us, for most of us, the natural pull is away from that. We all want to keep our
614: interactions with other people, you know, kind of smooth, and to not feel that we're out of our
615: comfort zone I suppose. We all want to keep our interactions with other people, you know, kind of smooth, and
616: to not feel and to not feel that we're out of our comfort zone I suppose. Sometimes it can be easier to sort of
617: nod and be sympathetic than to actually ask a difficult question about, oh well, why do you think you find it
so difficult to leave the house or whatever it might be.

Appendix 4: Participant information sheet

**PCPCS Qualitative Research Study
(Participant information sheet, for clinicians)**

A grounded theory study of therapeutic engagement among patients with medically unexplained physical symptoms (or MUS)

A qualitative research study is currently being conducted at the City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS) to explore engagement of patients presenting with 'medically unexplained' problematic physical symptoms (MUS) in brief individual therapy. As a clinician in the service, you are being invited to participate in this study.

I am conducting this study to fulfil the research component of my Professional Doctorate in Counselling Psychology. The proposed research has ethics clearance from my university's ethics panel and has been approved as a service evaluation by the Risk and Governance Advisor for the Tavistock and Portman NHS Foundation Trust, in agreement with the Service Director, Brian Rock. This information sheet gives you a very brief overview of the study. If you are would like more information please feel free to contact me (see contact details below).

What is the purpose of the study?

The aim of this research is to develop an understanding of the factors which promote or inhibit engagement in brief individual psychotherapy for patients with MUS. The literature has highlighted that therapeutic engagement can be very challenging for this patient group. It is hoped that this research will provide insights into effective strategies for engaging these patients.

How will it be conducted?

To meet the aims of this study I hope to conduct semi-structured interviews with eight clinicians in the service who have experience working with patients presenting with MUS. All PCPCS clinicians who have worked with patients with MUS are being invited to participate. The interviews last about one-and-a-half hours and will be scheduled at times to suit participating clinicians. The interview will involve an open ended exploration of clinicians' views of the process of engagement.

Am I obliged to take part in the study?

As a clinician in the service you are encouraged to participate in this study, but are under no obligation to do so. Your participation is entirely voluntary and your decision to take part will not affect your position in the service. You are free to withdraw from the study at any time up

until two weeks after your interview, and your withdrawal from the study will have no adverse consequences. If you decide to withdraw then any information that you have given us (and analysis based on that information) will not be included in the study.

What about confidentiality?

The management of data relating to this study is in full compliance with NHS data protection regulations so your confidentiality is assured. With your permission, all interviews conducted as part of this research will be audio-recorded and transcribed verbatim, however, your identity will remain anonymous. Anonymous participant codes will be used keep track of all research materials and your name and identity will not be directly linked to them.

All the research data will be located on the secure servers at the Tavistock and Portman NHS Foundation Trust for the duration of the study (within the researcher's personal file storage area). Comments made during interviews may be incorporated (anonymised) into a final report and any subsequent publications. Confidentiality will be assured both through the use of pseudonyms and through the alteration of other potentially identifying information, as necessary.

What are the potential risks of taking part?

As a clinician in the service you may feel some anxiety about taking part in this study. The research is exploring how therapists engage their patients so you may be worried that you are being evaluated in some way. I'd like to emphasise that this research is not a clinician evaluation exercise but is oriented towards understanding a complex therapeutic process.

In order to understand engagement it is helpful to understand occasions when clinician's words, gestures, or actions may be perceived to have hindered engagement, which is valuable information with respect to the objectives of the study. In line with grounded theory, the findings will formulated and communicated at an abstract level, although anonymised examples will be used for illustrative purposes.

If I am interested in taking part, what happens next?

If you would like to take part in this research please contact me to let me know. I will then liaise with you to organise a suitable time and location for the meeting. FYI, I will ask you complete and sign the participant consent form prior to conducting the interview. If you are still unsure if you wish to participate, have questions, or would like further information before making a decision, please contact me by email or mobile and I will be happy to discuss this with you.

What if I am unhappy about any aspect of the research?

If you have any concerns about the study at any time, please feel free to contact me directly, or alternatively, my university research supervisor, Dr Philip Hayton (Tel: 0207 133 2685; email p.hayton@londonmet.ac.uk), or my research point of contact at the service, Brigid MacCarthy (Tel: 020 7683 4900; email BMacCarthy@tavi-port.nhs.uk).

Thank you for taking the time to consider my study. Please contact me if you would like to discuss further or with any questions that you may have.
Janet Balabanovic, Counselling Psychology Trainee (London Metropolitan University)
(Mobile: 07970 453567; email: janetbalabanovic@gmail.com)

Appendix 5: Participant consent form

City and Hackney _NHS_
Teaching Primary Care Trust

The Tavistock and Portman _NHS_
NHS Foundation Trust

LONDON
metropolitan
university

Therapeutic Engagement Study Participant Consent Form

(Please circle Yes or No and mark your initials on the right hand side↓)			
I have been given an information leaflet on the study and have had the opportunity to ask and receive answers to my questions.	Yes	No	
I understand that the information I provide will be treated confidentially and that my name and identity will not be revealed in any presentation of the study's findings.	Yes	No	
I understand that I have the right to withdraw from this research at anytime during my participation.	Yes	No	
I can also notify the researcher if I do not want my information used in the study up to two weeks after my interview (or final interview, if more than one interview is conducted).	Yes	No	
I give permission for the researcher to audiotape my interview and for these interviews to be transcribed verbatim for the purposes of analysis.	Yes	No	
I understand that, for the purpose of the research, I will be given a code number and that no transcript or other research materials will record my name or identity.	Yes	No	
I understand that comments that I make during the interview may be quoted (anonymously) in the final report and/or published papers, but that I will not be in any way personally identifiable through these quotations.	Yes	No	
I confirm that I agree to take part in this research.	Yes	No	

Name of participant   **Date**   **Signature**

_____   _____   _____

Investigator's Statement: I have informed the above named participants of the nature and purpose of this study and have sought to answer their questions to the best of my ability. I have read, understood, and agree to abide by the British Psychological Society's Code of Conduct, Ethical Principles and Guidelines for conducting research with human participants.

Name of researcher   **Date**   **Signature**

_____   _____   _____

Please sign 2 copies of the consent form. One is for you to keep and one is for my study file.

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Appendix 6: Informed consent protocol

1. Introduction:

a) Thank the clinician for attending and summarise the rationale for the study e.g. "*Hi, thanks for coming. As you know this research is focused on therapeutic work with patients who have problematic physical symptoms which are not easily explained by underlying known medical conditions. I am interested in speaking with clinicians who have experience working with this patient group which is why I invited you to participate in this study to try. Would you like to know more about this?*"

b) Explain what will happen at the interview, including the following information 1) that the interview will take about an hour and a half, 2) that they will be provided with some information about the study and given the opportunity to answer any questions and 3) that we will seek to obtain their informed consent to participate. e.g. "*This session will take about an hour-and-a-half. Before we proceed you have a chance to find out more about the study and ask any questions. Then you can decide whether to take part or not. If after that, you decide to take part, we will first need to obtain your informed consent to participate. After you have signed the consent form we can proceed to the interview.*

2. Consent procedure:

a) Check if the clinician has read the Participant Information Sheet. If not, explain the study using the text in the clinician information sheet as a guide. Ensure all the points covered in the Participant Information Sheet are covered verbally. Give the clinician a copy to keep.

b) Ask them if they have any questions or concerns about the study. When you have answered all their questions, ask them whether they would like to take part in the study, and explain that if so we need a signed consent form from them if they wish to do so.

Explain that:

- They are under no obligation to sign a consent form if they do not want to take part, and if they do they are free to change their mind and withdraw from the trial at any time.
- Their decision either way will not affect your position in the service.
- If they need more time to consider they can take the information and consent form away and if they decide they want to take part they can return to complete the interview at a later date.

If they want to take part:
- Ask them whether they brought in the consent forms that were emailed to them and if not give them a new consent form to read and sign.
- Collect the consent forms and check that ALL boxes are INITIALLED and NOT TICKED.
- If the form has been incorrectly completed give the participant another set of forms to sign.
- Sign and date the consent form and give the clinician a copy.

If they do not want to take part:

- Thank them for their time.
- Do not ask them for a reason, although they may volunteer it.
e.g. "OK, that's fine. Thank you for showing an interest though, it's much appreciated.

Appendix 7: Initial interview schedule (1st phase interviews)

Introduction

Hello. Thanks for agreeing to take part this study. As you know this research is focusing on psychotherapeutic work with patients who suffer from persistent, medically-unexplained physical symptoms (conventionally referred to as MUS or MUPS). I am interested in exploring how you work these patients in general. There are no right or wrong answers. Please be as open and honest as you can and remember that the purpose of this exercise is not an evaluation of therapist skills, but rather, to understand the special issues involved with working with this patient group, and what adaptations may be needed. The interview should take about an hour-and-a-half. Are you happy to go ahead with this? Any questions before we start?

Audio-recording Reminder: I just wanted to remind you that I would like to audio record the session. As indicated on the consent form, the tape recording will only used to for data analysis purposes and all data will remain completely confidential. Is this still ok with you? [If ok, switch on recorder]

NOTE: The schedule below outlines general areas of exploration. All areas of discussion will be probed fully to encourage the participant to elaborate and clarify their answers where appropriate.

General therapeutic orientation

- **Would you like to start off by telling me a little bit about your clinical background (e.g. your training and your clinical experience so far?)**

- **How would you best characterise your CURRENT day to day clinical practice? [Probe] What do you consider to be the most unique characteristics of your own personal style of practice?**

General experience working with patients with MUS

- **I'd now like to move on to talk to you about your experiences as a clinician working with patients with MUS. When you think of this patient group, what kinds of patients come to mind?** [*Explore how the therapist defines this group, which kinds of terminology are used e.g. diagnoses, what types of MUS are included or excluded, and how understood*]

- **How would you describe your experience of working with this patient group? What has this experience been like for you?** [*Explore how much experience the therapist has had with this group, types of patients etc, general attitudes towards patient with MUS, feelings about working with this patient group, perceived characteristics, etc.*]

- **Overall, what do you perceive to be the major challenges of working with patients with MUS? How do you work to address these challenges**? [*Explore key barriers, including patient characteristics, therapist characteristics (e.g. confidence with this patient group), relationship challenges, etc.*]

Engaging patients with PPS

- **I am interested to understand what strategies you use to try to engage patients with MUS in the therapeutic process. But first of all, please tell me what you understand by the term engagement?** [Probe] **How do you know if a patient is engaged? What criteria would you use to judge this?**

- **Having considered what engagement means to you, what do you do to try to help patients with MUS engage in the psychotherapeutic process? What are your reasons for doing this?** [*Explore if and how they adapt their approach in any way to help promote engagement, what exactly do they do differently and why?]*

- **What challenges do you generally find in engaging patients with MUS? How do you address these challenges?** [*E.g. if clients with MUS spend a great deal of time talking about their physical symptoms how do they manage this*?]

- **How do you manage assessments of patients with MUS differently to other patients? What are your reasons for doing this?** [*Explore any adaptations made for this patient group and reasons for this*]

- **How do you approach the task of developing a common or shared understanding of the problem with these patients?** [*Explore how the therapist works with the patients during formulation, how formulation is shared, etc.]*

- **Have you ever struggled to engage a patient with MUS? How did you try to address this? What was the outcome?** [If positive] **What did you do that made a difference**? [If negative]. **What do you think happened? Did you learn anything from this experience? What would you do differently if you were working with the same patient again?**

- **In your experience working with this patient group, what can be done to promote patient engagement?** [*Explore any factors within our outside therapy that the therapist believes may contribute to engagement*]

Wrap up

That's all the questions I have. Thank you very much for the time you have taken to participate in this study. I look forward to meeting with you again to explore your experiences of working with one or two specific MUS cases. Before we finish, is there any other feedback that you'd like to provide?

Thank and Close.

Appendix 8: Revised interview schedule (2nd phase interviews)

Introduction

Hello. Thanks for agreeing to take part this study. As you know this research is focusing on therapeutic work with patients who suffer from persistent, medically-unexplained physical symptoms (MUS or MUPS). I am interested in exploring how you work these patients in general. There are no right or wrong answers. Please be as open and honest as you can and remember that the purpose of this exercise is not an evaluation of therapist skills, but rather, to understand the special issues involved with working with this patient group, and what adaptations may be needed. The interview should take around an hour and a half. Are you happy to go ahead with this? Any questions before we start?

Audio-recording Reminder: I'd like to remind you that I'd like to audio record the session. As indicated on the consent form, the recording will only used for data analysis purposes and all data will remain completely confidential. Is this still ok with you? **[If ok, switch on recorder]**

NOTE: The schedule below outlines general areas of exploration. All areas of discussion will be probed fully to encourage participants to elaborate and clarify their answers.

General therapeutic orientation

- **Would you like to start off by telling me a little bit about your clinical background (e.g. your training and your clinical experience so far?)**

General experience working with patients with MUS

- **I'd now like to talk to you about your understanding of MUPS. When you think of this label or category, what kinds of patients come to mind?** *[Explore how the therapist defines this group, which kinds of terminology are used, what is included or excluded, how understood, etc.]*

- **How would you describe your experience of working with patients with MUPS?** *[Explore therapist's experience with this group, types of patients etc, general attitudes towards patient with MUS, feelings about working with this patient group, perceived characteristics, etc.]*

Engaging patients with MUS

- **I am interested in the topic of therapeutic engagement of patients with MUS . But before we discuss this, please tell me what you understand by the term therapeutic engagement?** *[Probe]* **How do you know if a patient is engaged? What criteria would you use to judge this?**

- **Having considered what engagement means to you, what do you perceive to be the main barriers to therapeutic engagement when working with patients with MUPS? How do you work to address these challenges?** *[Explore key barriers, including patient characteristics, therapist characteristics (e.g. confidence with this patient group), relationship challenges, etc.]*

Clinicians direct experience (clinician/patient factors, TR, etc.)

- **What challenges do you <u>personally</u> find in engaging patients with MUS in brief dynamic therapy? How do you address these challenges? What are your reasons for doing this?** *[Explore if and how they adapt their approach in any way to help promote engagement, what exactly do they do differently and why?]*

- **How do you manage assessment of patients with MUS? in this service? compared with other patients without MUS? What are your reasons for doing this? When assessing patients with MUPS, how do you make a decision about the kind of therapy to offer the patient, if any?** *[Explore any adaptations made for this patient group and reasons for this].*

- **How do you approach the task of developing a common or shared understanding of the problem with these patients?** *[Explore how the therapist works with the patients during formulation, how formulation is shared, etc.]*

- **In what way, if any, do you work with the body when you are working with patients with MUPS?**

- **Have you ever struggled to engage a patient with MUS? How did you try to address this? What was the outcome?** *[If positive]* **What did you do that made a difference?** *[If negative].* **What do you think happened? Did you learn anything from this experience? What would you do differently if you were working with the same patient again?**

- **If a patient is attending dynamic therapy but struggling to engage in the process, how would you typically deal with this? At what point might you consider adapting your way of working? How would you go about finding a focus for an alternative piece of work?**

Service context and stakeholder influences

- **What role, if any, do you think the context of the service (the way it is set up) plays in promoting or inhibiting therapeutic engagement?** (e.g. political factors, commissioning, stakeholder influences, service ethos, psychoanalytic and systemic orientation, cost of service delivery, etc.)

- **What role, if any, do you think that existing service policy or processes have on therapeutic engagement?** [Probe fully. If no ideas forthcoming, offer example of separate assessment and treatment phases, and the fact that different clinicians involved. Explore what impact this might have]

- **If you could make one change in the way your service operates to promote better engagement, what would that change be?**

Wrap up, Thank and Close.

That's all the questions I have. Thank you very much for the time you have taken to participate in this study. I look forward to meeting with you again to explore your experiences of working with one or two specific MUS cases. Before we finish, is there any other feedback that you'd like to provide?

Appendix 9: Participant debriefing document

MUS Patient Therapeutic Engagement Study Debrief

Thank you for participating in this study. It is greatly appreciated. This debriefing aims to give you an opportunity to learn more about this research study, how your participation plays a part, and why it may be important.

The purpose of this study is to understand how therapists can encourage patients experiencing problematic physical symptoms to engage in psychological therapy to help them with their difficulties. This research is important because many patients in the health system experience problematic and debilitating physical symptoms which are not easy to explain medically. In fact, between 25-50% of complaints seen in primary care fall into this category. Furthermore, we know that these symptoms can be extremely debilitating and cause considerable suffering.

The health system struggles to care effectively for patients with unexplained problematic physical symptoms. The large numbers of patients who are affected by these problems are not easily catered for in a system which is largely split into 'physical' and 'mental' health care. Concerned with their physical symptoms, patients with PPS are understandably often reluctant to engage with psychological therapy. Often 'stuck' in the health system, they can experience considerable anxiety about their symptoms and/or frustration trying to locate their cause.

A great deal of research has been conducted to try to understand the causes of unexplained PPS. No definitive answers have been found but the present research suggests that that the causes are extremely complex, being influenced by interacting biological, psychological, and sociocultural factors. Furthermore, the experience of unexplained PPS can itself lead to psychological distress in the same way that this can occur for patients with diagnosed medical conditions, like diabetes or coronary heart disease. With this understanding, there is an increasing consensus that patients suffering these types of problems should be offered a more holistic approach to treatment, addressing all the different aspects of their difficulties.

The NHS is committed to improving psychotherapeutic service provision to patients with unexplained PPS but in order to deliver this, it is important that we better understand how to reach patients. Very little research has been conducted to explore how patients with unexplained PPS experience psychological therapy. However, the research that does exist suggests that therapeutic engagement is a critical issue. I am particularly interested in exploring how therapy can be modified to accommodate the needs of this patient group.

Your generosity and willingness to participate in this study are greatly appreciated. If answering any of these questions has caused you anxiety or concern and you would like to speak to someone about your thoughts or concerns, please do speak to me about this.

As stated before, the information that you provide will be kept anonymous except for me, my supervisor and those formally assessing the report. It may be possible that the results of this study are presented at academic conferences or published as an article in a journal. No information distributed will identify you (i.e. pseudonyms will be used in any reports and/or publications).

If you would like to receive a summary of the findings of this study or have any additional questions, please feel free to contact me.

Thank you once again for participating in this research!

Janet Balabanovic

Counselling Psychology Trainee, London Metropolitan University

Email: janetbalabanovic@gmail.com

Mobile: 07970 453567

Appendix 10: Trust confidentiality agreement

This form must be signed by all employees and those working for or on behalf of the trust who may have access to confidential information (including contracted consultants, bank, agency, volunteers, locums, student placements, suppliers working on site) Completed forms will be retained for inspection by the HR department

Your personal responsibility concerning security and confidentiality of information
(relating to patients, staff and the organisation)

During the course of your time within the Trust buildings, you may acquire or have access to confidential information which must not be disclosed to any other person unless in pursuit of your duties or with specific permission given by a person on behalf of the Trust. This condition applies during your relationship with the Trust and after the relationship ceases.

Confidential information includes all information relating to the Trust and its patients and employees. Such information may relate to patient records, telephone enquiries about patients or staff, electronic databases or methods of communication, use of fax machines, hand-written notes made containing patient information etc. If you are in doubt as to what information may be disclosed, you should check with a manager.

The Data Protection Act 1998 regulates the use of computerised information and paper records of identifiable individuals (patients and staff). The Trust is registered in accordance with this legislation. If you are found to have made an unauthorised disclosure you may face legal action.

I understand that I am bound by a duty of confidentiality and agree to adhere to this Code of Conduct and the requirements of the Data Protection Act 1998.

Print name:	JANET BALABANOVLC
Signature:	*Chloe Bee*
Date:	1/10/14
ON BEHALF OF THE TRUST	
Witness Name	CHARLES OMWAKA
Signature	*signature*
Date:	1/10/14
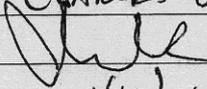
Appendix 11: Sample memos

Memo 042: Learning to go with the patient's preoccupation (05/09/14)

Participants often talk about how their practice has changed over time as they have gained experience working with patients with MUS in the service, and give many examples of learning from mistakes. These stories are very relevant to my topic because the changes that participants describe making are very often in the service of promoting better engagement. One participant told me about a patient seen shortly after joining the service, who stormed out of an assessment. The patient in question had been crippled with pain for many years and responded in an angry way when the clinician asked about his early life. According to the participant, the patient had felt that this enquiry was irrelevant because he just wanted the pain to go away. Learning from this incident the participant learned to meet his patients half way, recognising that this may be vital for engagement. Other participants have expressed similar views.

Having experienced chronic pain myself in the past, I couldn't help but identify with this patients emotional state at some level. From the patient's perspective, it may feel extremely invalidating if a therapist focuses too soon on exploring psychological issues and personal history when the patient has been struggling with debilitating physical symptoms for some time. If one accepts that the patient is indeed suffering 'real' distressing physical symptoms, there is nothing inherently strange or unusual about wanting to relieve these symptoms. Patients with 'bona fide' diagnosed physical illnesses (including terminal illnesses) are offered treatments to alleviate their pain and improve their quality of life, and this is considered a legitimate intervention in and of itself - a compassionate response to relieve intolerable suffering.

Memo 069: Constructions of engagement (11/09/14)

Participants' accounts suggest that there is no straightforward, unitary definition of therapeutic engagement and that it seems to be understood as a multi-dimensional concept. Although participants expressed some shared understandings of the construct, there was variation in what was emphasised across participants. It was variously defined as a process which unfolds over time, a level whereby patients may be engaged to different degrees signalled by certain external signs, and also as a state of mind that can shift back and forth within and between sessions. Therapists also define engagement as a relative concept, in the sense that a patient may be defined as successfully engaging or not, not in relation to a unitary normative standing, but rather in relation to where they started from. While therapists note that there are various service-related indicators or engagements, they also acknowledge the inadequacy of such indices because attendance alone does not necessarily equate to deep engagement, as a patient may attend but be superficially compliant and make no changes. In a similar vein, another

patient may attend a little sporadically but make links between sessions, think about the material, and make active changes outside the sessions. On paper, they may not be seen to be as engaged, whereas in reality they are in fact engaging more deeply with the process.

Memo 199: Tacit dualism (21.11.2015)

In constructing the central categories and subcategories of my model, analysis has been heavily influenced by participants' descriptions of 'disengagement events' and the meaning attributed to those events. As I have reviewed and compared these disengagement events, it has become increasingly apparent that dualistic beliefs and attitudes may play an important contribution.

From participants' accounts, patients often arrive at the service with a dualistic perspective on their problem "I'm physically ill - psychology has nothing to do with it". This dualism may be defensively strengthened by doctors who manage the referral badly "there's nothing wrong with you – I recommend you see the Psychologist". Reflecting their training and service context, participants in this study tend to embrace psychoanalytic/dynamic perspectives on MUS and predominantly view MUS as an emotional/relational problem, rooted in developmental influences. However, this is clearly not a black and white situation, as all participants expressed acceptance of the complex and uncertain aetiology of MUS, and the multifactorial nature of the problem. Also, participants who had significant experience working with MUS patients exhibited a genuine appreciation of the real level of physical disability involved.

However, it appears that the clinicians interviewed, like patients, may exist on a spectrum in terms of the way that they understand MUS. At one end of the spectrum, some seemed highly integrated and holistic in their thinking about MUS patients and their experience. From this holistic perspective, MUS patients were seen to be suffering both physically and psychological with a complex bi-directional relationship between the two. At the other end of the spectrum, some clinicians interviewed showed an occasional propensity to slip into a more dualistic position, where they might view the problem in psychological terms. I am calling this 'tacit dualism' because this appears to be an unconscious or automatic shift, in a therapist who ordinarily embraces quite a holistic attitude to MUS. The interviews suggest that when clinicians switch into a psychologising modes of thinking, they may lose sight of (deny, or feel sceptical about) the physiological suffering that may go along with this condition. In these moments there may be empathic failures which could be easily picked up by their patients, who may themselves be highly sensitised to such issues. When patients feel their (physiological) suffering has not be validated and empathised with, this compromises the therapeutic relationship, If not rectified, this can precipitate sudden or gradual disengagement.

Participants' descriptions suggest that the risk that this could occur may be greater when clinicians are faced with highly entrenched patients with MUS who repeatedly return to talk about their bodily symptoms and medical experiences over and over again, eventually eliciting negative countertransferential reactions in therapists, who may begin to feel overwhelmed, irritated and frustrated. Strained or exhausted by these difficult conditions, therapists may inadvertently switch into a 'tacit dualistic' mode, where empathy for the patient's physiological suffering is temporarily compromised. Participants who attend carefully to the therapeutic relationship may detect this rupture quickly and make efforts to repair it. However, this may not always be possible depending on what kind of patient they are working with. Some more vulnerable patients who may be especially sensitive to incidents of invalidation, however momentary, may experience strong negative emotional reactions which are difficult to contain, triggering disengagement.

Appendix 12: Audit trail

Below is the audit trail that was completed after the five first stage interviews. The audit trail documents the analytical coding process that was conducted to construct one of the categories in the interim model 'pragmatism, purism and flexibility'. It should be noted that the interim model evolved quite significantly after this stage, as the category construction exercise was repeated a second time with greater attention to axial coding. Nevertheless, the audit trail illustrates the nature of category construction process as a 'bottom up' rather than a 'top down' process.

The table below illustrates the category formation process by showing the how different codes were clustered together to form higher level concepts, eventually reaching the status of a category. The example below, the high level category is 'Pragmatism, pluralism and flexibility' (Level 1), However, underlying this are multiple layers of lower level categories (Level 2). Underlying each level 2 category is a number of level 3 categories or concepts. Underlying each of these level 3 concepts are the initial codes, reflecting the underlying raw data. All levels of the analysis are shown in the table below, illustrating how the higher level category was contracted from the data.

CAT LEVEL	CODE & DESCRIPTION	RAW DATA
Cat (L1)	**THERAPIST DIMENSION 1 PRAGMATISM, PURISM AND FLEXIBILITY: Clinicians try to adopt a flexible and pragmatic stance when working with patients with MUS and believe that this will promote engagement. This involves being willing and able to deviate from prescribed norms of the psychodynamic model in the interests of developing and maintaining the therapeutic relationship, and being willing and able to integrate interventions from other modalities that clinicians have found helpful when working with patients with MUPS in the past. When patients are really struggling to engage in dynamic therapy, clinicians try to find an alternative focus and offer something that the patient can relate to, and work with. This often leads to a very practical piece of work targeting an important aspect of the patient's functioning related to their MUPS (and how they cope with it).**	
Sub Cat L2	**FLEXIBILITY OF THE CLINICIAN'S STANCE IN RELATION TO THE THERAPEUTIC PROCESS: Clinicians perceive a need to work flexibly to engage patients with MUS, and emphasise a willingness to try lots of things, and to locate a piece of work that it tailored to the individual patient's needs. This stance is facilitated by the ethos and mission of the service and by the freedom that clinicians have to deliver tailored treatments that are not protocol based. Perhaps going along with this, clinicians are able to hold a flexible attitude in terms of what is regarded as clinically significant change, which is then located within the specific focus of the work and to the patient's individual position and starting point. Clinician's capacity to be flexible is however seen to be finite, as it is recognised that not all clinicians can get along with all patients and that there can at times be a 'lack of fit' between the two.**	
Sub Cat L3	**NEED TO BE FLEXIBLE IN RESPONSE TO THE NEEDS OF THIS PATIENT GROUP Therapists perceive a need to work flexibility with patients with MUS and describe adapting their own preferred style to meet the needs of individual patients, especially during the early stages of therapy. This flexibility reflects clinician's beliefs that flexibility may enhance engagement and that it is not helpful to force a certain style or way of working on a patient if it is not experienced as meaningful for the patient.**	

Initial Code	0289 Needing to be flexible to work with this patient group	*"Yes, I mean I have a flexible approach, but in terms of, I don't think that there is any other way that you can work with this group."* (P1, 052-054)
Initial Code	0767 Clinician has a flexible approach and adapts their style depending on the patient, but always rooted in psychoanalytic stance	*"I try to be flexible depending on the person who is coming, but it's routed in a sort of psychoanalytic stance."* (P2, 046-047)
Initial Code	0865 Adopting a more flexible stance to engage patients initially (e.g. calling them, making use of knowledge available to contact them in the optimal way)	(Clinician talking about how her gets over barriers to engagement that he identified) *"Being more flexible in engaging, like calling them. Just using all of the knowledge we have."* (P2, 254-257)
Initial Code	1132 Clinician expresses need to change the way she works a bit (rather than forcing a patient to working psychodynamically if not making any sense to them)	*"I think you have to be quite intuitive with it, and not push something, I think, if it's not meaningful to the person. What's the point, you know, you need to change the way you work a little bit more."* (P5, 100-101)
Sub Cat L3	**CLINICIAN'S WILLINGNESS TO TRY LOTS OF DIFFERENT THINGS TO ENGAGE PATIENT Clinicians describe adopting a trial and error approach when working with patients with MUS, trying lots of different things. They may begin with their preferred approach but if this doesn't work they may switch gears and try other things. In trying things out, clinicians test the water, for example, trying out an interpretation and observing the response, before deciding where to go next. However, clinicians sometimes rely on their intuition do work out which direction to take with a particular patient.**	
Initial Code	0439 Trying lots of different things to engage a patient e.g. seeing a patient with her GP, with her sons, etc.	*"I saw her with loads of different things. And it was a bit like that. Being a bit, like, engagement by stealth. Because it was a bit like "so I know that you're not coming, ... but let's talk a little bit, ..."* (P1, 549-551)
Initial Code	1120 Clinician might use systemic approach when tries to work with patients psychodynamically but finds they just can't get to grips with it	(Talking about how she decides to go in dynamic or systemic direction) *"I think sometimes when I work with patients and I try to work more psychodynamically and they just can't get to grips with it."* (P5, 81-82)
Initial Code	1126 Clinician's using intuition to decide which direction to lean (psychodynamic, systemic, CBT, etc.)	*(Talking about deciding which way to go in therapy)* *"Um, I think it's totally quite intuitively really, just knowing."* (P5, 94)
Initial Code	1127 'Throwing in an interpretation' to help decide which way to lean	(Talking about deciding which way to go in therapy) *"Sometimes you can throw in a bit of an interpretation, like a psychodynamic interpretation, and you just get this kind of blank look. And then it's about thinking, well do I need to express this in a different way."* (P5, 95-97)
Initial Code	1135 Clinician has a hierarchy of approaches which she tries with patient (starting with psychodynamic then switching to other methods if the latter doesn't work)	*"And I do genuinely believe that with medically unexplained symptoms, the psychodynamic way of working is probably. I don't know. I think it has some much potential for unlocking things for people, but that's not always going to work for everyone. So I suppose, yeah, I almost have this kind of hierarchy, I suppose (laughs), of trying different things."* (P5 106-107)
Sub Cat L3	**TAILORING THERAPY TO MEET INDIVIDUAL CLIENT'S NEEDS Clinicians describe ways in which they try to personalise and tailor therapy to individual client's needs. This personalized stance is seen to be in keeping with their broad approach which places the person and their experience at the centre (rather than a protocol) but is also linked to practical considerations (for example offering therapy sessions that fits with the constraints of the patient's life, were possible).**	

Initial Code	0379 PDy, AT and systemic ways of working place the person, the relationship and what the individual is experiencing at the centre, not the protocol	*"So I think in this way a more psychodynamic way or even an attachment based way, and systemic ways of working do acknowledge a lot of that. OK you might be an MUS person and I have here a protocol for MUS people, but there is something here that is happening that I don't know what it is but you are obviously a bit distressed so acknowledge that something is going on."* (P1, 358-362)
Initial Code	0722 Framing therapy to tailor it to the patient, i.e. based on what might be interesting to them, or what might be off-putting or persecutory	(Therapist talking about her how she has tailors her opening intro for therapy) *"I suppose by that stage I've got an idea what's tolerable, or what might be interesting to them, what might be off-putting and what might be persecutory.* (P4, 697-698)
Initial Code	0867 Using knowledge about the patient in order to offer something workable (e.g. offering sessions that don't clash with school drop off or pick-up times for parents)	*"Knowing a bit more about the patient, you know, are they a parent, so then I could offer them something that doesn't interfere with them dropping off or picking their kids up from school, um, so knowing a bit more about them I think. And the relationship with the GP is vital."* (P2, 257-259)
Initial Code	0991 Clinician acknowledges that the service is not offering pure p-d or p-a therapies and need to adapt what is offered to the kinds of patients who are referred	*"But what we're doing is something a bit different here. You can't be too precious about eh who you take on. And you have to adapt. So it's about adapting."* (P2, 476-477)
Sub Cat L3	**HOLDING A FLEXIBLE PERSPECTIVE REGARDING WHAT CONSTITUTES CLINICALLY RELEVANT CHANGE Clinicians exhibit a flexible attitude regarding what might be considered a clinically relevant change for patients. This seems to be in keeping with their model and also with their perspective regarding therapeutic engagements as a relative construct, which is best understood in relation to the individual patient's starting point. Willingness to focus on change that is relevant and meaningful for the individual.**	
Initial Code	0981 Clinician recalling chance encounter with a former patient where patient came to say hello and was really happy to see him (yet would have run a mile from any therapist previously)	*"Months went by and I saw him in the reception area of the practice and he came over and said hello and was really happy to see me. And this was somebody who would run a mile from any therapist....And he was keen for either a re-referral, or to go on for some longer term psychotherapy."* (P2 457-460)
Initial Code	0984 Patient who had therapy still struggling with his MUS but something shifted in a positive way	*"(Int) Ok so this is someone who shifted from being quite resistant to the process of therapy to actual... (Participant Interjecting) to actually asking for some more. And he was resistant all the way through. There was a lot that he wasn't able to tell me and he still struggles with his symptoms but something had shifted in a really positive way for him."* (P2 463-464)
Initial Code	1386 A small shift in one domain of a patient's life made during therapy may continue to blossom after therapy	*"If you can just produce a small shift for somebody that then might blossom away from therapy then that's fine, but I think it's about instilling in people's mind that this is about, you know, let's make something a bit different here."* (P5, 545-546)
Sub Cat L3	**LACK OF FIT MAY LIMIT FLEXIBILITY Although clinicians expressed valuing flexibility to engage patients with MUS, they also acknowledged that there can be an inherent lack of fit between therapists and patients. This was predominantly seen to reflect a mismatch between the clinician's theoretical preferences and the degree to which these 'fit' with the material that a patient is bringing, Different clinicians have different theoretical proclivities, and may not be able to find a way to work effectively with all patients.**	

Initial Code	0637 Engagement difficulties can occur when clinicians who are very comfortable with a particular way of thinking meet patients who don't really suit that way of thinking	*"You know, you might get a therapist who is very very comfortable and convinced and accustomed to working in a Kleinian way, for instance. And they may get a patient who just doesn't suit that way of thinking. You know, as I'm speaking, it sounds a bit odd but the patient might be more sort of Freudian."* (P4, 453-455)
Initial Code	0640 Non-engagement also relates to the therapists themselves as not all therapists can get along with all kinds of patients	(Talking about factors contributing to non-engagement) *"Um, but then, I suppose with the therapist as well. Not all therapists get on with all types of patients."* (P4, 461-462)
Initial Code	0641 Clinicians may try to fit patients into their favourite models at times	*"But somebody might not feel very comfortable with that, and they are thinking about object relations, or paranoid-schizoid, or depressive positions. Which is fine, but there might be something about that model which might not suit what that patient is actually bringing. And then there's going to be a bit of a mismatch.* (P4, 459-462)
Initial Code	0642 Patients picking up on the fact that there is a mismatch between them and their therapist, relating to the therapist's theoretical preferences	*"And then there's going to be a bit of a mismatch. And the patient will pick that up. I mean, you must have had patients where they say, oh I had that therapist and she was... I just didn't get on with them."* (P4, 462-462)
Sub Cat L2	**NOT BEING A PSYCHOANALYTIC PURIST: Clinicians feel it helps not to be too 'analytically purist' when working with MUS patients. With experience they have learned to adapt their assessments when working these patients and often deviate from tradition psychoanalytic conventions. For some clinicians, this 'softening' of stance is borne out of negative prior experience when they 'lost' patients due to being over analytic. Contrary to a more classic analytic approach, clinicians describe being highly active, persistent and tenacious to engage reluctant patients.**	
Sub Cat L3	**ADAPTING THE ASSESSMENT PROCESS Clinicians perceive the assessment as crucial to engagement. Although they adhere to core principles of psychoanalytic assessments (e.g. attuning to patient's anxieties about attending), they also describe ways in which they adapt their Ax (deviating from p-a norms) for patients with MUS based on their past experience of difficult assessments. Key 'compromises' include accepting a bit less of a history and giving greater space and attention to the patient's physical health concerns.**	
Initial Code	0352 Adapting the standard introductory blurb during Ax to engage a patient with MUS	*"The only difference if that I will, for instance, it's really at the introduction where I say ... (outlines her standard intro) ... But with an MUS patient the only difference is that I would say, I know that you're having a lot of physical problems, and your GP is worried that this has an impact on other areas of your life and it might be helpful to talk to a psychologist."* (P1, 236-241)
Initial Code	0800 Clinician describes experience of an ambivalent patient with MUS who was annoyed about being asked questions about his life during Ax	*"He came to an assessment with me and he walked out half way through the assessment because he got very angry at being asked about my life. He said what is the point in asking me these questions, you know, about my life. I just want my pain to go away. He's been like this for several years. It's difficult to make sense of him because he doesn't see the sense in telling his story."* (P2, 121-124)
Initial Code	0810 With experience working with MUS patients, clinician has learned to adapt the assessment style (to accept a bit less of a history)	*"You might think sort of well possibly that bit can come later on, but let's start with what they feel more able to talk about right now, which is different from sort of a formal assessment in a way. I might accept less of a history than I would hope to or want to get from a patient usually."* (P2, 138-140)

Initial Code	0870 Eliciting patient's concerns about attending the first session important (as there's always something)	*"I think that reflecting that back if you get a sense that that's what the patient's concerns are. I think maybe one of the things that, 90% of the time when I'm meeting with any patients for the first time, whether they have MUS or whatever they are bringing, is to try and get a sense about what concern they have about coming to the meeting because there will always be something."* (P2, 263-266)
Initial Code	0871 Look out for themes in the patients narrative in the first session as may convey something of their anxieties about attending therapy (e.g. this will be waste of time like all my prior medical consultations)	*"If the person starts talking very quickly about all these frustrations they've had with things that have not gone anywhere, and a series of appointments where nothing worked, and they seem a bit pissed off and not really happy to be there, then you may say something like, you may be imagining that today like all these other things is not going to lead anywhere"* (P2, 265-269)
Initial Code	0888 Clinician provides a rationale to the patient for exploring their early history (taking a more psychoed approach)	*"You can go kind of two ways with it really. You can either be a bit psyched about it and then say, ... people learn ways of coping from their childhood so it helps me to ... know a little bit more about how you managed things earlier in your life. That would be a more psyched way of saying it to somebody who needed to hear it like that."* (P2, 302-305)
Initial Code	0914 Clinician considers Ax experience as crucial to the process of engagement (Ax is also engagement)	*"Yeah, and especially in the early days, at an assessment stage. Because going back to what you were saying about engagement, assessment is also engagement, I think. And actually, it's also about what the patient can hear at that time. What they are able to take on."* (P2, 357-358)
Initial Code	1272 Clinician's perception is that a standard mental health assessment will give very little time to a persons' physical health (which is what patients with MUS will talk about)	*"I think if you were just doing a standard mental health assessment you'd give very, very little time to someone's physical health. And quite often with medically unexplained symptoms will just present and that's what they will talk about."* (P5, 371-373)
Sub Cat L3	**DEVIATING FROM PSYCHOANALYTIC CONVENTIONS Clinicians describe a variety of ways in which they deviate from psychoanalytic conventions in order to offer therapy which meets the needs of individual patients. These deviations include variations in the structure of treatments (e.g. seeing patients less frequently), doing more supportive work, making use of goals, and altering their style of make patients feel more comfortable. Tongue in cheek, one clinician described this as "doing therapy light"**	
Initial Code	0346 Offering a monthly, supportive intervention to help an anxious patient deal with lots of investigations, keeping them longer in the caseload	*"This is not someone that I see for weekly psychotherapy. I see him here once a month for what we call in the service a supportive intervention which means that I keep him longer in my caseload so that when there are exams and things, because he does go through a lot of investigations as well that we can work about how are you going to cope going to the hospital for this exam, what are we going to do about that. So in a way it's almost very solution-focused, it's very step by step"* (P1, 211-215)
Initial Code	0435 Being willing and able to see patients less frequently when they are struggling to engage	*"I've seen her. Gosh I've seen her for over a year but not weekly, so you know, once a month because. And I tried to. She was very socially isolated. And I thought this woman is never going to start going out there and doing her physiotherapy."* (P1, 542-544)

Initial Code	0443 Clinician not really doing therapy sometimes (just getting the patient to talk to someone for a little bit about anything)	*"I gave up any hope that she would talk about any of her emotions or reflect about how her pain affected The whole thing was just about getting her to talk to someone for a little bit about anything. So any kind of idea about therapy is just out of the window."* (P1, 558-560)
Initial Code	0808 Building relationships with patients through the language they prefer (i.e. relating to the body)	*"I would focus more on the physical symptoms to start with to meet them at where they're at with that, the kind of treatments they've had. Almost therapy light in a way, where you're building up a relationship with them through the language that they prefer, and what they can talk about."* (P2, 133-135)
Initial Code	0991 Clinician acknowledging that the service is not offering pure p-d or p-a therapy and the need to adapt what is offered to the kinds of patients referred	*"But what we're doing is something a bit different here. You can't be too precious about eh who you take on. And you have to adapt. So it's about adapting."* (P2, 476-477)
Initial Code	1040 Importance of being flexible to engage patients (not providing pure psychodynamic therapy to everyone who walks through the door)	*"So I've learned to be just a bit more flexible in how I engage people. So I'm not providing pure psychodynamic therapy to everyone who walks in the door because quite a few people that we see won't be able to make use of that. It would just be too stressful."* (P2, 580-583)
Initial Code	1092 Clinician draws on ISTDP but doesn't use it in a pure way because it's very direct and too difficult for patients who are more troubled	*"And I think I um. It's a very direct model and it can be too difficult I think for patients who are more troubled or more um, I don't know. It has its drawbacks I think. And so I never use that model in a very pure form."* (P5, 030-031)
Initial Code	1143 Clinician breaks out of the traditional psychoanalytic way of working to make patients with MUS feel comfortable	"I think you have to really make an effort to make them feel comfortable. So I think I do sort of break out of the traditional, more psychoanalytic way of working in that way." (P5, 124-125)
Initial Code	1384 Clinician acknowledged the need to have some fairly modest goals for therapy sometimes (producing a shift in one area of the patient's life might be meaningful)	*"And if you can get something to change in all of the domains of their life then great, but even if you can just get one shift, I sometimes think you know, you have to be, you have to have some sort of fairly small goal for therapy sometimes."* (P5, 543-545)
Initial Code	1455 Doing 'therapy light' (when working with patients who are preoccupied by their symptoms)	*"I would focus more on the physical symptoms to start with to meet them at where they're at with that, the kind of treatments they've had. Almost therapy light in a way, where you're building up a relationship with them through the language that they prefer, and what they can talk about."* (P2, 133-135)
Sub Cat L3	**DANGERS OF BEING OVERLY ANALYTIC OR INTELLECTUAL Some clinicians described adapting their technique over time to be less classically psychoanalytic, and using less psychoanalytic formulations. This was based on learning from earlier experience of being overly intellectual and 'over-zealous' in making very psychoanalytic interpretations about patient's symptoms that patient's couldn't relate to, precipitating patient's disengagement, or experiences of 'scaring patient's off' by appearing to know too much and/or touching on sensitive areas too early in therapy.**	
Initial Code	0103 Risk of scaring patients off by understanding a lot about them quite quickly or understanding one very sensitive thing about them	*"I think for some patients, if you understand quite a lot about them quite quickly that, or even if you only understand one thing but it's quite a sensitive area, then that could actually scare them off."* (P3, 272-274)

Initial Code	0775 Clinician's early p-a practice a bit too intellectual - coming from intellectual understanding of analysis, not focusing on what is happening in the room in a simple way.	*"I think I was still practicing with my version of psychoanalysis, being a bit, sort of intellectual. So I would say things to patients that were coming out of my intellectual understanding of analysis rather than just talking about the process of what was happening in the room in a more sort of simple way, in a way which kind of helps the feelings to come out." (P2, 64-67)*
Initial Code	0883 Risk of having too much therapeutic zeal (having fixed ideas that symptoms are something else, talking about them in that way, etc.)	*"I think it would be wrong to go in there with too much therapeutic zeal to think, you know to have a very fixed idea that I know that these symptoms are actually something else, and then talk to them accordingly, or try to distract them away. I think that they need to have a space to discuss what is first on their mind, and what is most immediate for them." (P2, 296-298)*
Initial Code	0931 Clinician moved away from using psychoanalytic formulations a little bit	*"It's not so much a case of me not still thinking like that (talking about making psychoanalytic formulations), but a case of me not thinking like that as much." (P2, 369-370)*
Initial Code	1032 When less experienced the clinician was trying to be much more psychoanalytic in his way of working	*"I think I was much more, a bit less well adapted to different ways of engaging patients and I was much more trying to be very psychoanalytic in my stance and way of working, but this women was not at all ready or able to use that way of working." (P2, 560-563)*
Initial Code	1033 Trying to use an very psychoanalytic stance with a women who was not ready or able to use that way of working	*"I think I was much more, a bit less well adapted to different ways of engaging patients and I was much more trying to be very psychoanalytic in my stance and way of working, but this women was not at all ready or able to use that way of working." (P2, 560-563)*
Initial Code	1036 Clinician being too analytic and challenging when he first joined the service (leaving lots of silence then interpreting the patient's worries)	*"It was one of my first cases here and I remember really struggling with it because for some similar reasons she wouldn't give much of a history she was very much focused on the physical, and I didn't know then to, you know, meet her half way. So I just talked, you know, I was a bit more challenging and analytic right from the start, so I'd leave a lot of silence, and then try to interpret what she was worried about when she got anxious about that." (P2, 568-572)*
Initial Code	1038 Patient who just stopped coming after the therapist was not receptive to her expressed desire to quit after only four sessions	*"And she was saying that she wanted to stop here and I wasn't very receptive to that. I was talking about her, not in these words perhaps, but about her resistance to thinking or getting into something a bit more, and she just stopped coming." (P2, 573-575)*
Sub Cat L3	**GOING WITH THE PATIENT'S PREOCCUPATION WITH THEIR MUS Clinicians perceive benefits in taking the lead from the patients (e.g. going with the patient's preoccupation with their physical symptoms), particularly at the beginning of therapy. This seems to stem from en experience-based perception of the real, detrimental impact of physical Sx on patient's lives, regardless of their cause. By acknowledging this suffering and showing interest in patients' experience of the health system, clinicians feel they can improve initial engagement.**	
Sub Cat L4	**GOING WITH THE PATIENT'S PREOCCUPATION IN THE INITIAL STAGES Clinicians feel that it's important give time, care and attention to patient's presenting medical problems and experiences "to go with their preoccupation" and to convey genuine interest and curiosity in these experiences, particularly when patients seem to be highly preoccupied with this. Where this is the case, clinicians willingness to start by initially focusing on their physical symptoms may be helpful for engagement as well as generating useful material about the patient and their style of coping**	

Initial Code	0181 Therapist simply expressing an interest in the patients experience of the symptom and her opinion that it might be meaningful	*"You're just showing them that you're very interested in their experience of it, and you think they're experience of it is very meaningful and relates to other things, besides the body alone. And I think that that's probably quite a big part of the work that we do really here."* *(P3, 450-453)*
Initial Code	0384 Going with the preoccupation by looking at it in detail	*"You know, it's just. I will ask actually quite a lot about their medical history and take quite a keen interest in. Not in a "oh I understand it" but actually going oh my god, so you had to do this exam and you had to do that and really sort of "gosh it must be really frustrating." Actually try to understand how it feels to the person to go through all these different things and you know, be poked and prodded. All these things can be incredibly distressing so I would actually go with the preoccupation. So ok, let's take a look at this." (P1, 373-378)*
Initial Code	0804 Switching focus more towards physical symptoms when patients are resistant to engaging in psychotherapy ('meeting patients where's they're at')	*"When it becomes clear quickly that somebody is very resistant to um, to engaging in psychotherapy, if I'm engaging them in an assessment I would focus more on the physical symptoms to start with and meet them at where they're at with that, the kind of treatments they've had." (P2, 132-134)*
Initial Code	0886 (When patients are more entrenched in their MUS) clinician starts with the physical first, then ask more about other things	*"I think in an assessment, if I got a sense of somebody being, you know, very entrenched in their MUS, I might do it in a more psyched way, but then say, it's also helpful for me to know a little bit more about your life more broadly. Focus on the physical first, get a full picture of that, then say now I'd like to ask you a bit more about these other things." (P2, 299-302)*
Initial Code	1270 Clinician thinks it's important to spend time with the patient talking about their presenting 'medical problem' (rather than jumping straight to emotional difficulties or early life experiences	*"I think you've got to give a bit of time to talking about it. I think if you just go to talk about just the emotional difficulties and their early life experiences then they will find that very difficult because they're presenting with a medical problem." (P5, 367-369)*
Sub Cat L4	**IMPORTANCE OF FOLLOWING THE PATIENT AND WHAT MATTERS TO THEM** **Although clinicians stress the need to follow the patient and what is important to them (which is considered in keeping with a p-d or p-a way of working, they stress the importance of following the actual preoccupations exhibited by the patient and not assuming what these are. For instance, patients may or may not be preoccupied by issues of labelling or diagnosis. This is seen to be a legitimate thing to pursue only if it is a real concern for the patient (rather than one presumed by the therapist).**	
Initial Code	0014 Presenting symptoms - physical or emotional - being the most manifestly distressing thing for most patients	*"We do short term work, and we see people who are primarily coming with a symptom of some sort, whether it's physical or emotional. Um, and that's the most immediate manifestly distressing thing for them, usually, so it's important to their GP you know, and then to us." (P3, 121-124)*
Initial Code	0312 Not about telling the patients they have MUS and then asking them how they feel about it	*"I'm very much in the camp of formulating as opposed to diagnosing. I don't actually in my work with patients eh go on about a diagnostic category but actually a formulation of the problems rather than you have MUS, how do you feel about having MUS. It really isn't about that." (P1, 116-118)*

Initial Code	0313 Clinician will only work with MUS labels & terminology if this is important to the patient - in which case could have a whole piece of work about that	*"I wouldn't avoid using it but I wouldn't use it for my sake. You know it depends if the patient, if this is something important for the patient then of course we can have the whole piece of work about that." (P1, 120-121)*
Initial Code	0317 Doing work based on what the patient brings, rather than imposing something on them that the clinician wants to talk about	*"And I have patient who I have worked, you know, very very hard on how it feels to be told that your symptom is medically unexplained, and the whole piece of work was about that, so I don't avoid it but I don't impose it as something that needs to, you know, because that would be what I want to talk about, not what the patient necessarily brings." (P1, 127-130)*
Initial Code	0761 Clinician's therapeutic style varies with every patient so difficult to generalize - but in keeping with psychodynamic way of working always takes the lead from the patient	*"But I wouldn't say that I'm the same with every patient so I think that there's a bit of a variety but I think, largely speaking, I would, in keeping with a psychodynamic way of working, I would take the lead from the patient." (P2, 38-40)*
Sub Cat L4	**SHOWING AN INTEREST IN THE PATIENT'S MUS & MEDICAL EXPERIENCES** **Clinicians accept that patient's MUS (and in some cases, the medical treatments received) can have a real debilitating impact on a patient's QOL and feel that this should be to acknowledged and that they should give time, care and attention to that, to show that they're curious about what their patient experiencing.**	
Initial Code	0330 Clinicians acknowledge that medical treatment for MUS have their own limitations (e.g. antibiotics which don't work after a time) and implications (e.g. further physical symptoms)	*"They were infections and she had to take antibiotics. There were a lot of limitations then in the sense that if you take a lot of antibiotics, eventually they don't work anymore. There were a lot of implications that were very physical things, you know." (P1, 166-168)*
Initial Code	0332 Clinician acknowledging 'real' debilitating impact of MUS Symptoms on patient's life	*"The truth of the persistent physical symptom remained. It was limiting her life. She could not go swimming although she loved swimming and because she was afraid of all these things." (P1, 169-171)*
Initial Code	0438 Appreciating the impact of MUS on the patient's family e.g. woman's sons being kept at home	*"I mean there are a lot of problems. And she had young sons, I mean her sons were young men. And to a certain degree her illness was keeping them at home." (P1, 548-549)*
Initial Code	0673 Importance of the therapist being actively and genuinely interested in the patients MUS symptoms and in tune with the fact that they are suffering pain (even if their pain might be seen as a different sort of pain)	(Clinician talking about strategies to promote engagement) "I think being actively interested in the symptoms. There's no doubt about it, without being duplicitous or disingenuous, to be really genuinely in tune with the fact that the patient is suffering pain. You might see it as a different sort of pain, but it is nevertheless pain." (P4, 542-544)
Initial Code	1042 Helpful to soften the pure psychodynamic approach by being much more interested in the patient's MUS, their treatments, and everything they've done to help cope with them	(Clinician reflecting on working with a patient after first joining the service) *"I think I would soften the approach to be much more interested in the physical symptoms, in all the treatments that she'd had to try to manage them and I'd take a much longer term view to getting her history from her." (P2, 585-586)*
Initial Code	1270 Clinician thinks it's important to spend time with the patient talking about their presenting 'medical problem' (rather than jumping straight to emotional difficulties or early life experiences	*"Well, I think you've got to give a bit of time to talking about it. I think if you just go to talk about just the emotional difficulties and their early life experiences then they will find that very difficult because they're presenting with a medical problem." (P5, 367-369)*

Initial Code	1271 Clinician feels it's important to let patients know that you're interested in and curious about their medical issues (as well as being interested in the bigger picture)	*"So I think you do have to spend some time, you know, talking about it. It's about letting them know, look I'm interested, I'm curious about this medical problem, um, but I also want to talk about the bigger picture as well."* (P5, 369-371)
Initial Code	1273 Needing to give time, care and attention to patients regarding their medical problems (letting you know that you're interested in that too)	*"Quite often with medically unexplained symptoms will just present and that's what they will talk about. They'll come in and talk at length about the medical problems that they've had, and I think you need to give some time and care and attention to that, and let them know that you're interested and that you're not just there to talk about their potential mental health problem."* (P5, 373-376)
Sub Cat L3	**THERAPIST PERSISTANCE AND TENACITY Therapists can be very persistent and tenacious in their efforts to engage patients with MUS, particularly patients who are highly reluctant. Deviating from a more p-a approach emphasising interpretation or insight they may make repeated efforts to this end, using direct encouragement and persuasion and making use of the GP relationship to facilitate this. At times, clinicians can struggle to 'let go' of patients and efforts to engage some patients may be quite costly for the service, in relation to outcomes.**	
Initial Code	0424 Being a bit persistent in trying to understand what a patient is feeling if they are not communicating this in a direct and straightforward way	*"And the person might say oh no, because everything is fine. And you can say, well are you sure because you changed your posture. You were sitting relaxed and then suddenly you were like that (tenses up). So you say "are you sure?" and check things with patients. So in a way you have to be a bit persistent."* (P1, 510-512)
Initial Code	0434 Clinician trying very hard to actively engage a highly reluctant patient (e.g. patient who came to the service in person to say she wasn't going to be coming to therapy)	*"She lived next door to the GP surgery so she would come to the GP surgery to tell me that she was not coming. And it was so funny because she didn't speak English so I did book an interpreter so it cost the service quite a lot. So she would come to say she's not coming. So then I would say "well come a little bit". With her it was such a slow progress."* (P1, 539-542)
Initial Code	0440 Engagement by stealth - I know you're not coming, but let's talk a little bit	*"So I saw her with the son. I saw her with the GP. I saw her with loads of different things. And it was a bit like that. Being a bit, like, engagement by stealth. Because it was a bit like "so I know that you're not coming, ... but let's talk a little bit, ..."* (P1, 549-551)
Initial Code	0444 Therapist tenaciously striving to engage a patient in a Turkish speaking health support group, referring her 3 times even though she kept DNA'ing	*"I referred her three times for the health support group in her language. She never went. And eventually the last one, she went. And she had to get a bus to go to it. And then she really liked it. And she loved the group. She didn't do ANYTHING (emphasis) that they asked her to do with the exercises. Didn't take in anything about the psycho education stuff but liked being in the group with the women."* (P1, 560-564)
Initial Code	0447 Clinician describing a saga of engagement working with a patient who has been engaged with the service since it first opened (so the patient has had extensive contact with the service).	*"This woman, I have known her since the service started so she had been discharged, re-referred. She went to her country for three months, came back. You know, it's a saga of engagement. If you look at her contact sheet, she just, OMG it's immense."* (P1, 571-573)
Initial Code	0487 Therapist responding by being as honest as possible and encouraging patients to persevere, if tensions arise in brief therapy (e.g. when therapy is becoming 'a bit of a battle')	*"I suppose I try to be as honest as possible, and sort of, say to the patient how very very important it is that they persevere with it."* (P4, 96-97)

Initial Code	0488 Therapist reminding patients why it might be worth persisting when things get difficult (e.g. because they are in agony, lots of people worried about them, things getting serious)	*"You know, sometimes it can be a very simple remedy to remind the patient that they are in a lot of agony, that a lot of people are worried about them, otherwise they wouldn't have been referred, and if they've got to this point in their life where things appear to have got this serious, then it's worth persisting." (P4, 97-100)*
Initial Code	0490 Reminding the patient that the GP has made the referral because he or she believes therapy will be helpful for them (when therapy getting difficult and the patient is at risk of quitting)	*"Sometimes it's very helpful to bring the GP into the room, if you like, in a metaphorical way, and remind them of that relationship, and the fact that this GP clearly has a lot of investment in them, and wouldn't have made the referral unless they felt that this could be something helpful, so it's good to bring them back to the structure, why they are here." (P4, 100-103)*
Initial Code	0717 Therapist urging the patient to consider what is being offered as something that they may have never had before which might be worth exploring	*"I would urge them to consider the fact that they have probably never had anything like that before. It sounds a bit measly possibly, or it might sound a bit overwhelming. Um, but I think it might be worth exploring." (P4, 688-690)*
Initial Code	0805 Clinician tried everything to engage difficult patient with MUS (had joint meeting with GP and pain clinic, who had also tried every way to engage him) - Patient rejected everything.	*"And we went through sort of, we actually had a joint meeting with the pain clinic about this guy and they tried everything. They'd tried kind of a psyched approach, they'd tried every way of engaging with him. And nothing was ever quite right for him." (P2, 125-127)*
Initial Code	0973 Clinician can find it hard to 'let go' of patients who drop out of therapy especially if he feels he's started something that they could potentially benefit from.	*"That can be very difficult. I mean you hope that people will increasingly engage but sometimes they don't. It can be a temptation when somebody is into some sessions to, when you've created a bit of a link with them and a bit of an understanding. It can be easy when they drop out to try to do a lot to get them back, and sometimes it can be hard to sort of let people go when they drop out because you've started something that you feel they could benefit from potentially." (P2, 432-436)*
Sub Cat L2	**BORROWING FROM OTHER MODELS: Despite expressed preferences for psychoanalytic ways of working, clinicians described the benefits they perceived in sometimes borrowing from other therapeutic models and, especially when they notice that patients are struggling to get to grips with the psychodynamic approach and appear a bit stuck. As might be expected the extent of this 'borrowing' reflected clinicians' background and prior clinical experience, including during training. Examples of interventions found helpful included psycho-education (CBT), circular questioning (systemic), externalization (narrative approaches). Alongside this, clinicians also integrate helpful strategies and tactics that they have developed over time to help them deal with patient reluctance (e.g. use of metaphors and well-rehearsed scripts to enhance patient's motivation).**	
Sub Cat L3	**CLINICIAN DESCRIBES BORROWING FROM DIFFERENT MODELS: Although clinicians are strongly influenced by psychoanalytic ideas they also describe borrowing from different models, often unconsciously. One clinician noted that this tendency reflects her previous training as a clinical psychologist (a training which emphasises plurality and introduces clinicians to multiple models of treatment).**	
Initial Code	1084 Clinician predominantly psychodynamic but borrows from different models	*"So I guess I'm in the overall bracket of being psychodynamic in this service, but borrowing from different models, I would say. I would say that's me, yeah that's me." (P5, 011-012)*
Initial Code	1108 As a clinical psychologist, clinician borrows from lots of different models without realising it	*"I guess that's the thing about being a clinical psychologist, you end up doing all these little bits and bobs without realising it, because you're borrowing from all these different models." (P5, 56-58)*

Initial Code	1119 Clinician struggling to find a way to blend psychodynamic and systemic ways of working	*"I went on some systemic training, um earlier this year and it made me think, how do I blend the two? And if I'm honest with you, it's really hard. I think sometimes I am with patients and I feel that there feels more, I think sometimes when I work with patients and I try to work more psychodynamically and they just can't get to grips with it." (P5, 79-82)*
Sub Cat L3	**BRINGING IN CBT & BEING A BIT MORE PSYCHOED** Most of the clinicians describe bring CBT into their work and find this helps for patients who are preoccupied with their bodily symptoms, and to break things down a bit for people who struggle to think this way on their own. Most commonly, clinicians use psycho education early in therapy especially for chronic pain and trauma where there are models to draw up, however some clinicians demonstrated 'cognitive thinking' when talking about their patient's difficulties. Several clinicians described using behavioural techniques occasionally.	
Initial Code	0154 Doing a bit of mind-body basic psycho-education if patients are defensive about seeing a psychologist and what that means (e.g. "are you saying I'm mental?")	*"Also quite often, particularly if a patient is very defensive about seeing a psychologist and what that means, you know, "are you saying I'm mental" you know, that kind of thing, um then um, I will tend to do a bit of very basic psycho-education, and say well actually, I think the body and mind are actually very closely linked" (P3, 388-391)*
Initial Code	0155 Using psycho-education to help the patient understand that the mind and body are linked and that physical symptoms are likely to have an impact whatever their cause	*"I will tend to do a bit of very basic psycho-education, and say well actually, I think the body and mind are actually very closely linked and um, and it strikes me that, you know, whatever the cause of these physical symptoms is, so acknowledging you know that I don't know in some sort of omnipotent way, that whatever the cause of these physical symptoms is, it strikes me that they are certainly having a psychological impact on you." (P3, 391-394)*
Initial Code	0354 Helpful to explain models of pain and how pain works for chronic pain patients as this can reduce anxiety significantly (but not possible for all kinds of MUS as causes not always known e.g. persistent UTIs)	*"Well, when you have a patient who is presenting with chronic pain, you know, it's a lot easier, than for instance the patient I mentioned earlier with the persistent urinary tract infection. Because you know with chronic pain it's a lot easier to explain models of pain and how pain works and you know, and that can help decrease a lot of anxiety" (P1, 251-253)*
Initial Code	0753 Clinician will very occasionally use behavioural techniques	*"Core influence is definitely a psychoanalytic/psychodynamic way of thinking about the patient. I think some, ... ever since my training there's been an influence of a more person centred way of thinking at times, in how I work, but it's mainly psychodynamic. Very occasionally I would say that I use more kind of behavioural techniques." (P2, 11-13)*
Initial Code	0885 When patients are more entrenched in their MUS may start in a more psychoed way to give patient a rationale for exploring early history	*"I think in an assessment, if I got a sense of somebody being, you know, very entrenched in their MUS, I might do it in a more psyched way, but then say, it's also helpful for me to know a little bit more about your life more broadly." (P1, 298-301)*
Initial Code	0887 Being a bit more psychoed about things (you know people learn ways of coping from their childhood)	*"You can either be a bit psyched about it and then say, it's helpful, people learn ways of coping from their childhood, so it helps me to understand how you're managing things now to know a little bit more about how you managed things earlier in your life. And that would be a more psyched way of saying it to somebody who needed to hear it like that." (P2, 303-305)*

Initial Code	0961 Clinician draws attention to the patient's counterproductive thinking processes during the session	*"I think I met somebody recently who was very anxious about going out with friends. She was really worried about feeling sick. She had done it in the previous year actually and she'd had a really good time. But she was talking herself out of doing it again this year"* (P2, 410-412)
Initial Code	1083 (Although predominantly psychodynamic) clinician brings CBT into their practice sometimes as well (as done a lot of CBT work during clinical psychology training)	*"But also I think by pure virtue of being a clinical psychologist, cos we're trained in so many different models, I think we're not always that purist anyway so I suppose I still will.... You know I did a lot of work using CBT so that will end up coming into my practice sometimes as well."* (P5, 9-11)
Initial Code	1103 Clinician pointing out that what starts a problem is not always the same as what keeps it going (like in CBT)	*"So what can start off as one thing, and that's kind of quite CBT oriented isn't it, what starts a problem is not always the same as what keeps it going. And I think you do have to think about the person's environment. So I think I don't just try to concentrate on the subconscious and things like that, I also think about the person's interpersonal world and their social environment as well."* (P5, 47-50)
Initial Code	1124 Clinician finds herself leaning more in the direction of CBT with certain patients (breaking things down a bit)	*"But also I think by pure virtue of being a clinical psychologist, cos we're trained in so many different models, I think we're not always that purist anyway so I suppose I still will.... You know I did a lot of work using CBT so that will end up coming into my practice sometimes as well."* (P5, 9-11)
Initial Code	1258 Talking to patients about what is known about 'so-called' MUS and the link between the latter and traumas and difficulties	*"And I don't try to sell the idea of, you know, this has been caused by this particular experience, but just sort of helping them to think like that, and I think I would talk to them about what we know about medically unexplained symptoms, or so-called medically unexplained symptoms, and talk about the link between that and traumas and difficulties"* (P5, 347-350)
Initial Code	1267 Clinician feels that a psycho-educational approach is needed when patients can only think about their bodies, but can't think about their minds	(Talking about using a psycho-educational approach) *"Yeah, yeah, as an initial way in. Yeah, I think you do need a psycho-educational approach to help people to understand the link between their mind and their body. I think when people are so,... you know, when they can't think about their mind and they can only think about their body"* (P5, 357-360)
Sub Cat L3	**CLINICIAN BEING WARM AND MAKING THE PATIENT FEEL COMFORTABLE: In contrast with a more traditional psychoanalytic technique, clinicians describe offering a warmer and reassuring approach towards their patients (more reminiscent of humanistic therapies). They try to be gentle with patients and make them feel comfortable.**	
Initial Code	0239 Striking a balance to help patients by talking about difficult things, but making it comfortable enough to make it bearable, so they feel held and understood when they do come	*"You know, they have to be comfortable enough to feel that it's bearable to come and to feel understood and held enough when they do come, but a lot of therapeutic work involves thinking about and talking about very difficult things and so, you're not really going to be able to help a patient without causing them some pain and some anxiety, you know."* (P3, 609-612)
Initial Code	1139 Clinician perceives sharp contrast between own style and her own detached psychoanalytic therapist who doesn't give much away	*"And that's useful in some ways because it makes you talk. And every so often I'd get an interpretation, I suppose. And it was interesting having that experience and thinking I'm not like that at all."* (P5, 117-119)

Initial Code	1140 Clinician makes an actively attempt to engage patients by being warm and making them feel comfortable	*"I'm really really not like that. I think I do make much more of an attempt to engage people by trying to be a bit warmer actually, and making people feel comfortable. Because, especially with the group of people we're working with here, they're often people who have tried lots of different things that haven't worked, and have often, especially with medically unexplained symptoms, have often feel very misunderstood." (P5, 119-120)*
Initial Code	1265 Clinician tries to be a bit gentle with patients, and break things down a bit for them	*"But I think it's about just being a bit gentle and breaking that down a little bit." (P5, 356)*
Sub Cat L3	**SYSTEMIC THINKING PERMEATES CLINICIAN'S PRACTICE** All the clinicians demonstrate strong systemic thinking and it's evident that this permeates different aspects of their work. Working systemically (e.g. collaborating with GPs) is considered helpful for initial engagement. Clinicians also consider patient's systems to help them formulate their patients' problems. However, this is also considered important input for evaluating the risk of engaging a patient "do I dare to disturb the patient's universe?"	
Initial Code	0226 Seeing patients who have powerfully convinced others of their helplessness and have family members running around after them	*"And a lot of these people are living in a set up where they've managed to convince quite a lot of people of that, and they get family members running after them in various different ways." (P3, 561-563)*
Initial Code	0410 Working systemically important for engagement when working with any patients who have medical conditions, not just MUS (e.g. helpful to see patient with the GP first to reassure them that they are not just being fobbed off)	*"And working systemically is really important, not just with medically unexplained symptoms, but also with people with any kind of medical condition. It's very important to work with the system. And engagement will depend on that as well. A lot of the patients might need you to see them with the GP to feel reassured that the GP is not just fobbing them off." (P1, 469-472)*
Initial Code	0663 Therapist being aware that shifts in symptoms can cause all kinds of crazy changes in their system, potentially revealing all sorts of unhappinesses that haven't been addressed	*"So there's a risk in an upset there, you know, I've known where things start to shift and suddenly there are all sorts of crazy changes in relationships, and you know, sudden realizations that there's all sorts of unhappiness, and things that haven't been addressed, and um, you know, then you've got kids in the mix as well." (P4, 515-518)*
Initial Code	0665 Thinking about whether it is safe to disturb the patient's universe	*"So you've got to think about, there's a book by Grotstein, a collection of essays celebrating Bion's life called 'Do I dare disturb the universe?' and it's sort of just come to mind now because as a therapist you are disturbing a universe." (P4, 518-521)*
Initial Code	1101 Reflecting her systemic influences, clinician always thinks about the reality of the patient's situation (as well as intra-psychic phenomena)	*"And I suppose if I was thinking a bit more systemically. You can't sort of not think about the reality of the situation for the person, you know." (P5, 44-46)*
Initial Code	1102 Thinking about what is happening in their patient's system (family, workplace) and how that may maintain their problems	*"I think you need to think about what is actually happening in their world, in their system, within their family, within their workplace, and all these things that kind of keep a problem going as well." (P5, 46-47)*
Initial Code	1104 Clinician pays attention to the patient's interpersonal and social world as well as the subconscious	*"So I think I don't just try to concentrate on the subconscious and things like that, I also think about the person's interpersonal world and their social environment" (P5, 49-50)*

Sub Cat L3	**USE OF NARRATIVE THERAPY TECHNIQUES TO ENGAGE PREOCC PATIENTS** One clinician talked about how she (unconsciously) draws on her experience using narrative therapy with patients with MUS patients, and how she finds this helpful to engage patients who are highly preoccupied with their symptoms. Using the technique of externalization she encourages patients to 'stand outside' their difficulties, to gain distance from their illness, to remember that they are more than their illness, and that there is a person underneath that she'd like to get to know.	
Initial Code	1107 Clinician acknowledges possible unconscious influence of narrative therapy on her practice with MUS patients as she often helps them to try to externalize their problem	*"But then again, I probably do do stuff about externalising a problem with adults now, but without thinking in a really conscious way that I'm doing narrative therapy." (P5, 55-56)*
Initial Code	1109 Externalizing the problem about putting the problem outside of the person	*"Externalising the problem is about putting the problem outside of the person, so um, often with children, when I'm working with children, they might have some sort of difficulty or some kind of anxiety about something that becomes so much part of their identity and they feel that is them, it's who they are." (P5, 60-62)*
Initial Code	1111 Helping children to externalize a problem by making it a character and naming it (so it becomes completely separate to them)	*"But it's about putting it outside of them and you kind of name it, make it a character, and then it becomes something completely separate to them that they can almost fight against." (P5, 62-64)*
Initial Code	1112 Clinician helps children to create distance from a problem so that they can fight against it	*"So it creates a bit of distance from the problem really, and almost frees them from it I think. With children it's great because you can draw it and you can give it a name and make it into a cartoon and do comic strips, and all silly things like that. So I think that's why it lends itself in particular to working with children." (P5, 64-66)*
Initial Code	1113 Clinician uses some narrative therapy techniques with MUS patients too (drawing on her previous experience using this approach with children)	*"But I do sometimes, with adults, also. I think people can become so identified with the difficulty that they have that it just becomes who they are." (P5 66-68)*
Initial Code	1115 Clinician tries to help patients create a certain distance from their problem so they realise they can fight against it	*"I think people can become so identified with the difficulty that they have that it just becomes who they are and I think if you can create a certain amount of distance for them and make them realise that this is something that they can fight against, you know, it's not all that they are. So I suppose I can do that a little bit with adults, yeah." (P5, 67-70)*
Initial Code	1276 Clinician lets the patient know that she'd like to know more about them (reminding them that there is more to them than their awful medical problems)	*"I always say, "I appreciate that you feel that it's all you are at the minute, these awful medical problems and this pain, but I'd really like to know more about you" because there is more to you than just that." (P5, 379-381)*
Sub Cat L3	**USING CIRCULAR QUESTIONING TO GET THE CONVERSATION GOING** One clinician described how she makes use of circular questioning to help get the conversation going when patients are presenting very passively and/or struggling to generate material. Her experience is that this helps to generate a fuller picture of the patient's difficulties as well as helping patients to start seeing different perspectives on their situation (e.g. seeing it at a different point in time or from other people's perspective)	
Initial Code	1122 Using more circular questions to help get the discussion going and free things up a bit (with patients who are struggling to work psychodynamically)	*"I think sometimes it helps me to start thinking, you know, a bit more about, you know, I might use a few more circular questions which helps to get the discussion going about the difficulties that they're having and frees them up a little bit." (P5, 83-65)*

Initial Code	1415 Clinician feels that circular questions get patients thinking about different perspectives and talking (good for passive patients)	*"I think sometimes I have found myself going and using more circular questions actually, which is not very, it's much more systemic, but just getting someone thinking about different perspectives on an idea, and getting them talking a little bit actually. I think that does work." (P5, 585-586)*
Initial Code	1416 Circular questions are a way to help patients see issues in a variety of different ways (e.g. different point in time, space, different people's perspective, etc.)	*"Circular questions are a kind of systemic tool of understanding an issue from different perspectives. It's about. I guess it's about thinking about the problem, um, in a different time, in a different space, from a different perspective." (P5, 588-590)*
Initial Code	1417 Asking the patient what another family member thinks about the problem that they are bringing (to elicit another view)	*"So it might be saying well what would, what does your mum think when that happens? So you're almost trying to get a different view of it. Rather than just, because if the patient is just bringing this problem and it's feeling quite hard to talk about it because they're not bringing much. It's about freeing yourself up a bit." (P5, 590-593)*
Initial Code	1420 Using systemic techniques (e.g. circular questioning) to obtain a fuller picture of the patient's difficulties	*"So it just gives a sort of fuller picture. So sometimes I will do that. So that's a more systemic way of thinking about it." (P5, 594-595)*
Sub Cat L2	**HELPFUL STRATEGIES TO PROMOTE ENGAGEMENT IN 'NAIVE' MUS PATIENTS Clinicians use a variety of 'hand holding' strategies to help patients with MUS engage in therapy. As many patients are naive about therapy, they try to position therapy positively and help patients understand (both verbally and experientially) what it's like. They also use a variety of active and persuasive strategies to promote engagement such as calling the patients before initial appts, making use of metaphors, and drawing upon well rehearsed scripts to manage common objections raised by MUS patients.**	
Sub Cat L3	**HELPING PATIENTS UNDERSTAND WHAT THERAPY IS ABOUT Although the type of therapy is rarely discussed, clinicians try to give their patients a sense of what therapy is about, positioning or framing it in an encouraging and non-threatening way, as well as managing patients' expectations about what it can deliver. Although clinicians will talk about this they believe it is most powerfully communicated by experience, particularly, by giving the patient a positive experience of what BDT therapy feels like in the initial Ax and early sessions.**	
Sub Cat L4	**POSITIONING THERAPY IN A POSITVE AND NON-THREATENING WAY Many clinicians describe ways in which they introduce and position therapy to their patients in an encouraging and non-threatening way. For example they describe therapy as "an opportunity to be a bit looked after", "an opportunity to understand yourself a bit better", while also actively encouraging patients to give this ago. In positioning therapy, clinicians are mindful of what they believe individual patients might find interesting, and what they might find off-putting.**	
Initial Code	0716 Therapist offering a very straightforward overview of what she is offering to the client - a space where they can think we her or just talk to her and where she can share ideas for them to consider	*"I suppose that at a very basic level, what I'm offering, and what I say I'm offering is a space that is just for them where they can think with me or they can just talk to me and maybe allow me to sometimes share an idea, and it's up to them whether they want it or not." (P4, 686-688)*
Initial Code	0721 Positioning therapy as an opportunity to bring something new into the patient's awareness which is not necessarily pathological (turning to the next chapter of the book)	(Clinician talking about what she tells patients to introduce therapy) *"But sometimes allowing someone else in might bring something else to their awareness that might actually be very interesting. It doesn't have to be pathological." (P4, 693-694)*

Initial Code	0722 Therapist framing of therapy tailored to the patient, i.e. based on what she thinks might be interesting to the client, or what might be off-putting or persecutory	*"I suppose by that stage (referring to the end of Ax) I've got an idea what's tolerable, or what might be interesting to them, what might be off-putting and what might be persecutory." (P4, 697-698)*
Initial Code	0733 Framing therapy as an opportunity for the patient to be a little bit looked after, for a patient who has never had that experience	*"I said, you know, I can't solve your money problems, I can't solve your physical problems, but I am prepared to think with you about how you might look after yourself a bit better." (P4, 734-736)*
Initial Code	0937 How clinician communicates the goal of therapy to patients - to help you understand your symptoms more with the aim of making things feel more bearable, and more manageable	*"Actually, what I do often say to patients is like, helping to understand you and your symptoms more with the aim of making things feel more bearable, and more manageable. And I think that that's most often the goal, actually." (P2, 377-379)*
Initial Code	0944 Positioning therapy as a space for the patient to understand themselves better in order to make things more manageable	*"So when you say, so we've had 2 of 3 meetings, we talked about things. This is the shared understanding that we have at the moment. I'd like to suggest going forward with a few sessions which will aim to continue with what we've just started. And this will help you understand yourself a bit better and hopefully make things seem a bit more manageable." (P2, 385-388)*
Initial Code	1268 Clinician uses psychoed to introduce the patients to psychodynamic way of thinking about their problems	*"Then I think I will you know, I guess I will talk a bit more about what happens sub-consciously, you know, what do we bury, and how does it come out in different ways, so borrowing a bit more from the psychodynamic way of thinking." (P5, 361-362)*
Initial Code	1269 Clinician uses psychoed re the psychodynamic model to actively persuade patients to give it a go 'let's just try this, you know, it might work'	*"Then I think I will you know, I guess I will talk a bit more about what happens sub-consciously, you know, what do we bury, and how does it come out in different ways, so borrowing a bit more from the psychodynamic way of thinking. I think that's how I make people, you know, just give it a go, you know, let's just try this, you know, it might work." (P5, 363-364)*
Initial Code	1353 Clinician always tells patients that their service is a psychodynamically informed service and what that means	*"I mean I will always say if people ask that we're a psychodynamically informed service and I will sort of tell them a little bit about what that means, but you have to be really careful not to get bogged down with language that doesn't make sense to them." (P5, 494-495)*
Sub Cat 5?	**KIND OF THERAPY UNDERTAKEN IS RARELY EXPLICITY DISCUSSED Although most clinicians try to introduce and frame therapy positively to patients and let them know what it involves, one clinician acknowledged that that the type of therapy undertaken is rarely explicitly discussed (unless patients know about therapy or express a desire to have/not have a certain type of therapy)**	
Initial Code	1346 Clinician finds question of how she agrees with the patient what sort of work they are going to do together and interesting one, because mostly this is not discussed explicitly	*"Um. That's an interesting question. It's funny because some people ask quite explicitly, you know, what kind of therapy is this, and so that sort of gets the conversation going about it straight away. But I never really" (P5, 485-487)*
Initial Code	1347 Some more educated patients ask what sort of therapy they are having which gets a conversation going about this	*"I never really (talk about what kind of therapy we're doing), unless people ask very specifically about the model, and that's often the more educated people who know about different types of therapy." (P5, 487-488)*

Initial Code	1348 Clinician may have a conversation about the type of therapy offered when facing clients who have had therapy before (e.g. in IAPT) and want something different	*"Often people who have had, you know, different types of therapy and know that they don't want that type of therapy anymore, you know, if they've come through the IAPT service, then they know that they want something different to CBT" (P5, 488-490)*
Initial Code	1349 Clinician sometimes has an open conversation with patients about the type of therapy they are having if they are well informed about therapy models or had prior experience	*"If they've come through the IAPT service, then they know that they want something different to CBT so it might be more explicit, then we'll have a much more open conversation" (P5, 490-491)*
Sub Cat L4	**GIVING PATIENTS AN EXPERIENCE OF WHAT THERAPY IS Although clinicians attempt to communicate the purpose of therapy directly to patients, several clinicians note that the most powerful method of communicating this is to demonstrate this to patients by giving them a positive experience during the initial assessment and early sessions. This experience (e.g. of feeling heard and understood) is seen to be a more powerful means of communicating the purpose of dynamic therapy than words alone.**	
Initial Code	0096 Importance of giving patients an initial experience that demonstrates a reason to come back and see you again	*"Um, I think it's also something about communicating, well (long pause), giving them a sense that there's some point in coming back and seeing you. And I don't think that has to be any one particular thing. I think it can be an, you know, any number of things." (P3, 257-259)*
Initial Code	0100 Importance of communicating to the patient that you've heard what they're saying about why they are there and that you're open to thinking about this with them	*"So I think it's about communicating to the patient really that you, that they're telling you something and you've heard it about why they are there in the first place, if you think that that's important for the two of you to think, to think some more about really." (P3, 264-265)*
Initial Code	0940 Best to communicate the goal of therapy (insight) at the end of Ax when the patient might have developed an understanding of what this feels like	*"But I would say that always at the end of an assessment, when a patient has some experience of what you mean by that. Hopefully by the end of an assessment they might have had an experience of you understanding them in a new way." (P2, 382-383)*
Initial Code	0939 Goals of therapy communicated at the end of Ax by the clinician	*"Yeah. But I would say that always at the end of an assessment, when a patient has some experience of what you mean by that. Hopefully by the end of an assessment they might have had an experience of you understanding them in a new way" (P2, 382-383)*
Initial Code	0941 Important to give patients an experience of being understood during Ax (to help the patient feel a bit less scared or alone with their Sx)	*"Hopefully by the end of an assessment they might have had an experience of you understanding them in a new way which will make them feel, hopefully, better understood, or a bit less scared, or a bit less alone with their anxiety or whatever it is." (P2, 383-385)*
Initial Code	0942 Patients more likely to understand the purpose of BDT after having 2-3 sessions	*"And then they're in a position to understand well this is how therapy works a bit. So when you say, so we've had 2 of 3 meetings, we talked about things. This is the shared understanding that we have at the moment. I'd like to suggest going forward with a few sessions which will aim to continue with what we've just started." (P2, 385-386)*
Initial Code	0945 Patient more likely to understand the purpose of therapy when they have already been through the Ax	*"But then that will mean something to them because they will have had an experience of their assessment already. And if it doesn't and they're very focused on wanting something sort of changed or different, I would have a conversation something like, you know" (P2, 388-390)*

Sub Cat L4	**MANAGING PATIENTS' EXPECTATIONS AND SETTING BOUNDARIES** Although clinicians try to frame therapy in a positive and encouraging way, they are also very wary of over promising and the need to manage patients' expectations about what therapy might be able to give them. A perceived 'red flag' for patients with MUS is the expectation that therapy will make MUS Sx disappear. Clinicians are careful to address this perceived unrealistic expectation (given the chronicity and severity of the typical patient's Sx) and to point out that therapy is not a 'magic wand.'	
Initial Code	0152 Therapist being quite explicit in managing patients' expectations regarding their MUS ('Since this problems been around a long time it's unlike that coming to therapy will suddenly change this')	*"I will say to them sometimes, quite explicitly, when they say to me "well talking about it won't change it will it?" I will say to them well we don't know what's going to happen in the future but it does seem to me since this problem has been with you for a long time, it seems unlikely that coming here is suddenly going to make a big difference" (P3, 384-387)*
Initial Code	0718 Therapist recognising that her offering a space may be received in different ways (sounding measly to some patients and overwhelming to others)	*"I would urge them to consider the fact that they have probably never had anything like that before. It sounds a bit measly possibly, or it might sound a bit overwhelming. Um, but I think it might be worth exploring." (P4, 688-690)*
Initial Code	0734 Therapist being realistic about what she can offering (a space to help the patient think about looking after herself a bit better, but not necessarily solving her financial or physical problems)	*"I said, you know, I can't solve your money problems, I can't solve your physical problems, but I am prepared to think with you about how you might look after yourself a bit better." (P4, 734-736)*
Initial Code	0740 Therapist feeling the need to be firmer about the contract with ambivalent patients	*"I'd probably say to her right at the outset "look, we're going to meet 8 times. Never mind all this let's see how it goes. I mean it took. It was like pulling teeth just getting her to the first appointment." (P4, 755-757)*
Initial Code	0946 Needing to have a conversation with patients to manage expectations (e.g. if the patient is focused on wanting something changed or different)	*"But then that will mean something to them because they will have had an experience of their assessment already. And if it doesn't and they're very focused on wanting something sort of changed or different, I would have a conversation about that" (P2, 389-390)*
Initial Code	0947 Needing to tell patients that therapy is not a magic pill that will make their MUS or pain Sx go away (if they have very high expectations)	*"If I felt that their expectations were very high I might say something like, well you know therapy isn't like a magic pill and nothing is going to make this pain or these symptoms just go away, and it's understandable that that's very frustrating." (P2, 391-393)*
Sub Cat L4	**REMINDING PATIENTS WHAT THERAPY IS ABOUT** As therapy progresses clinicians seem to switch gears a little, starting to push patients to really engage in the process. For example, when perceiving poor engagement they will remind patients that therapy is about making changes, that talking about MUS symptoms all the time is not a good use of time. Some patients can be surprised when pushed in this way suggesting that they have not fully understood what they are engaging in (and may see therapy as 'just having a chat')	
Initial Code	0074 Patients' initial ambivalence about having therapy for MUS can change over time if you persist with it	*"Yes, and it can be difficult for some people to see the point of it. And that can change over time if you persist with it, their views can change but it can be difficult for people to see the point of it, when their reason for going to the doctor in the first places wasn't "oh, I'm anxious or I'm depressed or my relationships are going wrong". Their reason was a physical symptom." (P3, 230-231)*
Initial Code	1302 Clinician reminding the patient that they are there to talk about themselves, their experiences and their feelings, not just their physical Sx	*"We're here to talk about you. We're here to talk about your experiences and how you feel, you know, and actually helping them to understand that this isn't helpful and that it's a defence against something more useful." (P5, 420-422)*

Initial Code	1369 Patients who just want to come and talk who are shocked when the therapist starts to push them a little bit	*"So yeah, I do think that people feel a bit...but then I think that some people just want to be able to come and talk, and then they're quick shocked when I actually start pushing them a little bit." (P5, 521-522)*
Initial Code	1370 Clinician tells the patient that they need to do more than just have a chat about what is worrying them	*"And they think they're just coming to have a chat about things that are worrying them. And I'm saying, well no, we need to do a little bit more than that. Actually we need to start really getting to the bottom of things and really understanding what's going on." (P5, 522-525)*
Initial Code	1380 Clinician tries to help patients keep in mind that therapy is actually about something changing	*"I don't do anything that's very goal-oriented. I would never sit down and say what are your goals? and write them down, but I think, helping people to keep in mind that this is about actually something changing." (P5, 537-539)*
Initial Code	1387 Important to instil in people's mind that therapy is all about making something different	*"If you can just produce a small shift for somebody that then might blossom away from therapy then that's fine, but I think it's about instilling in people's mind that this is about, you know, let's make something a bit different here." (P5, 545-547)*
Sub Cat L3	**USE OF ACTIVE AND PERSUASIVE STRATEGIES TO PROMOTE ENGAGEMENT** **Clinicians use a variety of active and persuasive strategies to engage their patients, especially during the earlier stages. Examples of strategies used included phoning patients to arrange initial appointments (facilitated by a service policy change), use of persuasive metaphors to promote curiosity and overcome stuckness, and drawing upon well-rehearsed scripts to address common MUS patient engagement barriers and objections.**	
Sub Cat L4	**HELPFUL TO PHONE THE PATIENT TO ARRANGE THEIR INITIAL APPT One clinician described finding it helpful to make initial contact with patients by phone prior to their initial appointment, since the service changed its policy on this matter. In this clinician's opinion this provides a valuable opportunity to identify, acknowledge (and potentially alleviate) any initial concerns and barriers to engagement and to start building a therapeutic relationships with the patient, and it seems to increase the likelihood that the patient will attend their 1st appt.**	
Initial Code	0861 Helpful when the service switched to using phone calls as the first point of contact with the patients - really beneficial for this patient group	*"Yeah, they do. I think that's why it's been a helpful thing in the service to change to often using phone calls as the first point of contact. I think that's a really beneficial way with this patient group as well." (P2, 244-245)*
Initial Code	0862 Initial contact by phone with the patient provides an opportunity to start building the relationship with them, making it more likely that they'll attend their first appointment	*"I think having a personal contact with someone on the phone can start to establish that relationship and make it more likely that they'll come to their session. And you can start to get a bit of a sense of if there are some of those factors there, like surprise at the referral or confusion." (P2, 237-249)*
Initial Code	0864 Initial phone contact provides an opportunity to alleviate any initial concerns a little bit, or at least to acknowledge them (to reduce barriers to attending the first session)	(INT) *"So perhaps you can alleviate those concerns?"* (P) *"Yeah, or at least acknowledge them. Invite them to... have the balance between not getting into too much of a therapy session on the phone, but also if there are obvious concerns, to address them a little bit there makes it more likely for people to come, I think."* (P2, 251-253)
Sub Cat L4	**USE OF METAPHORS TO PROMOTE CURIOSITY AND-OR ADDRESS STUCKNESS** **Some clinicians make regular use of metaphors to promote their patients' curiosity about their symptoms and to actively encourage them to engage in exploratory work. In an attempt to talk in their patient's language this might include medical metaphors e.g. framing therapy as an opportunity to have an 'x-ray of the mind'. Metaphors were also used to help patients understand challenging concepts (e.g. a clinician introducing the concept of secondary gain using the 'safety zone' metaphor).**	

Initial Code	0214 Using special phrases quite often - e.g. the zone of comfort or the zone of safety - to sensitively explore dependency issues	*"And I think, you know, one phrase I probably end up using with patients quite often is something about the zone of comfort or the zone of safety, you know. You know, we do see quite a lot of patients who have these kinds of dependency issues whose way of coping with illness is to be increasingly withdrawn and/or increasingly dependent on a small number of people in the household." (P3, 525-528)*
Initial Code	0229 Using the safety zone metaphor to address the patient's stuckness (acknowledging how hard it is to leave the zone while also highlighting good beneficial reasons to do so)	*"So when you do talk to people about, that's why I do find the sort of comfort zone or the safety zone quite a good phrase to use with some of these patients. When you're talking about that, you're acknowledging how hard it is to leave that zone, but you're not saying therefore, let's never leave it, you're actually saying, but I think there might be a reason why the health support group or a course of therapy sessions or whatever it might be, might be a good idea for you, because at the moment you're very stuck and nothings actually changing." (P3, 569-574)*
Initial Code	0720 Promoting curiosity and interest by using the analogy of the mind being like a book and they might be stuck on a particular chapter where there is only one thing that they believe about themselves	*"Sometimes I use the analogy of the mind being a bit like a book, you know, that's really interesting to think about. And they're stuck on a particular chapter where there is only this thing that they believe about themselves. But sometimes allowing someone else in might bring something else to their awareness that might actually be very interesting. It doesn't have to be pathological." (P4, 691-694)*
Initial Code	0745 Positioning therapy as a once in a lifetime opportunity - an investigation that they haven't tried yet	*"You might never have the opportunity ever again in your life. You might be relieved that it will never happen again in your life, but it's one of those investigations that you haven't tried yet." (P4, 769-771)*
Initial Code	0746 Using a medical metaphor framing therapy as an x-ray of the mind - an opportunity to explore one part of the patient that hasn't been looked at yet	*"I'd think of the investigation in our service like any other medical investigation. I'd be quite medical about it. Use medical metaphors. This is a little bit like an X-ray.... that's a bit too much isn't it, but you know what I mean. This is us looking inside somewhere and it's one part of you that probably hasn't been looked at yet." (P4, 771-774)*
Sub Cat L4	**DRAWING ON WELL REHEARSED SCRIPTS One clinicians described how she has accumulated a repertoire of scripts that she employs to deal with 'typical' challenges that she has encountered when working with MUS patients, for example the common objection "well talking about it won't help anything will it"**	
Initial Code	0150 Clinician having things she habitually says to see if they strike a chord with the patient or not	*"And then beyond that there are certain things I suppose that I will habitually say, and then see, you know, whether they strike a chord with the patient or not. Sometimes, for example, it would be about putting it to the patient, you know "well it seems like you have been having these difficulties for a very long time and um, and the doctors haven't been able to solve this problem for you. And I can see why that's hard." (P3, 380-384)*

Initial Code	0151 Clinician having a well rehearsed response to a common challenge made by patients 'well, talking about it won't change it will it'	*"When they say to me "well talking about it won't change it will it?" I will say to them well we don't know what's going to happen in the future but since this problem has been with you for a long time, it seems unlikely that coming here is suddenly going to make a big difference, but I wonder whether, given that that is the situation, we need to give more thought to how you manage these problems as long as they are with you." (P3, 384-388)*
Sub Cat L2	**06.5 WORKING IN DIFFERENT WAYS & FINDING A SUITABLE FOCUS BASED ON WHERE THE PATIENT IS AT: Clinicians believe that not all patients can engage in insight-oriented, exploratory work and communicated more or less willingness to work in different ways with patients. Often working in different ways involved doing a very targeted and practical piece of work aimed at helping patients to cope with their illness, often involving a systemic component (e.g. work with a cardiac nurse and a patient to promote better collaboration by helping the patient develop their mentalising skills so they can handle their medical consultations more effectively). However, clinicians vary in how they attempt to find a suitable focus for their work. Only one clinician expressed a willingness to work collaboratively with the patient to explore the patient's goals for therapy and to openly negotiating goals in order to find a mutually acceptable focus. Others considered explicit goal seeking as incompatible with their way of working. In this instance, clinicians seemed to adopt a more paternalistic approach to finding a focus for therapy, relying on their own intuition as inspiration as well as drawing on their prior clinical experience. Clinician's ability to work creatively to find a suitable and helpful focus for therapy when a more dynamic and exploratory work is not possible may be an important engagement skill in this service context.**	
Sub Cat L3	**MEETING PATIENTS WHERE THEY ARE AT Clinicians believe patients arrive at therapy more or less 'ready' to make use of more analytic ways of working. A crucial task therefore is to make an assessment of where the patient is at in order to try to establish how best to work with the patient. In practice this mean trying out analytic strategies (making trial interpretations, use of silence, etc.) to decide whether they might be able to engage in exploratory work, or whether it may be preferable to locate an alternative focus for therapeutic work.**	
Initial Code	0157 Patients who arrive a bit more ready to think about the fact that something psychological might be causing their MUS	*"Some patients are a bit more ready by the time they come to you to think about the fact that something psychological might be causing the physical symptom, but where they're not I will just put it to them the other way round, well perhaps not, but certainly your physical symptoms are creating psychological problems for you because you're telling me how depressed your pain makes you feel." (P3, 394-398)*
Initial Code	0763 Clinician tries to gauge how much a patient can make use of a more 'analytic' ways of working (e.g. allowing silences to develop, etc.)	*"I would, in keeping with a psychodynamic way of working, I would take the lead from the patient. I would allow for silences to develop within a therapy. I'd be trying to make sense of what they were bringing. It's about how gauging how much a person can use that way of working." (P2, 39-42)*
Initial Code	0807 Clinician notices when patients are very resistant to engaging in psychotherapy (in Ax) and adapts accordingly	*"When it becomes clear quickly that somebody is very resistant to um, to engaging in psychotherapy, if I'm engaging them in an assessment I would focus more on the physical symptoms to start with and meet them at where they're at with that, the kind of treatments they've had." (P2, 132-134)*
Initial Code	0847 Clinician perceiving a patient's limits - the most a patient can manage	*"We see patients sometimes who, their GPs send them off for referrals left right and centre, and they won't turn up to anything..if they come to three out of six sessions, that might be the most they ever managed, and that might be the most they can manage." (P2, 213-215)*

Initial Code	0872 Making an interpretation in the first session to acknowledge the patient's anxieties about attending (you may be imagining that today like all these other things is not going to lead anywhere)	*"I try and get a sense about what concern they have about coming to the meeting because there will always be something. If the person starts talking very quickly about all these frustrations they've had with things that have not gone anywhere, and a series of appointments where nothing worked, and they seem a bit pissed off and not really happy to be there, then you may say something like, you may be imagining that today like all these other things is not going to lead anywhere?" (P2, 269-269)*
Initial Code	0891 Needing to make a judgement in Ax as to whether the person might be able to work psychodynamically	(INT) *"And how do you make that judgement?"* (P) *"Um, it's very tricky, especially at the assessment stage. You might well make the mistake sometimes of.....um I think, um. It would quite simply be based on my understanding of the patient up to that point, based on what I knew from the referral, what I knew from the GP, what my sense was of the person in the room, how likely are they to engage."* (P2, 312-314)
Initial Code	0892 Judgment whether a patient could engage psychodynamically made based on the sense of how they are in the room in the first Ax (as well as info from referral info, GP, etc.)	(INT) *"And how do you make that judgement?"* (P) *"Um, it's very tricky, especially at the assessment stage. You might well make the mistake sometimes of.....um I think, um. It would quite simply be based on my understanding of the patient up to that point, based on what I knew from the referral, what I knew from the GP, what my sense was of the person in the room, how likely are they to engage."* (P2, 312-314)
Initial Code	0895 Information clinician relies on to predict patient's likelihood of engaging in the first session (how the patients is talking, what they say, how they relate to him)	*"I'd rely on the referral with the GP firstly, the discussion with the GP if I had one, and then I would be relying on my sense of the patient in the room and how they were talking to me about things and what they were saying, how they were relating to me and to the process." (P2, 320-322)*
Initial Code	0915 (To promote engagement) the clinician needs to understand what the patient can hear and taken on during Ax	*"Yeah, and especially in the early days, at an assessment stage. Because going back to what you were saying about engagement, assessment is also engagement, I think. And actually, it's also about what the patient can hear at that time. What they are able to take on." (P2, 357-358)*
Initial Code	1041 Recognising that lots of patients seen in the service won't be able to make use of pure psychodynamic therapy or would find it too stressful	*"So I've learned to be just a bit more flexible in how I engage people. So I'm not providing pure psychodynamic therapy to everyone who walks in the door because quite a few people that we see won't be able to make use of that. It would just be too stressful." (P2, 580-583)*
Initial Code	1054 Importance of calibrating where the patient is at and how much they can tolerate (for example being challenged)	(INT) *"So it seems like the central thing that I'm getting back from you about this is that need to always calibrate to where you think the patient is at and what they can tolerate, you know, how challenging you can be without being too challenging."* (P) *"I think that's totally right and I think it's very much about the individual patient as well."* (P2, 606-607)
Initial Code	1056 Clinician makes an initial formulation or hypothesis about where the patient is at and then explores and pushes to see how far they can go or how much they can take	*"You make an initial formulation which is an initial hypothesis about where they're at, and also, you get a sense of how much you can work with them and how much they can take, and then you're kind of pushing and exploring and finding out as you go." (P2, 607-609)*

Sub Cat L3	**WORKING IN DIFFERENT WAYS AND FINDING A FOCUS Reflecting the ethos of the service, clinicians talk about doing 'different pieces of work' and 'working in different ways' with different patients (e.g. doing a more structured piece of work, or systemic work), reflecting an acceptance that it's not possible to do dynamic/exploratory work with all patients. It seems that clinicians rely primarily on their clinical intuition (and prior experience) to find a suitable focus when exploratory work is not possible.**	
Initial Code	0285 Doing different pieces of work. Needing to be active and structured with some patients, but being able to be more explorative with others.	*"You know with some patients I have to be more active and structured. Others I would be able to be more explorative and do a different piece of work."* *(P1, 42-43)*
Initial Code	0316 Doing a whole piece of work about how it feels to be told your symptom is medically unexplained	*"And I have patient who I have worked, you know, very very hard on how it feels to be told that your symptom is medically unexplained, and the whole piece of work was about that, so I don't avoid it but I don't impose it as something that needs to, you know, because that would be what I want to talk about, not what the patient necessarily brings."* (P1, 127-128)
Initial Code	0326 Doing a piece of work all about being told you have a medically unexplained symptom	*"I remember particularly well a MUS patient, a patient who was referred to us because of MUS. And she was someone who did really well with therapy and all the work was about being told that she had a medically unexplained symptom. And she had persistent urinary tract infections and it really was quite awful in the sense that it had a huge impact on her life."* *(P1, 159-162)*
Initial Code	0333 Doing a systemic piece of work - working with the GP to help a patient access the physical health services that they really need	*"And a lot of my work with her was a more systemic thing which was actually with the GP and helping the GP to help her in terms of accessing the physical health services that she actually needed."* *(P1, 171-172)*
Initial Code	0448 Evaluation of therapy a highly subjective process e.g. may be perceived as a success if the patient experiences an improvement in their QOL (even if symptoms remain unchanged)	*"There hasn't been any improvement (in the patient's symptoms) I can guarantee you that … I consider her a success because I think there has been a significant improvement in her quality of life"* (P1, 576-577)
Initial Code	0449 How outcome of therapy can be evaluated depends on the focus of therapy, which is not always the physical symptoms	(INT) *"So that's really interesting ... there are different measures really as to what is the end goal of therapy, and in all the examples you have given me there has been different kinds of outcomes, and here, it's quality of life."* (P) *"And the focus of therapy, because it's really rare that the focus is really the symptom, you know, the physical symptom. Um Although there are cases where it is."* (P1, 581-582)
Initial Code	0452 Therapist needing to find a focus in their own mind when patients are unable to say what they want help with (e.g. focusing on the most worrying thing identified during assessment)	*"Sometimes people find it very hard to say what they want help with. Um, and it's very hard to find a focus in the traditional way how you would work with more structured therapies. And in these cases I am a bit vague with them, but I create a focus in my mind, what I think might be helpful, at least to guide me a little bit, based on what I assess to be the most worrying thing. The person may have MUS or whatever but is so incredibly depressed, you know."* (P1, 590-594)
Initial Code	0688 Finding another piece of work to do with patients who are resistant to exploratory work e.g. working systemically to help a patient focus on herself as a mother	*"And with her, what I ended up, sort of focusing on was her as a mother and to think about herself and whether there was any way that she could salvage something for herself as a mother, and for her children's sake, and not so embittered and shameful and so on. So I ended up working quite systemically with her, contacting her school and GP about stuff at home."* (P4, 583-586)

Initial Code	0696 Therapist suddenly having an inspiration about something important to work on that is relevant to the patient's central complaints	*"And I said to him, but it you have had the nouse to go to a computer, research this, find out all about it (he was very knowledgeable about it), what stopped you then just clicking the application button? "Well it's his F***ing job ain't it?" (laughing). So I thought, well actually, what I could work with him on is this idea that there is only so much responsibility." (P4, 611-614)*
Initial Code	0697 Therapist having an idea about a useful piece of work to do with a complex client who has been profoundly neglected in childhood (re taking responsibility and locating their own agency and potency)	*"And again, profoundly let down by carers. It was unbearable to listen to the amount of neglect. But it's persisting until he's nearly 50, you know, you lot sort it out. So I thought, actually, what we could work on is, ok yeah, mum and dad profoundly disappointing to say the very least, but you're nearly 50 now, what's going to happen with the rest of your life. Why can't you click that button, that application button. What's wrong with a bit of potency, you know, what's going to happen?" (P4, 615-619)*
Initial Code	0698 Therapist doing ego development work - you know "just click that bloody button"	(INT) *"So in this case, what kind of work are you doing? How would you describe that work?"* (P) *"Well I suppose it's ego development, sort of thing. I'm not quite sure yet but that's what I had in mind. Just ordinary, you know, click that bloody button?"* (P4, 621-622)
Initial Code	0735 Patient transformation from being hostile to not being able to believe she hasn't used therapy before in response to the therapist's positioning of therapy (a space to consider how she can look after herself better)	*"I said, you know, I can't solve your money problems, I can't solve your physical problems, but I am prepared to think with you about how you might look after yourself a bit better. And that's been quite something actually. It's really been amazing. From a very hostile response to somebody who says she can't believe that she's not used therapy before." (P4, 734-737)*
Sub Cat L3	**CLINICIANS WILLING TO FOCUS ON COPING WHERE NECESSARY AS THIS IS SEEN TO BE MORE ACCEPTABLE TO PATIENTS Clinicians perceive a coping focus to be an easier sell when patients seem defensive about being referred to therapy. A piece of work of this kind is seen to be legitimate and helpful when clinicians perceive that patient's Sx are having a real impact on their QOL and are unlikely to change. Clinicians can help patients cope day to day or help them cope with ongoing contact with the health system, where this is perceived to be problematic.**	
Sub Cat L4	**DOING A PIECE OF WORK ON COPING WITH MUS IS VIEWED AS LEGITIMATE AND HELPFUL A piece of work focusing on symptom impact is considered legitimate as clinicians see that their patient's quality of life can be severely affected by MUS. From past experience, clinician's acknowledge that insight alone may not change the reality of their patient's symptoms, so helping patient's cope better is valuable in its own right (either alongside insight work, or instead of this).**	
Initial Code	0034 Clinician likes the term 'problematic physical symptoms' as conveys primary issue is whether the Sx are experienced as problematic on an ongoing basis	*"And then, even in your study, you use a slightly different term which is, you know, problematic physical symptoms, where you're saying the primary issue is not whether it's medically explained or not, but the main issue is that the symptoms are experienced as problematic on an ongoing basis for the patient." (P3, 150-152)*

Initial Code	0153 Therapist suggesting that she and the patient think about how the patient manages the symptoms given they are unlikely to disappear	*"I will say to them sometimes, quite explicitly, when they say to me "well talking about it won't change it will it?" I will say to them well we don't know what's going to happen in the future but it does seem to me since this problem has been with you for a long time, it seems unlikely that coming here is suddenly going to make a big difference, but I wonder whether, given that that is the situation, we need to give more thought to how you manage these problems as long as they are with you."* (P3, 384-388)
Initial Code	0318 Doing a structured piece of work about how to cope with physical symptoms e.g. noticing Sx are worse when they are feeling low or anxious	*"How to cope with the physical symptoms, and do a very structured piece of work, you know, noticing that when they are very low in mood it gets worse, or when they are feeling very anxious things seem a lot worse. But that varies immensely."* (P1, 133-135)
Initial Code	0334 Doing a wonderful psychoanalytic formulation about the meaning of a patients' symptoms not the be all and end all - practical interventions important too	*"So in the end I could think oh yes wonderful psychoanalytic formulations about the meaning of her symptoms, and she could think about them too but there was something very practical, you know, about how to deal with this, how to work with a physical symptom that is persistent and it's not going away and the treatment itself for that also had long term consequences. There were long term consequences for that."* (P1, 172-174)
Initial Code	0335 Importance of doing work to help the patient deal with persistent physical symptoms and treatments for this that have their own long term consequences too	*"So in the end I could think oh yes wonderful psychoanalytic formulations about the meaning of her symptoms, and she could think about them too but there was something very practical, you know, about how to deal with this, how to work with a physical symptom that is persistent and it's not going away and the treatment itself for that also had long term consequences. There were long term consequences for that."* (P1, 173-176)
Initial Code	0344 Focusing on helping a person manage day-to-day anxiety about a lot of things (not just physical symptoms)	*"This is somebody who is incredibly anxious a lot of the time. And actually we're not working on his physical symptoms at all because what he finds very difficult is to manage how anxious he feels not just about his physical symptoms but about a number of different things."* (P1, 203-208)
Initial Code	1156 MUS is anything which has a severe impact on a person's quality of life	*"But I think it's anything which has a severe impact on someone's life really, their quality of life."* (P5, 156)
Sub Cat L4	**FOCUSING ON SYMPTOM IMPACT IS SEEN AS THE SAFETY ZONE OF ENGAGEMENT Positioning therapy support for coping with MUS is seen as the "safe zone" for engaging patients who appear to be defensive about their need for psychological therapy. Clinicians perceive it to be relatively easy to help patients accept that MUS has an impact and that psychological support to promote coping might be beneficial. In addition, by focusing on coping the clinician can gain insight about the patient's functioning as their coping style is medicated by many factors (personality, environment, etc.)**	
Initial Code	0158 Working with patients who are not ready to think about psychological factors as a potential cause of MUS by turning things around and focusing on their impact	*"Some patients are a bit more ready by the time they come to you to think about the fact that something psychological might be causing the physical symptom, but where they're not I will just put it to them the other way round, well perhaps not, but certainly your physical symptoms are creating psychological problems for you because you're telling me how depressed your pain makes you feel."* (P3, 394-398)

Initial Code	0159 Positioning the problem in a way that the client can work with it (e.g. seeing someone about the psych impact of MUS rather than seeing someone because the GP thinks I have psychological problems)	*"Sometimes if people have it put to them that way, oh so, you know, here I am to see someone about um the psychological impact of my physical problems rather than "Oh my GP tells me I have psychological problems but I don't agree with him" and then are more able sometimes to work with that." (P3, 398-402)*
Initial Code	0169 Helping patients to see how MUS are restricting their life and to get in touch with the pain and loss of that	*"And perhaps pointing out to them how much, and it's rarely just about the sessions, it's often happening in all kinds of domains, pointing out to them how much their symptoms are restricting their life. And seeing if they can get in touch with some of the pain of that and that the loss of that." (P3, 420-421)*
Initial Code	0244 Engaging patients who present fixated on their MUS and denying psychological issues by focusing on the psychological impact of their MUS	(INT) *"Um, you talked earlier about the particularly hard group being the patients who are more fixated on the physical symptoms and a denial of connection with any psychological issues. How do you in the earlier stages, address that particular subgroup to try to overcome that?* (P) *(long pause). "It's a good question. I think partly by, I think I gave an example earlier of, you can always say there's a, for anyone coming to you complaining about physical symptoms is at some level complaining about the psychological impact of that, so you can always bring that it."* (P3, 631-633)
Initial Code	1154 Individual differences in impact of MUS and how people cope (e.g. one person can't get out of bed while another goes to work every day)	*"So somebody who has a certain medically unexplained symptom can't even get out of bed, yet the next person is managing to go to work every day who has got the same symptoms so I suppose there is a lot of variation in how people might experience it, which again is mediated by personality, by experience and by their environment, by lots of different things." (P5, 152-155)*
Initial Code	1155 How Sx are experience MUS mediated by personality, environment, and lots of other things	*"So somebody who has a certain medically unexplained symptom can't even get out of bed, yet the next person is managing to go to work every day who has got the same symptoms so I suppose there is a lot of variation in how people might experience it, which again is mediated by personality, by experience and by their environment, by lots of different things." (P5, 152-155)*
Initial Code	1419 Exploring the impact of a problem, issue, behaviour on other people	*"And thinking a little bit about well, what is really going on? And how does this impact on other people? What happens when...if that happens then, you know, how does that other person respond?" (P5, 593-594)*
Sub Cat L4	**HELPING PATIENTS TO COLLABORATE WITH HEALTHCARE PROFESSIONALS** **Work to help a patient cope with his physical symptoms might include systemic work helping the patient to collaborate more effectively with healthcare professionals. For example, some clinicians make use of mentalization-based techniques to help patients with insecure attachment to cope better with anxiety-provoking medical consultations, in which the patient's mentalising capacity may be impaired.**	
Initial Code	0345 Helping an anxious patient, with a perceived anxious attachment style, work more collaboratively with his GP (rather than being dismissive of them) without raising too much anxiety about what is wrong with him	*"What he finds very difficult is to manage how anxious he feels not just about his physical symptoms but about a number of different things. He is someone who has a very anxious attachment style and again, another person who my main work has been helping him work with his GP in a way that is more collaborative and less, oh the GP doesn't know anything, but not raising too much anxiety with respect to what is the problem with him." (P1, 207-211)*

Initial Code	0349 Helping patients communicate effectively with health care professionals is an important part of working with patients with MUS	*(INT) "So liaising with other professionals is also important..." (P) "It's a big part of working with patients with MUS. Sometimes a lot of the work that I have done has been more about, you know, how can you ask your GP to tell you what's wrong. When you go and see, I mean I do have a lot of people who go to the cardiologist especially if they're having panic attacks. It's complicated, you know, because a lot of them will have other 'explained' physical, you know medically explained physical symptoms, they might have diabetes, they might have COPD, or actually might have you know, high blood pressure, history of heart disease in the family." (P1, 223-228)*
Initial Code	0351 Using mentalization based techniques to help patients deal effectively with high-stress medical consultations (e.g. helping patients to consider in advance how their will process information during the appointments so that they can think things through and ask questions rather than just reacting in the moment)	*"You know, how can you actually try to be, and this is more of a mentalization based technique, so you know you're going to be anxious in these situations, how can you start thinking and reflecting and mentalising because the GP or the doctor or the nurse are going to give you a piece of information and you need to be able to process that information and ask questions about it, so there's a lot of work in trying to help them mentalise and think things through before just acting and doing something" (P1, 228-232)*
Sub Cat L2	**ATTENDING TO TIMING AND PACING: Clinicians carefully consider the timing and pacing of all their interventions when working with patients with MUS. Though not always the case, it's generally felt that these patients can sometimes need more time to get to the point where they are able to talk about negative emotional experiences and difficulties, especially patients who are more vulnerable. Allowing patients time and space, and intervening at the right moments without pushing too hard, is seen as a valuable therapist engagement skill**	
Sub Cat L3	**ALLOWING THE PATIENTS TIME AND SPACE: Most clinicians acknowledged the perceived need to give patients with MUS more time to engage in therapy, especially when working with patients who are highly vulnerable. Although they perceive that patients can often focus on their bodily symptoms from experience they believe that patients will often move to explore difficult emotions and experiences in later sessions, particularly if they are not pushed too soon and are given the time and space for this to unfold.**	
Initial Code	0054 Psychological issues predating the patient's MUS tend to surface over time as the clinician works with a patient	*"And sometimes it becomes clearer after you've been working for a while that actually, although they say, you know, my psychological problems have been since my physical symptoms came on, or in the case where there has been organic damage, it might be since my injury or something like that, but the more you investigate it the more you realise that there was stuff going on before that time as well." (P3, 185-189)*
Initial Code	0556 Patient suddenly thinking symbolically about her MUS symptoms after the therapist allowed her to talk about them every session	*"And I used to let her talk about her symptoms for like half an hour. Every session would be let's talk about the symptoms, and then one day she said, cor, she said "God, you must think I moan all the time", which she did (whispers, laughing), and she said "it's as if I'm carrying something on my back all the time. I feel as if I've got, like, I feel like I'm responsible for the whole of London." (P4, 253-256)*
Initial Code	0762 (Describing his therapeutic style) clinician tends to allow silences to develop while trying to make sense of what the patient is bringing	*"I would, in keeping with a psychodynamic way of working, I would take the lead from the patient. I would allow for silences to develop within a therapy. I'd be trying to make sense of what they were bringing. It's about how gauging how much a person can use that way of working" (P2, 39-42)*

Initial Code	0880 Important to give patients the time to voice all the physical pains that are bothering them in the early stages so that they are heard	*"So, if part of the engagement process is about giving patients the time to voice all of the physical pains that were bothering them and the physical symptoms. It might be really really important to them to have them heard." (P2, 289-291)*
Initial Code	0884 Importance of giving patients the space to discuss what is most on their mind and most immediate (and not trying to distract them away from this)	*"I think it would be wrong to go in there with too much therapeutic zeal to think, you know to have a very fixed idea that I know that these symptoms are actually something else, and then talk to them accordingly, or try to distract them away. I think that they need to have a space to discuss what is first on their mind, and what is most immediate for them." (P2, 296-298)*
Initial Code	0899 If the clinician is struggling to understanding a patient will defer sharing formulation and acknowledge more time needed	*"And, um, the only reasons to not do that (share his formulation) would be is if I still feel very confused and feel as if I don't have a very good understanding in which case I would kind of acknowledge that we need a bit more time, or if there's some very possibly entrenched or paranoid view of things which they have got, which it would feel antagonistic of me to offer something different to." (P2, 333-335)*
Initial Code	0997 Giving patients a space to voice difficult feelings (e.g. patient's feelings of shame to be seen in public - a big strong guy shaking, and walking with a crutch)	*"And we would talk about the shame that he felt when he was in public and how he would sometimes not want to leave the house because people would see this big strong guy obviously shaking and walking with a crutch. He just had a place to voice those feelings really." (P2, 486-488)*
Initial Code	1043 Allowing a much longer time to get a history from a patient (being patient)	(INT) *"So if you were to work again with that woman now, how would you approach things differently?"* (P) *"I think I would soften the approach to be much more interested in the physical symptoms, in all the treatments that she'd had to try to manage them and I'd take a much more longer term view to getting her history from her." (P2, 585-586)*
Initial Code	1055 Clinician discussing a patient who took a long time to progress from talking about her physical pains (following a hysterectomy) to the emotional pain (of the losses and everything that went with it)	*"She was someone who I felt needed a quite sensitive approach. Um, and um, it took a little bit of, it took a few sessions to progress from talking about the physical pain to talking about the emotional pain, and talking about the loss and everything that went along with it." (P2, 616-618)*
Initial Code	1201 Giving patients time (letting them know they don't have to explore things straight away)	*"Yeah, this is a possibility. I think there might be a relationship here (between their emotions and their MUS). And letting people know that we're not necessarily going to have to jump into it and explore it straight away." (P5, 238-239)*
Initial Code	1202 Allowing patients time to get to talk about difficult experiences (e.g. it might be in the 5th or the10th session)	*"Because often they are very difficult experiences and often that will come, you will get there. It might be the 5th of the 10th session but you'll get there and you'll start talking about it." (P5, 239-241)*
Initial Code	1203 Significant things may not be brought to therapy in the early sessions	*"And often there are things that people haven't even brought that are so significant. And they'll just pop up later on, and then it feels like you've really unlocked something. So yeah, I don't think I push people too much but I let them know that I think there is a relationship." (P5, 241-243)*

Initial Code	1204 Recognising that significant things may pop up later in therapy unlocking something important for the patient	*"And often there are things that people haven't even brought that are so significant. And they'll just pop up later on, and then it feels like you've really unlocked something. So yeah, I don't think I push people too much but I let them know that I think there is a relationship." (P5, 241-243)*
Sub Cat L3	**NEED FOR CLINICIANS TO ATTEND TO TIMING AND PACING: Clinicians believe that it's important that they consider the timing of their interventions when working with patients with MUS. Being too early or pre-emptive with a formulation or making a mistimed transference interpretation are both seen as risky and having the potential to alienate patients with MUS. Considering when to intervene (as well as how) is considered an important skill for engagement.**	
Initial Code	0126 Processing material between session not a requirement for continuing and making progress in treatment (although pace will be slower as limited to work during sessions)	*"It's not necessarily a barrier in terms of patients continuing to turn up and continuing to progress in treatment, but it does tell you something about the patient's state of mind, you know, whether they're able to be more, whether they're able to keep the link going in their mind and to sort of, be receptive to that, you know, over the breaks, or whether they have to shut it out till it's time to sort of physically engage again" (P3, 320-324)*
Initial Code	0420 Importance of considering timing when thinking about how to share something difficult with the patient (e.g. not in the first session - wait 'til you've have got to know the patient a little)	*"Well, you know, I wouldn't do that (sharing a very challenging interpretation) in the first session (laughs). You just have to learn a little bit from the patient. You know, how they are." (INT) "Trial and error kind of thing? Just testing the water?" (P). "Yes." (P1, 502-594)*
Initial Code	0485 Risk of an mistimed transference interpretation alienating a patient especially high for MUS or patients with a narcissistic wound	*"Well because sometimes if the patient isn't quite where you think they are, an interpretation can sound like the most egomaniacal thing that you could possibly say, and then you alienate the patient, you know, especially with something like MUS, or with somebody who's got, you know, a narcissistic wound, and suddenly it appears to them that there is another narcissist in the room, you know (laughing)." (P4, 86-90)*
Initial Code	0609 Therapist questioning the timing of a challenging interpretation when patient due to the extent of the patient's projections	*"Why am I irritated with this niceness? Ah, I know, because deep down she's doing something incredibly violent and aggressive, and horrible. But then I have to think, but hang on a minute, do I say that now. Do I not dare to say it because of the extent of her projection. Do I ride roughshod over that and think what the hell, I'm going to say it. And in the end I did." (P4, 385-388)*
Initial Code	0678 Getting to an importance transference insight much much later on in therapy - trying to get the patient to think about this	*"So what we then, much much later on, tried to think about, and she sort of got it, was that her relationship to her GP, her transference to her GP, was like the relationship to her mother. You know, I'm in agony, I'm alone, I've been exiled, I've been sent away, instead of being able to think well actually what your mother did is tried her absolute upmost to bring about a very very painful separation in order to keep you safe." (P4, 559-563)*
Initial Code	0811 Clinician finds therapy with MUS patients a bit of a slower process	*"Start with what they feel more able to talk about right now, which is different from sort of a formal assessment in a way. I might accept less of a history than I would hope to or want to get from a patient usually." (INT) "So a little bit of a slower process?" (P) "Yeah." (P2, 139-142 ® 141-142)*

Initial Code	0833 Rate of engagement variable for different patients (some engage very quickly, others take years, some never fully engage)	*"Some patients engage very quickly. Others, it can take years, you can feel like they're never quite fully. They might still be missing, or clearly not quite trusting the process, a couple of sessions in." (P2, 187-188)*
Initial Code	0907 Being too early or pre-emptive (in sharing a formulation with a patient)	*"Because patients go from one specialist to another and each specialist has a go, and then you're kind of doing the same thing a bit, I think. And it's a bit pre-emptive, a bit early." (P2, 344-345)*
Initial Code	0987 Taking things at the patient's pace when working with patients who are very vulnerable	(INT) *"What do you think was behind the success in engaging this patient?* (Participant) *"Um. He um. I think it was really just taking things at his pace a bit. I think I allowed quite a long period of time of not really knowing much about his early years and not really pushing it, actually."* (P2, 471-472)
Initial Code	1001 Taking time to uncover the patient's unusual beliefs regarding the causes of his symptoms (that a witch had put a spell on him)	*"In fact, actually that reminds me that was his explanation for why he had the symptoms, he thought they were due to a spell. You the GP didn't know that and no one knew his beliefs as to why he had these problematic symptoms. But it took me quite a while." (P2, 494-495)*
Initial Code	1046 Importance to speak frankly and openly to patients but the clinician must gauge how and when to do that to engage patients	*"I think it's very important to speak frankly and openly to patients about things but to gauge, you know, when and how to do that is really important for engaging people." (P2, 592-593)*
Initial Code	1052 Timing of sharing formulation is dependent on the patient	*"I think that the aim of good therapy is to try and speak honestly and frankly to what's going on as soon as you can, and not hold back, but you find a way to say it that's kind of OK for them to hear." (P2, 602-604)*