The Role of Emotion in Psychotherapeutic Change for Medically Unexplained Symptoms

Abstract

Objectives: Evidence of the contribution of emotional processes to the emergence, maintenance and experience of Medically Unexplained Symptoms (MUS) suggests that clinical approaches which target these processes could be beneficial. In this study, qualitative methods were used to examine patients' perspectives and subjective experiences of emotional processes in the context of a psychotherapy assessment and treatment service for MUS provided in a hospital emergency department (ED).

Methods: Seven semi-structured interviews were conducted with ED patients presenting with MUS who received a course of Intensive Short-Term Dynamic Psychotherapy (ISTDP) treatment.

Results: Interpretative Phenomenological Analysis was employed with three super-ordinate themes emerging: barriers to examining emotional processes; reflections on the therapeutic process; psychological change and improved wellbeing. Obstacles to clinical engagement in treatment for MUS were described in relation to patients' and therapists' ability to identify, address and utilize emotion processes. Specific elements of this work were identified as integral components of the psychotherapy change process for MUS.

Conclusions: Directly observing the physical effects of emotional experiencing in MUS provides sensory evidence that can enable patients to make mind-body connections. Psycho-emotional processes warrant further study to explore the

applicability to other conceptual models for assessing and treating MUS.

It is common for individuals to experience distressing bodily symptoms that are not entirely explained, following appropriate, often extensive and time-consuming investigations for possible organic disease. Despite the significant expenditure associated with this (Bermingham, Cohen, Hague, & Parsonage, 2010; Creed, Barsky, & Leiknes, 2011; Lumley et al., 2011) often there is little to no health gain. The term Medically Unexplained Symptoms (MUS) has been widely used to describe this heterogeneous group of health conditions that is becoming a priority area in need of health service innovation. Thus, assessment and interventions for MUS should be closely informed by current research on the mechanisms and processes that contribute to peoples' experience of MUS.

For example, models of emotion suggest that emotions are a source of rich information that can be used to guide and inform adaptive behaviour. The lack of awareness, expression and experiencing of negative emotions is associated with and likely contributes to greater physical pain, symptoms and dysfunction (Lumley et al., 2011). Indeed, people with MUS are more likely to associate somatic sensations with physical illness than negative emotional states (Dendy, Cooper, & Sharpe, 2001) and have negative beliefs about emotional expression (Hambrook et al., 2011), despite the observation that emotional inhibition can predict greater somatic pain in contrast to the beneficial impact of expression (Burns et al., 2008; van Middendorp et al., 2010). Furthermore, there is extensive empirical evidence that emotion is a key change process in psychotherapy for a range of conditions (Greenberg & Paivio, 2003; Greenberg & Pascual-Leone, 2006; Pascual-Leone & Yeryomenko, 2016).

This research suggests that the role of emotional contributors both as a cause

and maintaining factor in the illness trajectory of MUS have important implications for treatment. However, this is not to say that clients receiving disproportionate levels of symptom investigation and treatment deny psychological problems and seek medical interventions (Goldberg & Bridges, 1988; Reid, Ewan, & Lowy, 1991). Research has shown that prior to medical consultations in primary care, clients with MUS self-report that they seek emotional support more than other patients (Salmon, Ring, Dowrick, & Humphris, 2005). Qualitative findings have shown that these clients indicate psychological needs (Dowrick, Ring, Humphris, & Salmon, 2004; Salmon, Dowrick, Ring, & Humphris, 2004) and will provide cues to psychosocial difficulties (Ring, Dowrick, Humphris, Davies, & Salmon, 2005). In fact, these emotional clues are often ignored (Kappen & van Dulmen, 2008; Salmon et al., 2004; Salmon et al., 2005) and medical practitioners, rather than clients, are more likely to request symptom investigation and treatment for MUS (Ring et al., 2005).

Although published advice recommends how to handle MUS assessment to incorporate a biopsychosocial view (Schaefert et al., 2012; Sharpe, 2002), this presents a challenge and there is a risk of iatrogenesis (Kouyanou, Pither, & Wessely, 1997; Page & Wessely, 2003). Qualitative literature describing patients' experience of MUS consultations commonly include feelings of distrust (Peters et al., 2008) and stigmatization (Kouyanou et al., 1997; Marbach, Lennon, Link, & Dohrenwend, 1990). They depict perceived or actual dismissal or scepticism from doctors (Deale & Wessely, 2001), hostile or adversarial meetings (Reid et al., 1991) and denial of physical symptoms (Peters, Stanley, Rose, & Salmon, 1998). Moreover, patterns observed in MUS consultations include clinicians' showing minimal evidence of

empathy (Dowrick et al., 2004; Ring et al., 2005), disconfirming illness attributions and rejecting patients' suffering (Salmon, Peters, & Stanley, 1999). Disagreement over the nature of somatic distress or collusion by passively sanctioning a patient's symptom beliefs (Salmon et al., 1999) can produce a therapeutic stalemate and the iatrogenic harm of continuing physical investigations and treatment (Page & Wessely, 2003). While clinicians recognise the importance of adequately explaining a diagnosis of MUS for patients, within the clinical encounter they often have difficulties.

The therapeutic relationship is often felt to be difficult on both sides in MUS consultations (Hahn, 2001; Hausteiner-Wiehle et al., 2011). Since positive clinician-client interactions may help to avoid somatic intervention (Salmon, Humphris, Ring, Davies, & Dowrick, 2007), less frequent attendance in primary care (Owens, Nelson, & Talley, 1995), clinical improvements in psychological distress (Cape, 2000), and perhaps enable improved engagement in further treatment, greater understanding is needed to understand how clinicians successfully address emotional and psychosocial contributors to MUS within a working alliance. Identifying specific issues that need addressing during this process has the potential to lead to improved outcomes for certain individuals.

Short-Term Psychodynamic Therapies (STPP) are an evidence-based treatment for MUS (Abbass, Kisely, & Kroenke, 2009) specified in competency frameworks for selecting psychological therapy packages suitable for MUS (Roth & Pilling, 2015). These psychological approaches have in common an emphasis on the development of a therapeutic relationship involving a shared collaboration towards

understanding and overcoming symptoms. In addition, contemporary STPP approaches to MUS, including Intensive Short-Term Dynamic Psychotherapy (ISTDP) (Town & Driessen, 2013), attend to specific impairments in emotional awareness around linking emotions to bodily states (Luyten, Van Houdenhove, Lemma, Target, & Fonagy, 2013; Subic-Wrana, Beutel, Knebel, & Lane, 2010). The aims of therapy are to increase insight about a person's subjective, implicit and explicit experiences of relational stress; then to employ more adaptive emotional processing strategies that involve experiencing and integrating complex emotional states that would otherwise go unaddressed, both predisposing and perpetuating individuals' vulnerability to somatic distress (Luyten et al., 2013). According to these theoretical distinctions, working with emotions would be expected to be central to the effectiveness of a psychodynamic treatment for MUS.

Current study and objectives

In the clinical setting of a hospital emergency department (ED), where MUS can account for a large portion of patient visits, existing research has described the effectiveness of a psychological approach for detecting and treating emotional aspects to somatic symptoms (Abbass, Campbell, Magee, & Tarzwell, 2009). In adjunct to medical assessment and investigation, an ISTDP based diagnostic and treatment service for ED patients with MUS demonstrated cost savings and service use reduction (Abbass, Campbell, et al., 2009).

Thus, while there is evidence that emotional processes are a major factor in the experience of MUS (Lumley et al., 2011) and effectiveness research supporting an emotion based psychotherapy approach to treat these problems, patients'

perspectives and subjective experiences of these processes in the context of clinical delivery is lacking.

This study aimed to examine ED patients' subjective experience of engaging and participating in an ISTDP based approach to explore assumptions about the role of emotion in MUS.

Method

Participants & Setting

This study was conducted in an ED hospital-based clinic in eastern Canada. Patients were assessed by an emergency physician and subsequently referred to a specialised MUS clinic after serious medical illness had been provisionally ruled out. Patients were offered a 'Stress Factors' consultation that is based on an ISTDP psychodiagnostic interview (Abbass, Campbell, et al., 2009). The objective is to assess the possible role of emotional factors contributing to physical symptom distress (see Psychotherapy Treatment). Following this initial assessment, patients are offered further psychotherapy meetings to further assess or treat the presenting and related target problems.

Seven participants were recruited, comprising four men and three women, with a mean age of 35 years, range 22-58. Based on a clinical interview with a psychologist, five participants met DSM-5 criteria for Somatic Symptom Disorder, and Functional Neurological Symptom Disorder was present in two participants; five participants had a comorbid Axis I disorder. Self-report symptom questionnaires completed pre-treatment showed that the sample reported multiple symptoms on the Screening for Somatoform Symptoms (SOMS, (Rief & Hiller, 2003) (symptom

count mean = 16.71; SD = 12.57) with marked symptoms impairment (SOMS-SI

symptom severity index mean score = 31.86; SD = 23.54); moderate symptoms on

the Generalized Anxiety Disorder scale (Spitzer, Kroenke, Williams, & Löwe, 2006)

(GAD-7 mean = 10.0; SD = 5.66); mild symptoms on the Patient Heath Questionnaire

depressive scale (PHQ-9, (Kroenke & Spitzer, 2002) (mean = 8.0; SD = 4.76). At the

end of treatment, the sample reported a reduction in symptoms distress across

domains (post treatment scores: SOMS-SI mean = 7.93, SD = 7.70; GAD-7 mean =

4.33, SD = 5.50; PHQ-9 mean = 4.17, SD = 5.56).

At the time of interview, two participants were still receiving treatment and

five had completed therapy between 1 and 18 months prior to interview. This range

allowed for a reasonable sample size and exploration of long-term outcomes, whilst

attempting to minimise prolonged retrospective recall. To ensure that detailed

information on participants' experiences was collected, qualitative interviews were

up to two hours in duration and averaged 90 minutes. We adopted a case study

approach by analysing one case at a time and then exploring themes across cases.

This method is well suited to small numbers and allows for detailed understanding

of the phenomenon (Smith, Jarman, & Osborn, 1999). It was agreed to end

recruitment with seven participants when saturation was reached following review

of the hierarchy by the analysts. This was determined when analysis of the final

interviews elicited no new thematic material resulting in additional themes.

The study was approved by the Nova Scotia Health Authority research ethics

board and written informed consent was received from all participants.

Psychotherapy Treatment

ISTDP began with an extended psychodiagnostic interview that focused with the patient on life situations in which strong emotional activation occurred and examined the physical effects of that activation. Any somatic effects of emotional dysregulation could be directly examined and reviewed collaboratively. These emotions, including the presence of unconscious components of anxiety affecting the striated muscle, smooth muscle, motor tone or cognitive perceptual functioning were identified to promote emotional awareness and specific techniques utilised to build anxiety tolerance. Typically, ongoing treatment sessions were weekly, lasting 50 minutes. The treatment was not time-limited, rather continuing/discontinuing therapy was decided by both the patient and therapist.

Participants in this study received an average of 11.57 sessions (SD = 6.63; range 6 - 25). Treatment was delivered by a clinical psychologist with six years post qualification experience and practitioner training in ISTDP. All treatments were video-recorded; the therapist received weekly expert supervision to promote adherence to the model.

Interview Procedure

Participants were contacted by letter, which included a study information sheet, and those who expressed an interest were subsequently contacted for enrolment by a researcher and a meeting with the researcher arranged. Interviews were audio-recorded then transcribed verbatim. Pseudonyms or numbers were used to protect participants' confidentiality; any other identifiable information was altered or removed.

Interview Schedule

An initial interview schedule was developed by adapting the Brief Structured Recall (Elliott & Shapiro, 1988) and Client Change Interview (Elliott, Slatick, & Urman, 2001) to include questions more focused on the role of affect and relationships in change processes. The interview schedule was organised into six parts: It began with a general invitation to describe the nature of the presenting MUS and the context for the referral from the ED for treatment. Second, open-ended questions broadly focused on developing a picture of individuals' experience in therapy. Where necessary, follow-up questions aimed to expand upon the perceived 'impact' and participants' 'understanding' of both helpful and unhelpful experiences in therapy. The third part of the schedule inquired if and how sessions attended to close relationships in the person's life. If not already discussed, the fourth part offered prompts for exploring the content of sessions' focus on emotional factors and the perceived role of emotions in relation to the presenting MUS and observed changes during and/or post therapy. The fifth and sixth parts aimed to use the participant's language and examples provided about the impact of therapy on MUS, to elicit the nature of observed changes and to examine participants' understanding of how these came about. The interviews were semi-structured to allow for open exploration of experiences. The interviewer used her clinical interviewing skills alongside her knowledge of MUS and ISTDP to further explore participants' experiences in relation to the subject area.

Data Analysis

Researchers

In total, there were four members of the research team, three of which contributed

to the auditing of transcripts and analyses. The first author was a doctoral level clinical psychologist and psychotherapy researcher who had six years of experience in the theory and practice of ISTDP. He attempted to approach the data as openly as possible although his knowledge and experience meant he was not naïve to ISTDP theory during the investigation of data. The second author was a third year doctoral candidate in clinical psychology who conducted the qualitative interview and served as the primary analyst for this study. As both a facilitator and user of health services, they considered the service-user perspective as important in research and theory development. This contributed to their desire to provide a thorough account of participants' experiences and stay true to these in analysis. The fourth author was a professor in clinical psychology and an experienced psychotherapy researcher who recognised the importance of common factors in psychotherapy.

Transcript coding

Due to the study's exploratory nature and aim to gain subjective accounts of participants' experiences in psychotherapy, Interpretative Phenomenological Analysis (IPA) was used (Larkin & Thompson, 2012; Smith, Flowers, & Larkin, 2009). We were interested in the participants' individual perspective on their therapy, and IPA is particularly suited to studying 'the person in context' and therefore fitted well with the aims of the study. IPA also utilises the analyst's knowledge and perspective to interpret the meaning of, and provide a narrative for, participants' lived experiences. IPA is based primarily on a critical realist understanding of the world.

Analysis was conducted following published recommendations for IPA (Smith

et al., 2009). It began with the second author reading the first interview transcript a number of times to first generate preliminary ideas and observations, then the transcript was analysed line-by-line, making detailed notes to extract patterns in the data while being receptive to new emerging ideas (Smith et al., 2009). In-depth notes were taken that informed the identification of emerging themes then connections or links across themes were sought and ordered to provide a structure which could be observed throughout transcripts. The emerging themes were clustered hierarchically into a table according to provisional superordinate and subordinate themes along with key quotations. This process was repeated iteratively for each participant. The themes found in the initial transcripts were looked for, while also considering new emerging ideas. When new themes became apparent, preceding transcripts were re-examined to explore the presence or absence of these ideas. This was achieved by checking the reliability of themes identified using transcript segments. Thoughtful discussion between the research team led to agreement on the superordinate and subordinate themes which were agreed upon through consensus discussion.

Quality Control

Two researchers (authors two and four) participated in the process of auditing the analyses to ensure a thorough exploration of themes, and that these were coherent and being explored reflexively (Smith et al., 2009). These analysts recorded their expectations before working with the transcripts. These expectations were considered at each stage of the analysis to understand how such expectations may be biasing the analysis. The fourth author, independently reviewed three

randomly selected transcripts and commented on the themes developed by the primary analyst. Discrepancies were discussed and agreed upon by consensus. They participated in further quality control by reviewing a reflexive journal kept by the primary analyst to allow additional discussion of the rationale for the findings. The first author, who was the therapist in the study and brought expertise in ISTDP, participated to contribute to the validity of the analysis by reviewing themes and offering a clinical context to the transcript material. To address his prior knowledge, this researcher did not access the interview transcripts until a preliminary version of the superordinate and subordinate themes had been generated by the rest of the team. His later comments on the findings were considered in this context and were helpful in enabling all analysts to further think about their own expectations and influences.

Results

A total of three superordinate themes emerged from the data: (a) Barriers to examining emotion processes; (b) Therapeutic process leading to change; (c) Psychological change and improved wellbeing. Under these superordinate themes, a further 16 sub-themes were identified. Table 1 provides sample quotes from participants to illuminate these themes.

For the purposes of this section, when every participant described experiences relating to a particular theme, they are referred to in the text as 'all participants…' For themes where between four and six participants described similar experiences, they are referred to as 'most' or 'many', and when one to three describe similar experiences, participants are referred to as 'some'.

1. *Barriers to Examining Emotion Processes*

In the initial ISTDP psychodiagnostic appointment and subsequent sessions, the therapist would typically inquire about emotionally charged life situations to examine emotional reactions and bodily effects of emotional activation. This theme, includes six sub-themes, described the challenges that participants experienced when they began to explore psychosocial stressors and the possible role of emotional factors in contributing to the development, exacerbation or maintenance of their presenting MUS.

The theme (1.A) "Global Emotional Avoidance" represented participants' shared narratives describing engrained, habitual patterns towards avoiding or suppressing emotions in multiple aspects of their lives. Some patterns were articulated as long-standing personality styles geared towards emotional avoidance, whilst others emphasised the impact of external reinforcement promoting avoidance, for instance, linking suppressive patterns to cultural norms. Participant 4 described how this habitual process began: "I always showed my emotions when I was younger but people around me didn't and looked at is as weakness. I learned to shut them away because I didn't really have anybody to talk to and that's where I learned to push my emotions down." All participants came to recognise that emotional suppression impacted upon both themselves and their interpersonal interactions and that this avoidance presented challenges to developing an emotionally attuned approach to managing their MUS.

The theme (1B) "Anxiety about the Impact of Emotion" was reflected in all

seven participants experience of engaging in this emotion orientated treatment.

They described anxious thoughts about how they would be perceived by others

should they choose to experience or express emotions, particularly anger. Different

reasons were provided, such as fear of losing control, going mad, or hurting others.

For example, Participant 1 described his conflict when he recognised his feelings, "I

was mad but how mad was I and how can I express that? It's like I'm saying I'm a

raving lunatic...I want to portray myself as somebody that's reasonable."

The theme (1C) "Strategies for Emotional Avoidance" highlights the various

strategies all participants referred to using for preventing moment-to-moment

experiencing or expression of emotions, often in the therapy sessions when the

therapist invited emotions (e.g., Participant 2: "I would take the high road on it and

get intellectual around the anger when I'd really want to say something totally

different"). Having habitually avoided or suppressed emotions, the theme (1.D)

"Difficulty Identifying Emotions" represented a problem many participants

acknowledged during sessions and in life generally (e.g., Participant 6: "To say a

certain event triggered a certain type of emotion was difficult because it was hard to be in

touch with the spheres of my mind that I didn't really grasp"). Many participants

described being surprised to realise that they did not have the language around

emotions to articulate their experiences. Some described attempts to explore the

onset of bodily symptoms in relation to an emotion-based stress reaction as

overwhelming or cognitively demanding because of how unaccustomed they were to

attending to their emotions.

The theme (1.E) "Mixed Reactions to Emotional Engagement" characterised

how many participants entered therapy with perceptions of bodily and psychological states as separate. Some began with high levels of motivation and desire to explore a possible connection while others described frustration or anxiety about seeing another professional. These conflicting motivations manifest in a transitional process of participants feeling simultaneously motivated and uncertain around engaging in a non-medicalised approach to MUS. Many described that their subsequent increased motivation to continue therapy resulted from directly observing improvements in physical symptoms (e.g., Participant 5: "[Previously] I just didn't understand. I didn't see the point. But [in this therapy] I could see an immediate change within the first couple of sessions". This led some to describe therapy as ultimately 'a good battle', though it was suggested that people entering therapy may need to be open to change in order to experience more immediate benefit. Similarly, the theme (1.F) "Unexpected Differences to Previous Psychological Therapies" describes how many participants were surprised by the approach used, particularly the intensity of their experience when focusing on emotions. Their expectations appeared to be based upon past psychological interventions which focused on therapists providing reassurance and developing coping strategies (e.g., Participant 6: "It got me out of my comfort zone instead of the normal therapy that I was used to…like visualizing leaves going down a stream. It was more directly dealing with the root problems, the root emotional problems"). Most described these differences as challenging, but positive because they associated the intensity of therapy having led to quicker improvements in bodily symptomatology. Some commented that previous interventions had not addressed their underlying

emotional trauma.

2. Reflections on the Therapeutic Process for MUS

This superordinate category summarises specific in-session processes that participants identified as central to their experience of overcoming MUS. Key tenets to an ISTDP formulation of MUS include the inadvertent blockage of emotional processing and associated anxiety being channelled into the body, manifesting as somatic distress. Six minor themes are presented within this category which describe participants' perspectives on their change process. The first theme (2.A), "Challenge to Habitual Avoidance", reflects participants' perception of the helpfulness of being persistently challenged in therapy on their tendency to avoid and suppress emotions, thus allowing them to see a mind-body connection (e.g., Participant 3: "He was the first person that's actually spotted what I was doing: 'Why are you doing it to yourself? Why are you damaging yourself like that?' Having him say it made me realize what I'd always been somewhat aware of"). Many participants acknowledged that changes occurred in their somatic symptoms from facing previously avoided and emotionally painful issues. They stressed the importance of the therapist's role in highlighting these barriers. Although some used language, such as feeling pressured, challenged or overwhelmed, the function of this "challenge" was understood and appreciated. Furthermore, some described it as both necessary and connected to the development and maintenance of new adaptive emotionally orientated behaviours. Part of the helpfulness of having the assumed mechanisms underlying participants' bodily distress symptoms challenged in therapy was reflected in participants' descriptions of subsequently gaining

"Insight into Strategies for Avoidance" (Theme 2.B). Most participants provided examples of the benefits of having their repertoire of avoidant tendencies brought to their attention during therapy (e.g., Participant 7: "I was always angry about the way things went as I grew up but I was always kind of angry at myself more than anybody else. That was misplaced anger"). This promoted new or increased awareness around a connection between emotional factors and their presenting somatic difficulties. This insight commonly brought internal motivation to change.

The theme (2.C) "Increased Emotional Awareness" underlines participants' descriptions of developing an awareness of greater depth to their emotions during therapy, which became distinguishable from the emergence of subsequent bodily anxiety and symptoms. Many participants commented that this awareness provided the opportunity to respond differently to emotions (e.g., Participant 4: "Noticing the anger has done a lot to reduce the anger. I'm aware of it which is probably the biggest part of all, rather than just shoving it somewhere"). A fundamental principle that enabled this type of flexibility to utilize alternative means of coping, that all participants had conceived through the psychotherapy process, was the "Necessity of Direct Emotional Experiencing" (Theme 2.D). Most participants provided specific examples explaining how they found that the process of emotional experiencing overrode bodily symptom formation (e.g., Participant 5: "I would start to get right tensed up and I'd start to shake and he was like 'just let it go… feel the emotion, feel it' and that's what I wasn't doing"). All participants described that emotional experiencing facilitated further therapeutic work through the emergence of otherwise avoided and in some case previously inaccessible material.

The theme (2.E) "Processing Feelings about Intimate Relationships" captured all participants descriptions of their treatments courses having involved experiencing varying degrees of emotional pain associated with disruption to an intimate relationship (e.g., Participant 3: "Realising that I need to deal with issues that I had as a child and bring them to the forefront, address them and experience the emotions associated with them...I see the value now that kind of goes with actually discussing those relationships"). Participants described having developed a narrative within therapy that brought meaning to these experiences and the often wide ranging difficulties they had experienced since. Many spoke about previously struggling to accept and therefore talk about mixed emotions, such as both love and anger, within relationships. One in-session technique many participants described finding helpful was the guided portrayal of visceral emotions in fantasy. For participants who discussed this process at interview, this process was likened to an "ah ha" moment in therapy that was associated to subsequent somatic symptom improvements and changes in relationships.

All participants depicted these specific in-session processes in context to their relationship with their therapist. The theme (2.F) "Therapeutic Relationship" emphasizes the importance of the interactional patterns and nature of the therapeutic relationship. Some used adjectives describing their therapist in a "coach" or "guide" like role. For all participants, the challenging context of sessions was embedded within a caring and supportive working dyad (e.g., Participant 6: "I felt that it was confrontational, though I understood why he was doing it and then it was just more like, okay, this guy's helping me". Important aspects of the therapist's

role included providing a sense of containment, the giving of insight, and establishing shared goals for treatment. The therapeutic relationship became the venue for addressing any ambivalence to emotional experiencing. Many participants expressed that this helped increase their desire to make positive changes, work with their therapist, not rely on avoidance, and ultimately face emotions.

3. Psychological Change and Improved Wellbeing

The third category describes the nature of the psychological changes participants observed in themselves and that which they associated to improvements in MUS and other related difficulties.

The theme (3.A) "Linking of Emotional and Physical States" describes a key area of change reported by most participants related to increased recognition of how the mind and body are linked, often despite initial misgivings (e.g., Participant 3: "The way my body felt when I first had an [emotional] breakthrough…it brought home that connection for me, whereas I kind of only thought they could be related before").. Most participants described how the awareness of the mind-body link became the platform for becoming better able to recognise and manage emotion, through awareness of physical manifestations of anxiety. Most participants also tied this change to greater self-management and reduced use of medical services and interventions.

With increased awareness of their emotions and avoidance strategies, participants articulated how they had changed their responses to emotions, using increasingly fewer distractions when faced with strong emotions (e.g., Participant 2: "Before I would have just swallowed it, grumbled about it in my head and carried it.

Now I try to speak for myself"). These observations are highlighted in the theme (3.B), "Reduced Use of Avoidant Strategies". Participants outlined behavioural changes, including reduced reliance on Emergency Department visits in line with these improvements. Changes experienced in interpersonal interactions included feeling increased confidence and assertiveness or openness with others about their feelings.

The theme (3.C)"Acceptance of Emotions" captures how all participants spoke about emotions as the inevitable product of life experiences, highlighting the impact that emotional contributors have played in their physical health and general well-being. Most described how embracing emotional experiencing led to positive changes in interactions or discussions of emotions with others. Participants described having reflections after therapy sessions or post treatment, outlining how their experiences in therapy had led to increased acceptance of the past and also hope for the future (e.g., Participant 7: "By accepting how things were, doesn't mean that you have to accept all the things have to be. You can make decisions to change things").

This final theme (3.D), "Perceptions of Change and the Impact of Emotional Experiencing", summarizes the consistent observation of all participants that emotional stressors in life now caused significantly less social and occupational disruption (e.g., Participant 1: "There's been more situations [since] that before I think would have forced me to the emergency [department] in some regard, but I haven't had that happen"). Most described being able to manage a broader range of emotions following therapy both in current relationships and in relation to previous

attachment traumas. Participants spoke about improvements in their bodily symptoms and improved emotion processing interchangeably. For some, the impact of these changes included returning to previous activities, and being able to gain greater enjoyment in life.

Discussion

In this study, seven patients attending the ED with MUS who received a psychological treatment (ISTDP) were interviewed about their experiences and specifically their perceptions of the impact of emotional processes. This group are typically underserved by health service provision: the value of studying this group for this purpose is the opportunity to explore the experiences of individuals who received a novel psychotherapeutic approach. The study results demonstrate a consistency of accounts and theoretical convergence with wider literature (Lumley et al., 2011) which lend support that emotions can be integral to conceptualization, assessment and treatment for MUS. Without reflecting a definitive statement, we present the current findings as a series of distinct observations that may be conceptualised within a heuristic model of change for MUS that should be tested and elaborated. In particular, these results have practical implications for informing how to handle the initial engagement process when screening for psychological factors in MUS.

The qualitative findings from this study suggest that patients with MUS do not find examining connections between their somatic symptoms and emotional factors an intuitive process that comes naturally. There were several reasons highlighted for this finding indicating that a combination of common implicit and

explicit barriers to developing a shared psycho-emotional formulation for MUS can manifest in the doctor-patient relationship. Participants identified having previously been less aware that talking about emotions caused them anxiety. They described inadvertent but engrained and habitual tendencies to suppress or generally avoid emotions alongside employing a repertoire of strategies for emotional avoidance. However, these observations are not to be conflated with a reluctance to admit psychological or emotional problems and seek solely physical explanations (Goldberg & Bridges, 1988). We offer an alternative view: when MUS patients are less explicit about their needs, help seeking behaviour can include a mixture of anxiety driven implicit responses that can create a vicious cycle of indirectly communicating their distress while simultaneously withdrawing. This is consistent with evidence that clinicians in primary care must often rely on detecting subtle cues of emotional need in MUS (Ring et al., 2005) and that requests in consultations can be contradictory because they do not always reflect the patients desired outcome (Salmon, Ring, Humphris, Davies, & Dowrick, 2009). This knowledge could contribute to health providers understanding of some help seeking behaviour seen with MUS, thereby enabling providers to relate better to patients' emerging psychosocial distress. Implications for engagement include that as patients with MUS begin to understand the negative impact of emotional suppression, they become increasingly motivated and confident to overcome these habits in the context of a therapeutic relationship. We found that these steps appear to precede improvements in symptoms, relationships and functioning.

It is common that patients with MUS perceive medical doctors' explanations

of their physical symptoms as at odds with their own (Nordin et al., 2006; Salmon et al., 1999). The current findings showed that patients' illness beliefs became more aligned with a psycho-emotional understanding of MUS as they noticed physical improvements in their symptoms. Our categorisation of patients' experiences indicated that clients commonly attributed improvements in physical symptoms to specific aspects of the emotion-focused treatment protocol. Patients indicated that directly observing the physical effects of emotional experiencing on somatic symptoms was a central process to enabling them to make mind-body connections: it offered a sensory experience that was in line with a psychological explanation, thus providing 'infallible sensory evidence' (Peters et al., 1998). The use of this specific method of focused interviewing to examine physical effects of emotions may therefore be particularly relevant for people who either do not report current stress or deny its valence during initial MUS consultations, as documented with the dismissive attachment style (Waller, Scheidt, & Hartmann, 2004). It may help to avoid conflict over authority in which the opinions of medical professionals are considered limited because of a reliance on indirect information provided by medical investigation (Peters et al., 1998). The potential application of this for MUS consultations include an engagement process that is less reliant on the health professional providing a theory driven formulation to the client on the origin of their physical symptoms, which risks them feeling stigmatized or blamed for their symptoms (Kouyanou et al., 1997).

Alternatively, theories of non-specific factors influencing the general effectiveness of psychological approaches might de-emphasize the role of emotion in

change for this MUS sample and instead highlight the active therapeutic ingredients inherent in forming a strong working alliance and patients having received a plausible theory explaining their symptoms. For instance, research exploring features of effective consultations for MUS clients indicate: the importance of a therapeutic alliance (Cape, 2000; Salmon, Wissow, et al., 2007); and suggest that explanations for MUS that are assimilated by a patient are more likely to empower a self-management approach by providing a tangible causal mechanism that invoked an internal adjustment (Salmon et al., 1999). Given the centrality of emotion processing in ISTDP theory, it is therefore plausible that the current findings are driven by sampling a homogenous group who found this this therapy model both acceptable and effective. Although MUS can be complex involving multiple factors, the consistent finding in this study was that patients associated emotion processes to the 'internal adjustments' made during therapy. It remains to be seen whether emotion processing is an underlying dimension that can be integrated effectively into other approaches to MUS other than ISTDP. This is a topic that warrants future research.

Difficulty identifying feelings was a common problem for this MUS sample. This insight was often experienced as a surprise to participants, thus, may partially reflect a deficit in emotional awareness but it was also described as a socially learned normative behaviour for some. These findings overlap with the construct of alexithymia and a model that identifies the active process of being able to identify and accurately label feelings as adaptive. Recent evidence suggests that high levels of alexithymia in patients with MUS may be more specific to a subsample of people

who have experienced early adversity (Pedrosa Gil, Scheidt, Hoeger, & Nickel, 2008; Waller & Scheidt, 2006) rather than a generalised deficit. Alternatively, some studies suggest that MUS is specifically related to deficits in the dimension of alexithymia related to difficulty identifying feelings (De Gucht, Fischler, & Heiser, 2004; Faramarzi et al., 2013). In this study, clients' difficulties identifying and differentiating feelings typically occurred in the context of a current life stressor. Psychological changes included examples of clients becoming better able to recognise primary feelings tied to relationship stressors which had become distinguishable from secondary, somatic responses such as feeling physically unwell or 'stressed'. Thus, these alexithymic features may be a temporary state impairment that can better understood according to the psychological context in which they occur, rather than a trait as had been proposed (Sifneos, 1973).

This study is particularly concerned with exploring assumptions about the processes of psychotherapeutic change in MUS, thus an idiographic and qualitative approach was favoured. When reflecting upon these aims, we would argue that by adopting this approach for capturing participants' subjective experiences of therapy, we have sought to deemphasize investigators preconceptions. That being said, in IPA the analysts have a clear and necessary role that involves interpretive engagement with the data (Smith, 1995). We would therefore acknowledge that prior knowledge around the psychotherapy treatment could have primed the researchers to the possibility of emotional processes being present within participants' accounts. However, the analysts were open to alternative or supplementary findings and there was a process for quality control which included independent audit of emerging

themes.

When reviewing the study findings, it is worth noting that although IPA is described as an idiographic mode of inquiry (Smith et al., 2009), we focused on similarity and consistent ways in which participants experienced the therapeutic process, rather than upon individual variability within participants' accounts. We found that the results thus lead to broad conclusions about the group rather than specific statements about individuals. Each theme identified therefore represents a distinct representation of how participants' experience can be understood. We believe this method is helpful for making sense of the role of emotional processes in psychotherapeutic change for MUS.

There are a number of factors about the design of this study that should be taken into consideration when drawing conclusions: First, while qualitative studies are important for understanding the unique perspective of the patient, they do not clarify causality between emotional processes and MUS. Second, the purposive sampling approach used (Smith et al., 2009) offered the benefit of exploring an in-depth account of a group of MUS patients with good treatment outcomes who were willing and able to consider their experience of an emotion focused short-term psychotherapy. However, it was not possible to assess other factors: such as those attributable to the individual therapist; variations between psychotherapy models; how these findings are generalisable to therapies with less successful outcomes; or the extent to which the recall period between end of treatment and the qualitative interview impacted participants' perspectives. Third, although the interview schedule did not lead with discussion about emotions and participants were blind to

the specific goals of the study, the emphasis on emotions may have contributed to the prominence participants placed on emotional processing.

Conclusion

The accounts of ED patients with MUS elicited findings especially relevant to the role of three psychological processes for the experience of MUS (Lumley et al., 2011): emotional awareness, expression and experiencing. Patients described patterns in each of these areas that had become obstacles to examining and incorporating a psycho-emotional view of MUS. Psychological changes and improvements in physical symptoms were attributed to a therapeutic process whereby these challenges were addressed and overcome. Consistent with previous findings (Pos, Greenberg, Goldman, & Korman, 2003), it appears that changes in emotional capacity are gradual and a carefully fostered ability, rather than a learnt coping strategy or skill.

Table 1: Participant sample quotes by category and theme

Theme	Example Quote
Category 1: Barriers to examining emotion processes	
(a) Anxiety about the impact of emotion	I haven't even mentioned something like that to my girlfriend, the person I'm closest with, because I'm scared I might frighten her just hearing something like that, you know, you have that much anger and rage inside of you. (Participant 3)
(b) Global emotional avoidance	I don't think I ever did it consciously. It was more just conditioning over the years. Like when I was younger…being afraid of doing something other than what I was told to do. I guess I hid anger and feared all those things. (Participant 6)
(c) Strategies for emotional avoidance	I would try and censor myself and limit what I say…. it was the emotions crippling me up. It was me trying to hold them back. (Participant 6)
(d) Difficulty identifying feelings	If you had a colour for each emotion, it was like a state of using only a few colours, but as you become more and more aware then you can use the shades in between the colours and if I was a painter, the colours might become a little bit more complex. (Participant 7)
(e) Mixed reaction to emotional engagement	I've already been in emergency a number of times and it's like 'oh gee do I got to go see somebody else…I was like 'I can't handle it but I need to go back and go further with it'… It was almost like you're on a teeter totter and you're 'yes', 'no', 'yes', 'no'. (Participant 1)
(f) Unexpected differences to previous psychological therapies	Like the other therapists I went to were really bubbly, warm, friendly, outgoing. When I came here it wasn't a social call. It was like let's get down to business, let's figure out what is going on with you because that's why we're here isn't it, and he almost made me feel like I had all the answers, I just had to keep peeling back the layers. (Participant 2).
Category 2: Reflections on the therapeutic process	
(a) Challenge to habitual avoidance	He made me stick with it like he didn't just let me skirt around it. He kept pushing me so that's what helped me make the connection otherwise I think I would have left with the same old thing. (Participant 2)
(b) Insight into strategies for avoidance	I need to experience my emotions; I need to stop following people; I need to stop letting people say what to do for me. It's easy to take a passive approach for that but once someone says it directly to you, recognizing that that's what you do and that if you want to feel better you have to correct it. (Participant 3)
(c) Increased emotional awareness	Being able to pick out what's bothering me opposed to the problem that's in front of me. Helping me decipher which emotion's which. I refer back to what he says all the time in my head. I'm like 'how am I feeling? Stressed. Okay, what else are you feeling besides anxiety?' (Participant 5)
(d) Direct emotional experiencing as necessary	I was able to cry, really cry, really a heartfelt hurt. I haven't experienced that in a long time, a long, long time. I might have cried about something but not a deep, deep, deep hurt. All this stuff was buried right down inside me and I shut it down and put a wall around me and kept it to myself and now it's opened up and I can experience it again and not be afraid to experience it or hide how I feel. (Participant 1)
(e) Processing feelings about intimate relationships	My relationship with my family, my mother and my sister, has gotten better because they would talk to me and I just didn't want to hear anything they'd have to say because I was so angry. (Participant 4)
(f) The therapeutic relationship	Even when my back was up against the wall I knew that his intentions were to help me improve my anxiety and I needed to focus on what he is saying and try to really experience emotions. (Participant 3)
Category 3: Psychological change and improved well-being	
(a) Linking of emotional and physical states	It sounds really stupid but I really didn't believe that was it…the sessions helped me to realise all this stuff that happened in the past and the next thing I knew it was like okay, this is having a physical effect on you. I just hadn't turned that switch. (Participant 2)
(b) Reduced use of avoidant strategies	I'm a lot more open, instead of always trying to avoid these emotions and situations where I feel emotions. I like knowing that I can be more in touch with it and not be detached but to look at things instead of being scared and just pulling away. I guess I feel stronger and more tooled to deal with it. (Participant 7)
(c) Changes to the acceptance of emotions	I don't think there's a patient you can't help if you look at the emotional side. Our emotions are very complex and if you look at what causes the emotions, like with myself if you look at the background and what happened to lead to this, you can see the bigger picture and help with the emotional side. (Participant 1)
(d) Perceptions of change & the impact of emotional experiencing	I had to learn where the sadness and anger were coming from. It's almost like discovering a new part of me that was always there but that I was never aware of. The more I spent time thinking about it and examining it, the more I'm becoming in control over it. (Participant 4)

References

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*(6), 529-534.

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

Bermingham, S. L., Cohen, A., Hague, J., & Parsonage, M. (2010). The cost of somatisation among the working-age population in England for the year 2008-2009. *Ment Health Fam Med, 7*(2), 71-84.

Burns, J. W., Quartana, P., Gilliam, W., Gray, E., Matsuura, J., Nappi, C., . . . Lofland, K. (2008). Effects of anger suppression on pain severity and pain behaviors among chronic pain patients: evaluation of an ironic process model. *Health Psychol, 27*(5), 645-652. doi:10.1037/a0013044

Cape, J. (2000). Patient‐rated therapeutic relationship and outcome in general practitioner treatment of psychological problems. *British Journal of Clinical Psychology, 39*(4), 383-395.

Creed, F., Barsky, 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. 1-42). New York: Cambridge Univeristy Press.

De Gucht, V., Fischler, B., & Heiser, W. (2004). Neuroticism, alexithymia, negative affect, and positive affect as determinants of medically unexplained symptoms. *Personality and Individual Differences, 36*(7), 1655-1667.

Deale, A., & Wessely, S. (2001). Patients' perceptions of medical care in chronic fatigue syndrome. *Social science & medicine, 52*(12), 1859-1864.

Dendy, C., Cooper, M., & Sharpe, M. (2001). Interpretation of symptoms in chronic fatigue syndrome. *Behav Res Ther, 39*(11), 1369-1380.

Dowrick, C. F., Ring, A., Humphris, G. M., & Salmon, P. (2004). Normalisation of unexplained symptoms by general practitioners: a functional typology. *Br J Gen Pract, 54*(500), 165-170.

Elliott, R., & Shapiro, D. A. (1988). Brief structured recall: A more efficient method for studying significant therapy events. *British Journal of Medical Psychology, 61*(2), 141-153.

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. *Psychological Test and Assessment Modeling, 43*(3), 69.

Faramarzi, M., Azadfallah, P., Book, H. E., Tabatabaei, K. R., Taheri, H., & Shokri-shirvani, J. (2013). A randomized controlled trial of brief psychoanalytic psychotherapy in patients with functional dyspepsia. *Asian J Psychiatr, 6*(3), 228-234. doi:10.1016/j.ajp.2012.12.012

Goldberg, D., & Bridges, K. (1988). Somatic presentations of psychiatric illness in primary care setting. *Journal of psychosomatic research, 32*(2), 137-144.

Greenberg, L. S., & Paivio, S. C. (2003). *Working with emotions in psychotherapy* (Vol.

13): Guilford Press.

Greenberg, L. S., & Pascual‐Leone, A. (2006). Emotion in psychotherapy: A practice‐friendly research review. *Journal of clinical psychology, 62*(5), 611-630.

Hahn, S. R. (2001). Physical Symptoms and Physician-Experienced Difficulty in the Physicianâ€"Patient Relationship. *Annals of Internal Medicine, 134*(9_Part_2), 897-904.

Hambrook, D., Oldershaw, A., Rimes, K., Schmidt, U., Tchanturia, K., Treasure, J., . . . Chalder, T. (2011). Emotional expression, self-silencing, and distress tolerance in anorexia nervosa and chronic fatigue syndrome. *Br J Clin Psychol, 50*(3), 310-325. doi:10.1348/014466510X519215

Hausteiner-Wiehle, C., Grosber, M., Bubel, E., Groben, S., Bornschein, S., Lahmann, C., . . . Löwe, B. (2011). Patient–Doctor Interaction, Psychobehavioural Characteristics and Mental Disorders in Patients with Suspected Allergies: Do They Predict. *Acta dermato-venereologica, 91*(6), 666-673.

Kappen, T., & van Dulmen, S. (2008). General practitioners' responses to the initial presentation of medically unexplained symptoms: a quantitative analysis. *BioPsychoSocial medicine, 2*(1), 1.

Kouyanou, K., Pither, C. E., & Wessely, S. (1997). Iatrogenic factors and chronic pain. *Psychosomatic Medicine, 59*(6), 597-604.

Kroenke, K., & Spitzer, R. L. (2002). The PHQ-9: A new depression diagnostic and severity measure *Psychiatric Annals, 32*(9), 509-521.

Larkin, M., & Thompson, A. R. (2012). Interpretative phenomenological analysis in mental health and psychotherapy research. *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*, 99-116.

Lumley, M. A., Cohen, J. L., Borszcz, G. S., Cano, A., Radcliffe, A. M., Porter, L. S., . . . Keefe, F. J. (2011). Pain and emotion: a biopsychosocial review of recent research. *J Clin Psychol, 67*(9), 942-968. doi:10.1002/jclp.20816

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.

Marbach, J. J., Lennon, M. C., Link, B. G., & Dohrenwend, B. P. (1990). Losing face: sources of stigma as perceived by chronic facial pain patients. *Journal of behavioral medicine, 13*(6), 583-604.

Nordin, T. A., Hartz, A. J., Anderson, M. C., Rosenbaum, M. E., James, P. A., Ely, J. W., . . . Levy, B. T. (2006). Empirically identified goals for the management of unexplained symptoms. *FAMILY MEDICINE-KANSAS CITY-, 38*(7), 476.

Owens, D. M., Nelson, D. K., & Talley, N. J. (1995). The irritable bowel syndrome: long-term prognosis and the physician-patient interaction. *Annals of Internal Medicine, 122*(2), 107-112.

Page, L. A., & Wessely, S. (2003). Medically unexplained symptoms: exacerbating factors in the doctor–patient encounter. *Journal of the Royal Society of Medicine, 96*(5), 223-227.

Pascual-Leone, A., & Yeryomenko, N. (2016). The client "experiencing" scale as a predictor of treatment outcomes: A meta-analysis on psychotherapy process. *Psychotherapy Research*, 1-13.

Pedrosa Gil, F., Scheidt, C. E., Hoeger, D., & Nickel, M. (2008). Relationship between

attachment style, parental bonding and alexithymia in adults with somatoform disorders. *Int J Psychiatry Med, 38*(4), 437-451.

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), 559-565.

Pos, A. E., Greenberg, L. S., Goldman, R. N., & Korman, L. M. (2003). Emotional processing during experiential treatment of depression. *J Consult Clin Psychol, 71*(6), 1007-1016. doi:10.1037/0022-006X.71.6.1007

Reid, J., Ewan, C., & Lowy, E. (1991). Pilgrimage of pain: the illness experiences of women with repetition strain injury and the search for credibility. *Social science & medicine, 32*(5), 601-612.

Rief, W., & Hiller, W. (2003). A New Approach to the Assessment of the Treatment Effects of Somatoform Disorders. *Psychosomatics, 44*(6), 492-498.

Ring, A., Dowrick, C. F., Humphris, G. M., Davies, J., & Salmon, P. (2005). The somatising effect of clinical consultation: what patients and doctors say and do not say when patients present medically unexplained physical symptoms. *Social science & medicine, 61*(7), 1505-1515.

Roth, A., & Pilling, S. (2015). A competence framework for psychological interventions with people with persistent physical health conditions: Retrieved.

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. *Br J Gen Pract, 54*(500), 171-176.

Salmon, P., Humphris, G. M., Ring, A., Davies, J. C., & Dowrick, C. F. (2007). Primary care consultations about medically unexplained symptoms: patient presentations and doctor responses that influence the probability of somatic intervention. *Psychosomatic Medicine, 69*(6), 571-577.

Salmon, P., Peters, S., & Stanley, I. (1999). Patients' perceptions of medical explanations for somatisation disorders: qualitative analysis. *BmJ, 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), 255-260.

Salmon, P., Ring, A., Humphris, G. M., Davies, J. C., & Dowrick, C. F. (2009). Primary care consultations about medically unexplained symptoms: how do patients indicate what they want? *Journal of general internal medicine, 24*(4), 450-456.

Salmon, P., Wissow, L., Carroll, J., Ring, A., Humphris, G. M., Davies, J. C., & Dowrick, C. F. (2007). Doctors' responses to patients with medically unexplained symptoms who seek emotional support: criticism or confrontation? *General hospital psychiatry, 29*(5), 454-460.

Schaefert, R., Hausteiner-Wiehle, C., Häuser, W., Ronel, J., Herrmann, M., & Henningsen, P. (2012). Non-specific, functional, and somatoform bodily complaints. *Dtsch Arztebl Int, 109*(47), 803-813.

Sharpe, M. (2002). Medically unexplained symptoms and syndromes. *Clinical Medicine, 2*(6), 501-504. doi:10.7861/clinmedicine.2-6-501

Sifneos, P. E. (1973). The prevalence of 'alexithymic' characteristics in psychosomatic

patients. *Psychother Psychosom, 22*(2), 255-262.

Smith, J. (1995). Semi-Structured Interviewing and Qualitative Analysis. In J. A. Smith, R. Harré, & L. V. Langenhove (Eds.), *Rethinking methods in psychology* (pp. 9-26). Thousand Oaks, CA: Sage Publications.

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

Smith, J., Jarman, M., & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray & K. Chamberlain (Eds.), *Qualitative Health Psychology: Theories and Methods* (pp. 218-240). London: Sage Publication.

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder The GAD-7 *Archives of Internal Medicine, 166*, 1092-1097.

Subic-Wrana, C., Beutel, M. E., Knebel, A., & Lane, R. D. (2010). Theory of mind and emotional awareness deficits in patients with somatoform disorders. *Psychosom Med, 72*(4), 404-411. doi:10.1097/PSY.0b013e3181d35e83

Town, J. M., & Driessen, E. (2013). Emerging evidence for Intensive Short-Term Dynamic Psychotherapy with Persoanlity Disorders and Somatic Disorders. *Psychiatric Annals, 43*(11), 502-507.

van Middendorp, H., Lumley, M. A., Moerbeek, M., Jacobs, J. W., Bijlsma, J. W., & Geenen, R. (2010). Effects of anger and anger regulation styles on pain in daily life of women with fibromyalgia: a diary study. *Eur J Pain, 14*(2), 176-182. doi:10.1016/j.ejpain.2009.03.007

Waller, E., & Scheidt, C. E. (2006). Somatoform disorders as disorders of affect regulation: a development perspective. *Int Rev 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. *J Nerv Ment Dis, 192*(3), 200-209.