Counselling Psychologists and Psychotherapists in the NHS: Learning from their Work with Clients Experiencing Persistent Embodied (Somatic) Distress

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… a therapist responds to a patient's needs…it can be said that in his supportive capacity he functions like a mother. However… his response to the patient is realistic. A mother… takes the burden of reality upon her shoulders and spares the child… as an ideal father the therapist is representative of outer reality, the reality of the world. In this capacity, he has to interpret the world for the patient, as a true father does for his own children. On the other hand, an ideal mother is representative of the inner reality, the reality of the body and its feelings. The therapist, whether man or woman, must be familiar with both realities so that he can help the patient reconcile his conflicts… (Lowen, 1969: p.250).

ABSTRACT

The intention of this research is to answer the question: Counselling psychologists and psychotherapists in the NHS: What can be learnt from their work with clients experiencing persistent embodied (somatic) distress?

Somatisation can be considered the most common health problem encountered in contemporary society, at both primary and secondary care levels within the NHS. Clients in persistent embodied distress often sit at the interface between health and mental health services, and this can prove very difficult for the clients and professionals involved in their care. This research explores the gap in the existing literature relating to the psychological understanding of working with 'persistent' embodied distress in the context of the NHS.

This research follows a qualitative constructivist grounded theory approach, and an explorative and reflective in-depth interview and focus group design. Eight counselling psychologists and psychotherapists with NHS specialist experience and knowledge of working with clients experiencing embodied (somatic) distress were interviewed as part of the study. The aim was to draw on existing experience and wisdom within the discipline to create a theory which can be used in future clinical practice.

The data was analysed, and the model was discussed within a sub-group of the original eight participants, who formed part of a data refinement process, before the finalised grounded theory was proposed: *The Embodied Therapist as a Bridge in the NHS,* highlighting a number of complexities and important connections and tensions within the work.

Unexpected findings from the study suggest that the cultural presence of the therapist is an important aid in the work with clients experiencing embodied distress

due to the therapist's own relationship with their body. In addition, new and exciting findings suggest the important contribution of the counselling psychology and psychotherapy professions 'working at the edge' of the NHS. Findings support a number of existing theories relating to attachment-informed practice in the NHS and the centrality of stress/trauma models and making mind-body-brain connections in work with clients in persistent embodied distress.

The research and grounded theory proposed have implications for the future clinical training and practice of both psychological and non-psychological staff working in the NHS with complex client presentations, experiencing persistent embodied somatic distress.

ACKNOWLEDGEMENTS

generosity and belief in me has made this all possible. This is dedicated to you, to us and to everything else we have created together…

TABLE OF CONTENTS

1 INTRODUCTION

1.1 Me as the Person-Practitioner-Researcher

I have always worked and studied in tandem. I feel these two streams feed each other well and have nourished and supported my development as a person and as a therapist, and have developed my understanding and belief in the importance of applied practice-based research and evidence.

I have chosen to work as a psychological therapist in the NHS. The reason for this choice is that here, I feel able to contribute in some way by providing good quality psychological support to those who need it and who would otherwise perhaps be unable to access it for financial reasons. My choice is very much in line with my personal values, my reason for entering the profession and my belief in social equality. There have, however, been many moments in my training career within the NHS when perhaps my own personal-professional values have not fit so well, and I have had to question my choice of work context in which I practice as a professional. On the surface, the NHS claims similar values to my own but, in reality, I have realised that these values and practices are restrained by lack of resource and inherent and historical power structures. As a (trainee) counselling psychologist and integrative relational psychotherapist, this has been a difficult reality to face and a source of constant tension in my clinical and therapeutic role.

For example, this contrast was highlighted recently for me when a client with a complex needs and a history of persistent embodied distress and who was coming to the end of his NHS-allocated sessions, asked me, 'But why can I not just carry on seeing you…?' I responded to him in the moment by saying that his question was a very important one to me.

1.2 The Origin of the Research

My interest in persistent distress and practice-based research question come from this dilemma and a number of other complex cases that I have come across in the NHS, which are probably best described in more depth with a real client case example.

More than ten years ago, I worked with a client who provided the inspiration and acted as the catalyst for my practice-based research endeavour.

My client was a fifteen-year-old girl who had been referred for therapy with recent limb paralysis and a painful lump in her throat which was affecting her swallowing. She was ridden with pain and fatigue throughout her body. Medical and neurological tests from a number of medical specialities had ruled out anything 'organic', and I later learned that this was the third of three large files we had archived for her at the Child and Adolescent Mental Health Services (CAMHS) where I worked. After spending considerable time reading through her clinical notes, that spanned some twelve years, I realised that this was her seventh referral to our service and that I would be her ninth psychological practitioner who was trying to offer some form of psychological opinion and help. Although this may sound like an extreme example, she was one of several cases of her kind that I had come across in my time in the NHS.

As our therapeutic work progressed, I became more curious about the possible meaning and importance of the persistence of her symptoms over time. I began to wonder about these therapeutic encounters over the years and if they had helped and why she had returned to us. As I spoke to other therapists who had been involved in her care previously, I began to notice patterns in professional responses as well as practices within the context of the NHS. I became curious about our personal, professional and service contribution to this ongoing therapeutic process. I

was concerned, 'how could I be of help if all others before me had tried and failed?' Her worsening symptoms also raised for me the idea of 'non-maleficence', or our potential contribution in causing her more harm than good (Edelstein, 1943).

Professionally, ethically and morally, I felt a responsibility and duty to review and reflect on her journey with us and ask the question, 'what are we doing?' For me, and perhaps others in the service and more widely, this raised some difficult but critical practice-related questions around how we continually reflect on the relationship with these clients and what we are doing in the context of their NHS journey each time they return to us. How do we contribute to their embodied, developmental and therapeutic process across the lifespan?

At a more intuitive level, and having worked within the NHS for nearly fifteen years, I believe that the question is important in the context of the client's life. Moreover, the answers have real therapeutic value and the potential to make a considerable contribution to counselling psychology and psychotherapy practice in the NHS and our work with clients experiencing persistent embodied distress. Therefore, the purpose of this research is to gain a deeper understanding of this work, which has the potential to support not only my own practice but hopefully the future practice of therapists more widely and the clients experiencing persistent embodied distress on their therapeutic journeys.

During this process I considered my own personal connection to this research, identifying my own somatic distress in the form of migraines which started in early adolescence, marking the start of a difficult developmental period. My personal understanding and experience of embodied distress allowed me to enquire from a personal and more empathic position and provided the motivation to go in search of answers that would be of real value to me at both the personal and practitioner levels.

The research now converges at a point in time, bringing together: my early history of personal embodied somatic experience with belief in the actual and symbolic representation (meaning) of symptoms (Freud, 1936); my own clinical experience across both mental health and clinical health services; unanswered clinical questions in relation to knowledge in the field; real practice dilemmas of working with these clients myself; my current professional positioning of power within the NHS; and, research and clinical interest in the context of my doctoral training as I move into the realms of becoming a responsible, qualified and effective counselling psychologist and psychotherapist in practice.

1.3 The Professional Context of the Research

As I reflect on my clinical experience over the years, some of the most challenging and all-consuming cases (in mind, body and resources) were those clients who presented for therapy in persistent embodied somatic distress. These clients are often referred to, in practice and the literature, quite provocatively as 'heart-sink', 'frequent attenders' or 'revolving door' patients. Part curiosity and part clinical need led me to conversations with close colleagues about these clients which, in turn, led to a wider exploration of the literature in the area. My colleagues and the literature only seemed to echo my own experience of them (Brown & Ron, 2002; Mohan et al., 2014).

After working in mental health services for thirteen years, I began to realise that something fundamental was missing in my knowledge, in my language, and in my therapeutic approach. My shift into clinical health was a conscious choice to address what was missing in my understanding of the embodied process, to develop my own practice framework and research ideas, and to put my research opportunity to good clinical use.

To give a sense of the clients I am referring to, they have often experienced severe and chronic distress, some spanning ten, twenty, thirty or forty plus years, and have experienced endless pain, fatigue, paralysis, numbness and multiple other symptoms. These patients can present frequently at various hospitals and specialities across both health and mental health services, sometimes with multiple admissions lasting for weeks or months at a time. Tests, scans, MRIs, X-rays and various referrals and interventions are excessive in number, without any obvious or objective sign of organic disease or pathology. Clients are often found in a limbo between the different specialities and services (Fink, 2017). These clients are often proving resistant to treatment, particularly if their symptoms are chronic (Brown & Ron, 2002). Multiple services may be involved, across health, police, social services and the voluntary sector.

Therefore, these clients can be considered complex in a number of ways. They generally present with functional difficulties. Co-morbid complex health and mental health difficulties can go undetected and untreated for any years. Their symptoms deeply affect their lives, key relationships and their families' lives, and often lead to fraught interactions and relationships with professionals leading to complaints and compensation being sought. As a result of their functional difficulties, attendance at appointments may become difficult due to pain or disability, which results in the patient being caught in a referral, non-attendance and discharge cycle.

As a result of these layers of complexity, progress can be limited, and NHS staff are often left perplexed, stressed and unsure how to proceed, becoming disengaged themselves in the relationship and the clinical work with the patient. Discussions at multi-disciplinary meetings, complex case forums and case review meetings can be ongoing. The high use of medical services leads to increased iatrogenic complications (Croicu, 2014), only adding to their difficulties. Further complications

can occur from patients' self-medicating through the use of alcohol, illicit drugs or excessive use of prescribed opioids (Ibid).

Limited progress and poor prognosis into adulthood are indicative of the gap in the way we currently support these clients. In so many ways, these clients become plagued with misunderstanding and prejudice from years in the NHS system (Fink, 2017).

This research considers the mind-body complexity of these clients as they present to various services across their lifespan, as well as their multiple symptoms, diagnoses and people involved over many years. The research pays attention to the context of the NHS, the commitment to the relationship with the client, and reflexivity and development as a professional discipline. Through the therapist, the research has the potential to make a significant contribution to these clients' lives and our own practice frameworks.

1.4   The Gap in (My) Knowledge

This research approaches the idea of persistent, embodied somatic distress within the context of the NHS. In this instance, I have focused my attention on the practitioners who have worked with these clients.

The need for this research relates to the central issues discussed above and the identification of a gap in the current literature, which has also been highlighted through my own clinical experience and intuitive sense of the work with these clients. The existence of this gap is supported by a number of recent studies exploring practitioner contribution in therapy. These studies have examined the links between physical symptoms and increased health care utilisation, and the long-term impact on the individual across health and mental health with associated medical,

psychosocial and economic costs (Carr & Springer, 2010; Woods, Priests & Denton, 2015).

The research aims to deepen our understanding of the work with these clients and improve our future practice efforts in working with clients experiencing persistent embodied distress. The nature and design of the research bring into focus personal/professional reflexivity and the significance of the NHS practice context, contributing directly to practice-based knowledge of counselling psychology and psychotherapy in the NHS.

Through discussions with eight experienced NHS therapists, I hope to develop our understanding of this phenomenon and inform and support psychological therapists in their therapeutic considerations and contribute in some way to improved therapeutic outcomes for these clients.

1.5   Rationale for the Study

The rationale for the study comes from my concern for these clients and questions in relation to what we are doing with these clients in practice. The hope is to begin to address the gap from a counselling psychology and psychotherapeutic disciplinary perspective.

There is considerable evidence to suggest that these clients are clinically complex. Currently, we hold a multidimensional understanding of persistent embodied distress related to developmental, biological, psychosocial stressors and genetic factors, as well as a history of childhood adversity such as child or family chronic illness, neglect, physical or sexual abuse and other traumatic experience (Croicu, 2014). Many practitioners across different services find this type of presentation difficult and overwhelming to work with, and professionals feel they do not have adequate

experience to understand the complexity of their clients' difficulties as they span services (Watson & McDaniel, 2000).

With healthcare cost savings and sustainability being the most critical factors in the current political, economic and healthcare climate, and with ongoing NHS transformation, this area of research and clinical practice is crucial moving forward, prioritising both clients' needs and the potential contribution of the counselling psychology and psychotherapy profession to the NHS in the work with these clients.

1.6   Early Self-Reflections on the Research

I believe I sit in a privileged position, as providing psychotherapy in the NHS, and this research offers me an opportunity to address an important clinical issue from a practitioner standpoint while offering an applied research perspective. My embeddedness within the context of the research and the NHS, and interest and passion for seeking the answers to the research questions, allow depth to the research that I believe is vital to truly understand the phenomenon under investigation. However, as a result of my position within the NHS, I appreciate that my experience of working with these clients has the potential to colour or bias my view and attention in the data.

Therefore, prior to commencing participant interviews, I decided to undergo my own self-reflective interview process. This process formed an important part of the reflexive design of the study and also piloted the interview questions.

The interview highlighted my own experience of embodied empathy and countertransferencial feelings of fatigue, helplessness and sense of responsibility to these clients. There was also a sense that I was missing something with these clients that was yet to be unearthed.

I was able to identify that my own model and approach were heavily supported and rooted in neuroscientific and psychoneuroimmunological research relating to the effects of early developmental trauma and health and mental health across the lifespan. I tended to take a holistic, attachment-based and trauma-informed approach to the work, with a strong sense that healthcare services should be built to respond to individual client needs with their history in mind.

I underwent a second reflective interview after the data gathering and analysis phase. The intention was to reflect on my learning as a result of the research process and understand how this has potentially changed my thinking and informed my practice, which I discuss in my concluding section.

2 CRITICAL LITERATURE REVIEW

2.1 Introduction

As I came to sit and write this chapter, I took the advice of Kamler and Thompson (2014). I imagined myself at a party full of the people who have contributed to this area of knowledge. In the middle of the party, I sit at a table with a handful of guests, selected for what I believe they have offered in terms of guidance on how to work with these complex clients. I then imagine myself turning to each one and asking:

'What was of central importance in the work?'

The following review aims to explore this question and the: psychological work undertaken with clients who present with embodied somatic distress, specifically those whose foci was persistent or chronic distress; the NHS as the context for the work; counselling psychology and psychotherapy as a professional contribution, and their points of intersection in the literature.

I first consider the scale of the clinical problem and why this research matters. I consider the major tensions/debates, recent developments, and unresolved issues creating a gap for the proposed research contribution covering theoretical, research-based and practice-based elements (please refer to Appendix B for the full search strategy).

2.2 The Scale of the Problem and Why it Matters

Somatic symptoms are the most common presentation to primary care services and constitute 50 per cent of presentations to secondary care (Nimnuan et al., 2001). A considerable number of these clients become 'frequent attenders' (Reid et al., 2002). A recent mapping study by Janssens et al. (2018) looked at the perpetuating factors for functional somatic conditions from the clinician's perspective (5/12 of

whom were psychologist participants). They found 99 perpetuating factors, which they reduced to 16 categories covering a range of biopsychosocial factors that contribute to the ongoing persistent nature of the symptoms, suggesting that factors impacting the persistence of symptoms are likely a broad and complex group of variables.

Reif et al. (1992) found that 'somatoform disorders' have a chronic life course (mean duration 11.9 years) and that lifetime comorbidity with affective disorders is 87 per cent. Chronic or recurrent forms of somatisation (De Gucht, 2006) not only cause disability and functional impairment but have lifetime implications for all areas of the client's life, their children's lives and their families (Geraldo, 2004; Marshall et al., 2007). They also have societal and economic consequences with implications for lost working hours and national benefits claims. The total estimated annual cost for medically-unexplained symptoms (MUS) is around £18 billion (Barsky et al., 2007; Bermingham et al., 2012). In addition, the documented cost of back pain is £12.3 billion (Pain Community Centre, n.d). EURONET-SOMA (the European research network for persistent somatic symptoms expert group) estimates that 20 million people in Europe alone suffer from persistent somatic symptoms, which suggests that this is a significant and prevalent issue with growing costs at a number of different levels.

2.3   Somatisation and Embodied Distress

Our relationship and understanding of the body have oscillated over time and between civilisations. The theoretical Cartesian ideas of the West exemplify a split between mind and body versus eastern traditions of 'oneness', where the body can be understood as a physical manifestation of the mind (Caora, 1975). From the body being beautiful and celebrated, to the post-modern era of being marginalised and split leave a powerful discourse and echo behind (Shaw, 2003). With the rise of

public health, the body became a political chip; the echo inherently dominating the way we currently provide national healthcare. In essence, the body really has been through so much already.

Literature streams in this area include medical, sociological and psychological contributions, with the most influential in the last 30 years being the emergence of a significant number of scientifically based interdisciplinary models for understanding embodied distress. These approaches have made considerable advances in our understanding and practice more generally; working more holistically within a strong evidence base, in line with the direction of counselling psychology and psychotherapy philosophy and professions, despite being somewhat at odds with the history and the mind/body dichotomy which exists within NHS practices.

The significance of our experience as an embodied phenomenon has been argued by many authors for many years. For example, Stern (1985) and Fonagy (1991) suggested that, from birth, our emotions (and related sensations in the body) are our (only) method of communication to our caregiver. Before that, Lipowski (1968) described 'somatisation' as the tendency to express psychological distress related to this experience at the embodied level (as physical symptoms). Therefore, how an individual experiences distress in their body can be considered both subjective and relational in nature.

In more recent years, embodied distress is understood to develop as a result of a number of contributory biopsychosocial factors; this link is now widely supported across a number of disciplines (Mulvihill, 2005). A number of studies now support the link between secure, healthy attachments in early life and healthy brain-body-mind functioning across the lifespan (Prussack 2015, Van der Kolk 2005, Schore 2001).

Therefore, to summarise, our current understanding of embodied distress stems from a multidimensional perspective of attachment, developmental and psychoanalytic theory rooted in interpersonal neurobiological and psychoneuroimmunological research.

2.4   NHS Culture - Diagnosis and the Classification Debate

I have referred to this phenomenon as 'embodied somatic distress' (Luyten and Fonagy, 2016) for its descriptive and inclusive quality and for honouring both perspectives by the embodied nature of experience and implied psychological component. This approach reflects the current interconnected understanding of human functioning (APA, 2013). However, the literary and professional use of these terms is not so clear-cut.

The classification of somatic distress has raised much debate, dating back 30 years to the introduction of the Diagnostic Statistical Manual (DSM-III). There are two aspects to this debate. Firstly, there is evidence to suggest the criteria for the various classifications do not imply specific aetiologies (Stuart et al., 2008), and secondly, the classification continues to reinforce the unhelpful mind-body split through the language we continue to use and our the service delivery models, in the NHS particularly.

These tensions have led to the inclusion of criteria of somatic symptoms going through a number of changes over the years resulting in the DSM-5 (APA, 2013), and more recently the International Classification of Diseases (ICD-11) (WHO, 2018) classification of mental and behavioural disorders. Reasons for the changes can be found in a number of papers which I will not go into further here due to space and the scope of this study. However, what I do take from these changes is the implication for a better understanding of what constitutes a somatic experience.

DSM-5 refers to the 'persistence' of symptoms for six months-plus. Both DSM-5 and ICD-11 also refer to 'chronic', 'recurrent' or 'persistent' distress which leads to increased help-seeking behaviours (see Appendix A for clarification of definitions).

Therefore, by its very definition, chronicity/persistence and help-seeking are embedded within the diagnostic language. Hacking (1987) raised this concern when he noted that psychiatric diagnosis could form part of a 'social looping process', where a number of factors, including the diagnosis itself, potentially reinforce the prevalence of the disorder. This view suggests a powerful cultural diagnostic (NHS) contribution embedded within our medical discourse and practices. I would also like to consider a possible inherent or unconscious aspect of formulating in this way, which potentially leads the client and professional to make assumptions about the nature of embodied somatic distress without fully exploring individual differences. Due to the significant influence of language and interpretation with those in persistent embodied distress, I suggest ongoing attention and reflection are needed by practitioners in the use of language and these diagnostic terms.

Fink (2001) discussed the challenges of the current professional climate for practitioners, with the 'absurdity' of clients presenting with multiple diagnoses from different specialities. For example, he noted that each speciality has at least one category in which to categorise these patients. Stuart et al. (2008) supported the notion that symptom clusters have been identified across the different speciality departments which included 'gastrointestinal (IBS), pain (complex regional pain syndrome (CRPS), rheumatology/musculoskeletal (fibromyalgia), cardiology/cardiopulmonary (chest pain), general unspecific symptoms groups (fatigue/chronic fatigue syndrome/myalgia encephalitis)', as well as gynaecology (chronic pelvic pain syndrome), neurology (tension headaches), respiratory (hyperventilation syndrome), multiple chemical sensitivity (Fischhoff & Wessly,

2003) and mental health (somatic symptom disorder/bodily distress disorder) (APA, 2013; WHO, 2018). Despite there currently being a lack of evidence for their differentiation and degrees of separation, the language and criteria used to define the disorders appears to take a speciality or theoretical bias (Stuart et al., 2008) in cases with very similar or the same presentations. This fragmentation within the NHS and through the NHS experience is very much in line with my experience of the clinical work, and clients' accounts of their NHS journey. This also highlights a professional role to help clients piece together their complex NHS experience and medical/psychiatric diagnoses.

These observations suggest that the different functional presentations may be more of an artefact of the medical speciality with, in fact, very little difference in underlying structure and cause (Fink 2017; Stuart et al., 2008). Furthermore, it has been suggested that these symptom profiles are not entirely independent and distinct conditions but share a common basis, and a 'multi-organ bodily distress syndrome has been detected' (Fink 2017, p.128). This point adds to a fascinating coming together of a body of literature and our developing understanding and practice with patients in embodied distress.

It is also important to recognise that not all pain or embodied distress can be seen or fully explained by current methods of physiology and pathology, but there is early evidence to suggest that answers lie in complex central mechanisms within the body (The British Pain Society, 2008). The British Pain Society suggests that, too easily, professionals 'invoke' the idea of somatisation when patients describe the heightened somatic experience when presented with chronic pain or distress. The society suggests this reflects the lack of clinical knowledge and experience of the complex mechanisms involved and this lends further support for the need for research and training for professionals working in this area of practice.

2.5 How do Therapists Work with Persistent Somatic/Embodied Distress? Contributions from Theory, Research and Practice Models

2.5.1 Persistent Embodied Distress – The Evolution from Psychoanalytic Beginnings

It has been widely considered that our bodies and behaviours are purposeful and that they hold functional significance for all of us in our lives and interpersonal histories (Dryden & Reeves, 2014; Rogers, 1951). From this, I would suggest a client's persistent physical symptoms/distress in the context of their development can, therefore, be considered important clinical information.

There are a number of insightful and creative ways in which to conceptualise and explain a client's persistent embodied distress from theoretical perspectives. In earlier theories, ideas related to structural and more symbolic and functional perspectives. In his early work, Freud (1914) theorised that symptoms themselves are symbolically meaningful in their formation and their 'conversion'. Physical symptoms were thought to be a result of an intrapsychic process where unconscious conflict is repressed, culminating in ego deficits and the fragmentation of the 'self'. However, Freud's most relevant idea in relation to the proposed research phenomenon relates to a compulsion to repeat that which is experienced as traumatic. He termed this symbolic defence the 'repetition compulsion' (Freud, 1914), which he believed related to the death/survival instinct, creating unconscious patterns in the individual. The idea of the repetition of this experience (in the form of symptoms) suggests that it is not just the form the symptoms take that potentially holds meaning, but also the specificities of their frequency, their duration (their persistence over time), and the associated behaviours (help-seeking/return to therapy). It is this attunement to the persistence and return, and how these are

understood and worked with, which is very much lacking from existing literature and practice-based models. More recent scientific findings support the link between early trauma and chronic somatisation, where something experienced as deeply traumatic is thought to be repeated in the brain and the body (Freud, 1914; Rothschild, 2003; Levine, 2015).

In more recent years, patients in persistent distress have been referred to as 'revolving door' patients and are hypothesised to reflect deficits at the intrapsychic/interpersonal/contextual levels (Harris & Bergman, 1984). At the intrapsychic level and interpersonal level, these clients potentially highlight a need for 'continuity of care'. This idea is aligned with Winnicott's (1945) key developmental idea of the 'continuity of being'. From the beginning of psychosomatic existence (birth), the process of continuity begins, where various aspects of psyche-soma become involved in a 'process of mutual interrelation' (Winnicott, 1945). Environmental impingements or failures to adapt (by mother) lead to a disintegration of 'self', as reflected in Freud's idea of fragmentation. Winnicott (1945) proposed a re-living or re-experiencing of this early gap in continuity, through acting out in the transference process (mirroring the early disruptions in healthcare interactions). These ideas lead me to consider the capacity of NHS practitioners/services to provide a level of 'good enough' and attuned 'continuity' responding to the client's earlier unmet needs. From a client's perspective, there may also be difficulty utilising this interpersonal/therapeutic relationship due to lack of ego function (Bachrach, 1981).

2.5.2 *Psychosomatic Medicine and the Biopsychosocial Model*

In amongst these ideas, Engel (1977) began to develop his 'biopsychosocial model' and theory, supporting the start of an integrative movement and approach and contributing to the relational understanding of persistent symptoms.

Engel (1977) began to conceptualise how the mind, body and environment (in particular the interpersonal relationships of mother-infant) interact across the lifespan and impact on biological mechanisms such as emotional regulation and bodily sensations which were interpreted as symptoms that lead us to take on a 'sick role' (Parsons, 1977) and seek help. This may vary from normal illness behaviours to excessive care-seeking.

There has been considerable subsequent scientific support in relation to attachment and somatisation (Fonagy, 1991; Maunder & Hunter, 2001). In line with my research, Engel (1977) held a particular interest in the conditions under which somatic conditions recur. His most relevant research investigated the interpersonal relationships of persistent ulcerative colitis patients. He found that when one of these key relationships is threatened, an episode of the condition will recur. To satisfy these relational needs, he introduced 'supportive psychotherapy' - Its aim was to reduce persistent symptoms and recurrent illness, where the therapeutic relationship is never completely terminated.

I now consider how plausible this idea is for the practitioner and service and the reality of this approach within the context of the current NHS. Taylor (2002) reviewed Engel's works and suggested that further research exploring the relational realms of the therapeutic encounter is still very much needed.

Stuart and Noyes (1999) offered support, proposing somatisation as a maladaptive communication to elicit care, resulting from a lack of secure attachment and 'failure to reassure'. They suggest that these patterns of behaviour directed towards healthcare providers are often met with apathetic responses which lead the patient to feel rejected and reinforces their belief that care is unavailable, this further increases the patient's demand for care which leads to the exacerbation of their (persistent) symptoms (Stuart & Noyes, 1999).

2.5.3 *Attachment and Persistent Embodied Distress*

The last 25 years have seen an overwhelming amount of scientific evidence emerge connecting attachment and distress, and insecure attachment and somatisation, pain and health-related complications connecting early trauma and health (Prussack 2015, Schetter, 2013, Ciechanowski, 2004). This strongly suggests a need for education of healthcare staff in applied attachment principles. Research suggests that those with preoccupied attachment styles are more likely to seek care when distressed. However, when a client's attachment experience has been confusing and contradictory, both attachment behaviours and defences may emerge (van der Hert et al., 2006), which Ogden (2014) suggested can be very confusing for the therapist.

Importantly, Stuart et al. (2008) addressed this issue from an attachment-based integrative perspective by integrating interpersonal and cognitive behaviour therapies; therefore, contribute something of value here. Developing a number of Engel's ideas in relation to this client group, Stuart et al. (2008, p.46) suggested the following questions need to be addressed in response to the client's difficulties:

(1) 'Should the patient be preoccupied and distressed? - i.e. is there compelling evidence that his or her health concerns are justified?' - suggesting a cognitive therapeutic task.

(2) 'What is the effect of care-seeking behaviour on the patient's relationship with family, friends and medical care providers?' - suggesting an interpersonal task, and

(3) 'Is the reassurance and treatment provided to the patient adequate?'

In the last point, Stuart and colleagues stressed the importance of 'appropriate reassurance' and that supportive care is necessary for all somatising patients, where the professional is available and reliable. This implies that the therapist has a

regulatory function. Stuart and colleagues went on to point out that the characteristics of the treatment provider and the quality of the interaction with the treatment provider have not yet been adequately recognised in classification criteria, with a critical element being the empathic therapeutic alliance in the treatment of somatoform disorders. This view is supported by the NICE guidelines available for health professionals on MUS (NICE, 2011) and adds weight to the following research question.

Offering reassurance and supporting the client to gain reassurance from others through improved communication analysis and from themselves, is considered in relation to meeting their attachment needs, adding support for attachment-informed NHS training and practice. This model therefore addresses both internal and external means of reassurance. Stuart et al. (2008) stressed that skill is needed in providing the reassurance that is often demanded by these patients and providing reassurance early is an indicator of compliance and positive outcome.

While considering the contribution of attachment theory to this area, the work of Goodwin, Holmes and Mason (2003) is worth mentioning. Their study made strides in applying attachment theory to practice and explored the ability of the current adult Mental Health Services to meet the attachment needs of their clients, discussing the complexities of working with attachment in the NHS. Whilst they acknowledged that within the NHS clients often have contact with more than one person from a service, they also differentiated between the attachment to the NHS (the place) and to an individual person(s), highlighting the subtle complexities of the relational dynamics and the contrast in working with clients in a public (versus private) and political organisation. They considered that mental health professionals might serve as temporary attachment figures and, again, that 'continuity of care' was a key issue in the client's recovery (Holmes, 1993). My concerns echo the views of Goodwin

(2003), who suggested that we may be actively causing harm by repeating experiences of insecure, disrupted care in our brief encounters. This concern lends support for attachment and soma models and further supports the need for the proposed research and how we work effectively with attachment and structure therapy with this group of clients in the NHS (Axelman, 2012).

While considering the intersubjective perspective (Gottlieb & Levy, 2013) and the therapist's contribution and presence in the work, I would also like to mention a key series of papers published by the American Psychoanalytic Association (Gottlieb & Levy, 2013) under the rubric 'A Patient Returns'. This series offered a contrasting perspective to the clients seen within the NHS, based on private practice client cases. However, this research constructed the therapist as the 'developmentally needed object' (Kohut, 1971; Winnicott, 1973; Clarkson, 2003), highlighting the importance of working with transference/countertransference processes with these clients.

2.6   A Review of the Effectiveness of Current Psychological Treatment

To gain a sense of what is already 'out there', I first reviewed the most up-to-date systematic review available on 'Nonpharmacological interventions for somatoform disorders and medically unexplained physical symptoms (MUPS) in adults' (van Dessel et al., 2014). This review aimed to assess the effectiveness of nonpharmacological interventions, locating 21 studies which all related to the effectiveness of psychological therapies. The search was comprehensive (up to November 2013) and included randomised controlled trials, controlled trials and systematic reviews. Fourteen out of 21 studies evaluated cognitive behavioural therapy (CBT), with the remainder reviewing behaviour therapies, third-wave CBT, and psychodynamic and integrative therapies across various healthcare settings.

Most of the studies included the review of chronic symptoms in line with 'persistent' distress; the focus of this research, hence its mention here.

Findings suggest that psychological therapy is better than usual care or waiting list in reducing symptom severity. Van Dessel and colleagues found that CBT was the only psychological approach that presently provided enough evidence to support practice after one-year follow-up; however, they found that CBT still only reduced symptoms with these clients with small effect sizes, with 'substantial differences' among the studies. The evidence quality was also rated low-moderate.

Implications for this review are the potential benefit of psychological therapies for this client group versus no therapy; however, further studies exploring various psychological modalities were found to be needed (other than CBT), adding further support to this integrative endeavour.

A meta-analysis (Koelen, 2014), which included 16 randomised and non-randomised trials in secondary and primary care, suggests that psychotherapy is effective for severe somatic symptom presentations.

Findings from these primary care studies cannot necessarily be compared or transferred to other secondary or tertiary care settings due to the client's level of impairment/distress. The studies focused on brief therapies, but it is worth noting that effect sizes were larger for brief treatments over a longer duration, which has implications for how brief psychotherapy is delivered in the NHS. Although the analysis only included 16 studies, the one-year follow-up data was positive. Improvements were considered moderate-large for psychological and somatic symptoms, and small for improvement to functional impairment. This finding may suggest that improvement in functioning may take longer due to the chronic nature of the condition (Koelen et al., 2014). Dose-effects studies also show that at least six months is needed for characterological and interpersonal change and changes to

social functioning (Hilsenroth et al., 2001, cited in Koelen et al., 2014). The authors suggest that aspects of the results should be interpreted with caution, as they noted publication bias with study quality being generally poor due to the heterogeneity of the studies and the outcome quality of measures used (Koelen et al., 2014).

In conclusion, there is extensive evidence for CBT-based therapies, which lends support to the need for further research on non-CBT-based and integrative approaches.

2.7   Contributions from the Interdisciplinary Sciences – Stress, Trauma and Regulatory Function

Current psychoneuroimmunological evidence suggests that our stress response and central nervous system act as our central operating system, interconnected to all other areas of functioning in the body (D'Andrea et al., 2011; van der Kolk, 2005; Hyland, 2017). Trauma research now supports this idea, suggesting that stress activation associated with early 'neurodevelopmental injury' (Kaffman, 2009) leads to adverse psychological and physical distress across the lifespan (D'Andrea et al., 2011). With complex traumatic experience strongly linked to a range of severe somatic phenomena across the lifespan (Finkelhor et al., 2007), culminating in complex PTSD reactions in adulthood (Herman, 1992). This linkage was clearly demonstrated by a significant study, and the largest of its kind, 'The Adverse Childhood Experiences (ACE) Study' (Anda et al., 2006). This study surveyed 16,000 adults and demonstrated that accumulative trauma exposure over time (in addition to health behaviours and genetic factors) is linked to physical health complaints across the lifespan. This study highlights a number of key points:

(1) The magnitude of the problem (supporting the potential contribution of the research in this area).

(2) The importance of stress regulation in early development and treatment and our understanding of its impact on long-term health.

(3) The importance of being 'trauma-informed' and attachment - informed when working with embodied somatic distress.

Neuroscientific evidence has strongly supported these ideas and begun to guide our practices around stress regulation (Schore, 2001; Siegel & Soloman, 2003) and trauma recovery (van der Kolk et al., 2005). Their research also suggests a connection between early stress and trauma with affect regulation, dissociation and somatisation (van Dijke et al., 2012).

2.8   An Integrative Movement

Due to the recognised need, each country appears to have developed its own set of practices in this area of work.

EURONET-SOMA, the European research network on persistent somatic symptoms expert group, was set up as an expert exchange to discuss healthcare for persistent somatic symptoms across Europe. In 2018, this group published the results of a qualitative study aimed at comparing healthcare for these patients across nine countries; 24 experts from these countries completed a semi-structured assessment of a case vignette. Commonalities/differences/best practices and implications for research were highlighted. Results showed that general management guidelines varied considerably, as did the recommendations for referral to psychotherapy. Although these recommendations did not detail any specific psychotherapeutic guidance, they did give a sense of timing in relation to my proposed research. Although this exchange is unsystematic, it does also begin to bring some understanding of the diverse practices 'out there' in the field. This expert group 'coming together' also gives a sense of the current focus, energy and expert interest

relating to persistent somatic symptoms more widely, outside of the UK and outside of the immediate psychological/psychotherapeutic field as a multi-professional issue and concern.

With the rise in the number of cross-disciplinary scientific models, our understanding of sensory and affective (emotional) processes in the brain and body and our understanding of the psychosomatic process has evolved to include a more sophisticated, evidence-based and multidimensional model (Prussack, 2015; Taylor, 2002). The introduction of psychoneuroimmunology now proves the direct impact of stress on the immune system and illness symptoms and helps us understand that stress and associated emotion, is not only an aspect of this but forms part of the same mind-body process and is itself one of the reasons for its persistence (Melzack & Wall, 1965). Prussack (2015) showed significant evidence for the centrality of emotion (stress) in the development of chronic pain and has gained considerable empirical support (Fonagy, 1991; Vania et al., 2012; Woo et al., 2015). The evolution of these disciplines coming together affords us, as psychological practitioners, the opportunity for a far more integrative understanding to a much firmer and more evidence-based position in which to consider potential clinical work.

Unfortunately, few make the next logical step and bring their ideas together in an applied up-to-date theoretical framework which can be applied to clinical practice within the NHS.

2.9   General Management Studies

The literature on the general management of somatic symptoms is more common than it is for psychological or psychotherapeutic management. Recently, Croicu et al. (2014) offered a holistic and inclusive approach for working with patients presenting with multiple somatic symptoms. They reviewed current practices,

drawing on a broad evidence base. Although their article offered considerations aimed at primary care and guidance for general management (not specifically psychological and psychotherapy), they put forward a comprehensive overview of key points, addressing both theory and practice issues for patients with multiple persistent symptoms. They also included some psychological aspects in their approach, which I suggest are applicable and transferable to all health professionals: for example;

Empathy – they suggested 'engagement and building a sound therapeutic alliance with the patient', with particular emphasis on providing empathy for those with somatic complaints. This relates to the client's need to feel understood and taken seriously by asking more about the problem and reflecting back our understanding (Croicu, 2014). Croicu et al. moved on to suggest educating the client on the brain-body connection relating to stress and symptoms to help restore hope. Their findings support the idea that CBT is the most effective therapy across psychological modalities at present, but this is likely due to the number of CBT studies available. Croicu et al. were clear that the aim with chronic patients should be to improve functioning and coping and not to cure the patient. Unfortunately, there is a lack of clarity from the outset about who the article was aimed at and what it would include; this may be because the authors did not anticipate it would be so helpful to psychology and psychotherapy alike. Although the article does not enable me to develop my existing ideas, it does contribute to the field directly and therefore is mentioned here, because it considers all aspects of treatment specific to those with multiple persistent symptoms. Points of interest related to their findings and advice on treatments include offering regular follow-up appointments and the need to screen patients to rule out mental health presentations missed previously, e.g. depression and anxiety; 50 per cent of somatic presentations are comorbid with, or masking, depression or anxiety disorders. Although the article touches on CBT as

the most effective evidence-based modality, it stops at a shortlist of helpful concepts and goals. Although I appreciate this was not their focus, it left the reader wanting to know more about what the psychological/psychotherapeutic perspective has to offer and therefore accentuates the psychological gap.

Madelon den Boeft et al. (2017) offered an up-to-date review of the general management literature and asked 'how should we manage adults with persistent unexplained physical symptoms?', persuasively supporting CBT-orientated practices. There is a general consensus around the lack of psychological studies to assess the effectiveness of other approaches (Madelon den Boeft et al., 2017). A key strength of this paper on management was that the patients with persistent unexplained symptoms were involved in the review of the article, which contributed to the refinement of their model. Despite being based in primary care, the model shows transferability to secondary psychotherapeutic care. Their recommendations for future research also included interventions and outcomes for patients with persistent unexplained symptoms.

Research suggests that somatoform patients are notoriously unresponsive to psychological treatment. Evidence for the effectiveness of psychological therapies for multiple symptom presentations is low-moderate at best for specific therapies (Stuart et al., 2008) and therefore is in need of further study.

2.10 How do Therapists Work in the NHS with Persistent Somatic/Embodied Distress?

2.10.1 NICE Guidelines

The NHS provides the setting for the research question and practice issue. NHS practices are generally guided by the National Institute for Health and Care

Excellence (NICE) guidelines, which rely, to a degree, on the cultural use of diagnosis as discussed above and practitioner compliance to these models.

The research relating to working with clients experiencing persistent embodied distress in the NHS is sparse, and the NICE guidelines that often sit alongside our therapeutic considerations in the NHS are limited to general management guidelines for health professionals (January 2011).

These guidelines highlight a number of key issues which overlap with psychological considerations and, for this reason as well as their context, are worth mentioning here. These guidelines (NICE, 2011) include:

- Listening to the patient's story and taking their concerns seriously.
- Responding with empathy, i.e. focus on the patient-professional relationship.
- Reassure and explain, being as explicit and honest as you can be.
- Focus on understanding and the management of symptoms and the improvement in functioning.
- Hold the uncertainty, introducing how emotions can play a role in aggravating symptoms (without implying you believe it is all psychological).

However, these very generic guidelines leave a considerable gap in the guidance and evidence-based psychological practices for psychotherapists and counselling psychologists.

2.10.2 CBT Approaches

There is growing evidence for CBT in the NHS across both individuals and group interventions for those with persistent somatic distress (van Dessel et al., 2014). The CBT model has economic appeal due to its short-term structure and provision for booster sessions if required (Proctor, 2017). The CBT approach includes the somatic, cognitive, behavioural and emotional dimensions, and environmental

elements (Sharpe, 1992), exploring the client's personal predisposing, precipitating and perpetuating factors in relation to their symptoms, and aims to address thoughts and behaviours to create change.

As I have discussed, interpersonal trauma is common in clients with persistent somatic distress; trauma can lead to affect dysregulation and body-focused attention (to avoid affect and cognitive states). This self-body-focused attention and redirection of attention to the symptoms is one of the precursors thought to lead to symptom chronicity. The CBT approach to somatisation addresses normal bodily sensations and symptoms and explains how they can be amplified due to the nature of their thoughts, feelings and responses, which feed the vicious cycle. Increased body monitoring, illness behaviours and mood changes are thought to make the situation worse by heightening the client's sense of ill-health (Barsky & Borus, 1999).

There is an extensive body of evidence supporting the effectiveness of CBT with low-moderate effects in clients with severe somatic presentations. However, Koelen et al. (2014) interestingly found that psychodynamic therapy was more effective than cognitive interventions for improving functioning (Koelen, 2014). These results show the potential for other therapies outside of CBT. Therefore, further studies looking at a variety of approaches are critical to explore the potential benefits of alternative methods of treatment for the different aspects of the condition.

2.10.3 Social Learning Theory

Parsons (1975), a key figure in sociological medicine, proposed the concept of a 'sick role', closely related to Pilowski's (1969) idea of 'abnormal illness behaviour', which defines adaptations by the individual shaped by social, psychological and cultural influences. Mechanic (1986) suggested that illness symptoms can lead to the activation of stress, which in turn leads to cognitive changes, including the level

of illness worry, body-focussed and self-focused attention often associated with somatic illness (Wells & Matthews, 1994). The client's response to these bodily indicators can lead to behaviours such as reporting of multiple somatic complaints, excessive health care utilisation, and inappropriate treatment-seeking. As already discussed, we now understand that relational trauma and the associated stress response can retrigger help-seeking (or attachment) behaviours and the 'emotionally needed object' or care provider (Kohut, 1971; Winnicott, 1973). Such views support the integrative development of ideas of persistent somatisation as a social/relational process (Mechanic, 1986). These views also support the need to develop therapeutic practices that match client needs with a comparable and responsive relational model, which addresses the management of stress that is related to interpersonal somatic triggers as well as the associated cognitive and emotional changes and resulting behaviours.

2.11 What can be offered by Counselling Psychology and Psychotherapy as a Profession?

Counselling psychology and psychotherapy may have something important to offer the NHS. The literature on the specific contributions of both the disciplines to the NHS is sparse; however, Frankland and Walsh (2005) acknowledged the diversity of psychological knowledge and practices provided across the counselling psychology profession, with the benefits of reflexive, ethical and evidence-based socially and culturally sensitive practices. They outlined the motivation and dedication of the workforce, who mostly self-fund their own training compared to other disciplines. They acknowledged that the training and competencies allow counselling psychologists to work with the most challenging and demanding patients across a number of specialist settings within the NHS. They emphasised the tensions in the models and approaches, in contrast to the NHS medical model, and the negotiator

role as part of this innovative, integrative endeavour (Ibid). In more recent years, the psychotherapy profession, by contrast, has remained relatively quiet about its contribution to the NHS, and this may reflect the wider shift away from psychotherapy-based services in the NHS.

2.11.1 Integrative Beginnings – Models for Consideration

The idea of an integrative behavioural medical approach, suggested by Rief and Hiller (1999), combined psychobiological treatment in the form of cognitive restructuring with relaxation, biofeedback, exposure work, communication training and family interventions alongside medical management. Although put forward nearly 20 years ago, this approach remains relevant today as it stresses the central underlying psychobiological dysfunction, which contributes to the maintenance of physical symptoms.

As well as offering a developmental (attachment) perspective, Stuart et al. (2008) also offered an integrative practice model, integrating interpersonal and CBT approaches in the psychological treatment of these patients. They stated that no current research studies suggest which patients will respond to which treatments in this area, and so proposed integrating treatments that allow a more flexible approach to client needs. For example, the interpersonal model in cases of somatisation is jointly based on attachment and interpersonal theory. Stuart et al. (2008) proposed that interpersonal stressors in insecurely attached individuals trigger somatic symptoms leading to care-seeking to communicate their distress and have their care needs met, suggesting that care providers form a critical role in the therapeutic work. The cognitive behavioural component of the model addresses inaccurate cognitions and implements behavioural strategies to moderate arousal.

In this supportive interpersonal approach, communication is considered a key element in this model. The reliance on medical care to meet patients' needs is

discussed openly, as is learning to communicate needs more effectively using role play. Stuart et al. re-iterated the 'continuity of care' concept and suggested no 'overt termination' of therapy with these patients but instead an agreement on treatment maintenance. This model is therefore important in offering a response to the literature on the relationship between attachment and somatisation.

The model integrates approaches based on different theoretical foundations and, as a result, both aspects contribute something quite different. Overall, the model allows for a flexible approach, addressing both internal and external methods and techniques to facilitate change. The model is still restricted to those trained in CBT/IPT and is applicable to the context of NHS as two already-approved evidence-based models. However, with the focus on prior-approved NHS models, the integrative contribution may be lacking the diversity and creativity available from within the counselling psychology field and profession to explore new possibilities and alternative approaches available. Interestingly, Stuart et al. (2008) also noted that the strategies used in interpersonal therapy with these clients do not differ from those used with other disorders, particularly with interpersonal issues of transition, grief and loss. Integration of these models is suggested and defined quite loosely (linked through the 'reassurance' elements within a therapeutic relationship). Despite being one of the first integrative models presented for persistent somatic distress, Stuart and colleagues put forward a persuasive argument for the integration of attachment-based principles with this client group.

2.11.2 Reassurance, the Therapeutic Relationship and Somatisation

On reading several articles relating to persistent somatic distress, the idea of reassurance continually surfaces. Howard and Wessely (2003) suggested that the primary role of the therapist for the somatising patient was found to relate to alleviating anxiety, encouraging hope and supporting the therapeutic alliance. The

process was described by Starcevic (1991) as providing the patient with all the information and explanations of the benign nature of symptoms after an adequate investigation has taken place. Most importantly, it is the delivery of this information that is crucial. Stuart et al. (2008) suggested that if the information is given in a 'routine and detached manner' it is often received as rejection. Instead, they suggest that if the patient is reassured with detailed information and a clear explanation by an involved clinician, they can accept such reassurance. Stuart et al. emphasised the trust within the therapeutic relationship; therefore, reassurance was suggested to be a central component of their integrative model. Pilowsky (1997) supported the idea of the internal deficit of reassurance, which I consider has some parallels to more recent ideas of emotional co-regulation (Bateman & Fonagy, 2006).

A second integrative study was offered by Houtveen et al. (2013), looking at the effectiveness of long-term multidisciplinary, integrative psychological treatment with a focus on 'body-related mentalization for patients with severe somatoform disorder', within a clinical health setting in the Netherlands. The study included 183 participants who took part in either an outpatient programme of three days per week or a five-day residential programme, both over a six-month period. Pre- and post-measures included a number of questionnaires including the Psychological Distress and Psychopathology (SCL-90) scale, the health-related quality of life scale (EQ-5D), and self-reported expenses on medical health scale (TiCP). These questionnaires were completed throughout the study and up to two years post-treatment follow-up. Houtveen and colleagues found improvements across all measures, with small-medium effect sizes and a significant reduction in self-reported medical costs.

Interestingly, there were also significant effects on the patients' quality of life, which was more pronounced for those in the outpatient group. This was one of the first

studies to explore integrative treatments for this group of patients, trialling

mentalisation-based treatment (MBT) for patients with severe somatoform

presentations. Therefore, interpretation should be tentative with further research

needed. Although the study lends support to integrative therapy with this

presentation, further studies may determine which aspects of treatment were most

effective (Houtveen et al., 2013).

Building on Houtveen's integration of mentalization-based treatment is a model that

was published after I started the research process nearly five years ago. My intuitive

sense of what felt important in the work at the time also developed in parallel in the

literary field. A chapter which most closely links to the answers I seek is offered by

Luyten and Fonagy (2016) and their chapter describing 'An Integrative, Attachment-

Based Approach to the Management and Treatment of Patients with Persistent

Somatic Complaints'.

They suggested that the most important issue for these patients with functional

somatic disorders is their interpersonal difficulties. In response, they supported the

view that a contemporary attachment-based theory can help therapists understand

these clients better, which in turn leads to better relationships and clients'

understanding of their difficulties and improved outcomes.

Luyten and Fonagy (2016) integrated three main areas of knowledge in the

treatment:

- Attachment issues

- Problems with embodied mentalizing

- Problems with epistemic trust – the capacity to trust others as a source of

  knowledge

This integration of mentalization-based ideas and attachment theory has a strong neurobiological-evidence base. They set out a detailed model of the theory, scientifically rooted with detailed application to clinical practice while addressing some complex client presentations. I appreciate their explanation that these patients are not 'difficult to treat', more 'difficult to reach' (reminding us of useful psychoanalytical conceptualisations of defence structures present with the clients). My present research, therefore, develops some of the ideas discussed in their paper in relation to attachment, while offering several additional elements previously considered.

2.11.3 The Embodiment Perspective - the Lived-Body Paradigm

The phenomenological idea of 'embodiment', which was first inspired by ideas of Merleau-Ponty (1962), proposed that our understanding and perception of the world comes from our conscious lived-embodied experience. Wilde (1999) defined embodiment as how we live in and experience the world through our bodies as a form of personal knowledge, affected by social, cultural, political and historical forces.

Shaw (2003) in his book entitled *The Embodied Psychotherapist* explored the therapist's embodied experience in therapy and the effects mind/body dualism have on the therapist's approach to the body, psychotherapeutic practice, and culture. Originating from his grounded theory study, Shaw interviewed therapists about their somatic experience during the therapeutic encounter and how they use this to inform the encounter. The findings highlighted the importance of the therapist's body in the therapeutic encounter and as a form of communication between client and therapist.

This was a comprehensive study including five discussion groups and 14 individual interviews composed of counsellors and psychotherapists (90 psychotherapists in

total). Shaw's research highlights the ethical dimension and our responsibility to work in a way that includes the body as part of the therapeutic process and the need for experiential training for therapists to explore embodiment in the work.

2.12 The Professional Context - Issues of Institutional Culture and Power in the NHS

There are a number of contextual issues which surfaced from the review, and these relate to (1) the context of the persistent distress relevant to the client, and (2) the NHS context which potentially influences the client, therapist and the work. Therefore, the reasons why an individual experiences persistent embodied distress needs to be considered both individually and contextually.

2.12.1 The History and Culture of the NHS

Kirmayer and Sartorius (2007) suggested that culture is made up of several areas which come together to create the environmental context for somatic experience, as well as how we practice as psychological therapists. They highlighted the iatrogenic risks of ignoring the crucial sociocultural dimensions of somatisation. They stated that cultural knowledge is considered to be embedded in schemas, images and stories and is socially embodied in individuals for all those involved: professional practices, institutions and the wider diagnostic systems, guidelines and local and international professional agendas (Kirmayer & Sartorius, 2007).

2.12.2 Issues of Powerful Influence

My curiosity about practitioner contribution has been echoed over more recent years. Hardwick (2005) made an important point related to the iatrogenic risk of somatising 'unwittingly' encouraged by practitioners and related intuitional and cultural practices. He highlighted issues such as the professional beliefs about the condition and living and working with uncertainty, such as cases with unexplained

organic cause, as contributing factors. He also highlighted the vulnerability in mirroring the split in the family relationships within the service/organisation and within the client work.

Clinicians are also in inherent positions of power (Proctor, 2017). The medical origins of the patient-doctor relationship and medical discourse, structures, roles, processes and context all reflect an inherent power that continues to exert control over patients. Power is exercised through the knowledge practitioners hold and the access they have to a valued therapeutic resource, through the decisions they make as well as through the coercive diagnostic descriptions and language used with patients and other professionals (Ibid).

The UK Council for Psychotherapy (UKCP) and British Psychoanalytic Council (BPC) suggested (UKCP/BPC, 2013) that over the years there has been a reduction in the length, intensity and type of psychotherapy provided by the NHS. This reduction makes it very difficult for those currently trained to work more relationally, psychodynamically, or longer-term, and who value patient need and ethical practice above economic value and resource issues.

For example, mental health liaison teams have been developed in an attempt to bridge the divide between health and mental health in hospitals with the intention of freeing bed space. 'Improving Access to Psychological Therapies (IAPT)' for mental health was created to improve access and deliver short-term 'evidence-based' interventions for clients with mental health difficulties (Proctor, 2016).

Proctor (2017), a key author, suggested in her book, *The Dynamics of Power in Counselling and Psychotherapy* that NHS organisations are now based around economics and targets and evidence of effectiveness to deliver cost-effective treatment. Short-term CBT, because it is manualised, can easily be evaluated and researched. She raised the question of whether services are set up around what is

important to the commissioners instead of what is important to the clients. With much of the CBT evidence funded by pharmaceutical companies (Proctor, 2017), the implication is that CBT continues as a result of discursive strategies and powerful alliances (Ibid), with assessment and outcome measures based on the medical model. Proctor suggested that these factors undermine the power of both therapist and client. Although my intention is not to review IAPT here, it is worth noting that 46% of IAPT workers report depression and 70% (Rao et al 2016) report stress themselves; therefore, Proctor appropriately queried the therapist's lack of power and voice within the NHS.

2.13 Summary of the Literature Search and Research Contribution

There is a considerable wealth of literature relating to somatisation. There is, however, a minimal contribution from the counselling psychology and psychotherapy profession, with behavioural medicine, psychiatry and CBT models having a strong presence within the research field, whilst psychoanalytic and social constructionist perspectives tend to dominate the theoretical field (Williams, 2005).

Presently, to the best of my knowledge, there are no qualitative studies which ask the specific research question of the therapist to reflect on what they are doing in their work with clients experiencing persistent embodied/somatic distress, within the context of the NHS. Much of the previous literature has centred on provision at primary care level and the general management of these clients or has reviewed aspects of the work within specific conditions and specific approaches, e.g. CBT.

A very small proportion of these studies focus on psychotherapeutic approaches, particularly integrative approaches and persistent distress. However, in the last few years, it is worth noting the increase in the exploration of practitioner contribution

(iatrogenic actors), relational and attachment perspectives, and the contribution of CBT, which has seen a sharp increase. As discussed, the integrative research contributions are limited and in their infancy stages.

It is these integrative, developmental, interpersonal aspects, including the application of attachment ideas to NHS practices, and the focus on persistence and practitioner/service contribution in cases of persistent somatic distress, which suggest further psychotherapeutic research, is warranted here.

Even though this research does not extend to exploring issues of diagnosis, the field continues to experience diagnostic and conceptual confusion potentially hampering research and communication efforts (Fink, 2017). I agree with Fink (2017), who suggested the need to, 'bridge the body-mind gap for ourselves as a profession and between medical specialities.' Counselling psychology and psychotherapy, therefore, hold the potential to offer the NHS some practice-based suggestions to begin to bridge this gap.

There appear to be a plethora of theoretical offerings available to consider the phenomenon of persistent somatic distress. Research studies examine the predominant CBT or CBT variants with the odd scattered psychodynamic or integrative study. The several integrative studies of recent years, which I have discussed in detail, supported the need for further integrative research study in this specialist area of psychotherapeutic practice.

2.14 Identified Gap in the Knowledge – Working with the Persistence of Embodied Somatic Distress

I have evidenced several gaps in the existing literature relating to somatic persistence as a phenomenon and how this is currently addressed psychotherapeutically. In the interrelationship between the individual therapists and

NHS organisation, we form part of this process in some way and have a responsibility to reflect continually upon our encounters with our clients over time to improve our practices. I have identified the potential disciplinary contribution needed from a research and practice perspective in this area, to develop ways to bridge the mind-body-brain divide that continues to exist within NHS.

In a changing economic environment, we need to explore and reflect on new ways of working with our clients that both meet their needs and NHS purse strings. I have highlighted the gap for counselling psychology and psychotherapy within the NHS and their potential fit and contribution to this client group. I have discussed the limited contribution from an integrative standpoint. With counselling psychology and psychotherapy heavily embedded within relational, holistic, evidence-based, ethical and inclusive practices and philosophy, I hope that the results from this study will go some way to supporting the contribution of counselling psychology and psychotherapy as a workforce in the NHS working with complexity and potentially support the case for funded training places in the NHS for the profession, in the future.

2.15 Research Questions

In light of the reviewed literature, I consider an opportunity for the development of knowledge from a disciplinary perspective relevant to the context of the NHS from a practitioner's standpoint. This question relates to my area of current clinical interest and practice, while considering an identified area of clinical need in the current practice and research field of mind-body-brain work:

Counselling psychologists and psychotherapists in the NHS: what can be learnt from their work with clients experiencing persistent embodied (somatic) distress?

Sub-questions:

   (1) How do counselling psychologists and psychotherapists work with persistent embodied somatic distress?

   (2) What can be offered by counselling psychology and psychotherapy as a profession to these clients in the NHS?

   (3) In what ways does working within the NHS impact the work with these clients?

2.16 Potential Contributions to the Field

The research has the potential to contribute at a number of different levels:

   (1) At the therapist-practitioner level, enhancing knowledge, awareness and competencies from practice-based evidence offering specialist knowledge from within the discipline.

   (2) It has the potential to inform the client-therapist relationship and the client's experience of therapy.

   (3) It also has the potential to inform services at a practice and economic level.

The research will be approached as an integrative endeavour, and therefore professionals trained or aspiring to practice integratively, as well as those in related disciplines, may find this research useful. As we are working with the same complex clients, quite often at different stages of their care, wider use may apply across both health and mental health services and contribute to bridging the divide between services within primary, secondary and tertiary care services.

Due to the focus, motivation and design of the research, I suggest the research has the potential to impact in a very useful and applied way, to draw from practice-based evidence and make a very much needed contribution to the area of persistent

somatisation in the NHS, from a counselling psychology and integrative

psychotherapeutic perspective.

3 METHODOLOGY

In this chapter, I explain my choice of research design and methodology, which I believed would best answer my research question in line with my own personal-practitioner-researcher philosophy.

I describe my choice of data collection, research context, and selection of participants. I go on to describe the data analysis and include my ethical process and journey. I conclude this section with a discussion on issues which arose in relation to the trustworthiness of the research, and research reflexivity in particular.

3.1 Personal and Research Philosophy

My approach to this research journey is very much grounded in my personal and philosophical views, values and assumptions. I view the world from a social constructionist and interpretivist perspective. This perspective allows me the opportunity to explore and research phenomenon through relationships in context; exploring social, linguistic, cultural and historical contributions and acknowledging the presence of power relations in line with my own personal experience of being in the NHS and being in the world. I therefore consider a relativist ontology, i.e. individual experience, is relative, and the meaning it holds and how it is experienced is relative to the individual's subjective lived experience (Merleau-Ponty, 1962). This view leads me to the idea that there are multiple possible meanings and ways of understanding the embodied somatic phenomenon (Finlay & Ballinger, 2006) where human experience is multi-layered and dynamic across time, context and individual. This idea supports my open and inclusive, relational and integrative position, and my approach to my clinical work and research, offering my own individual and unique perspective and contribution to my work and to this research endeavour. This

perspective is congruent and embedded within the counselling psychology,

integrative philosophy and the intersubjective realm.

3.2   Choice of Research Methodology

While considering my research question, I explored the possible contribution from

several different research methodologies, which I considered in relation to my

epistemological belief and assumptions. I considered my ontological interest in the

therapist's personal experience and implicit learning from working with these clients

and what could be drawn from this experience. I considered the nature of the

phenomenon of persistent embodied distress, paying attention to the hermeneutics

of the NHS and counselling psychology and psychotherapy within this context.

While exploring research methods, I first considered action co-operative inquiry

(Heron, 1971). I was drawn to its relational, collaborative participant-researcher

approach, where I could be part of the group learning process, researching 'with'

rather than 'on' participants and thus creating a supportive group process where

knowledge could be shared, reflected upon and refined. This research methodology

was excluded, as it would have been difficult for me to gather the specialist group of

practitioner/experience of counselling psychologists and psychotherapists locally

with relevant experience and interest, and would not allow the individual time and

space I considered to be needed for the depth of individual practitioner reflection I

was seeking.

Then, after attending a workshop at the Metanoia Institute with Professor John

McLeod on in-depth case study design, I felt this approach would give the depth of

understanding to work with persistent embodied distress as a phenomenon from the

perspective of the participants. This approach would allow me to capture the

complexity of the process of working with the persistent somatic phenomenon,

attending to the story of the body over time and context. However, it would potentially require access to historical information, patients and therapists and clinical archives, which could prove practically and ethically very difficult in the NHS due to confidentiality and consent dimensions.

I considered interpretative phenomenological analysis (IPA), with its origins in phenomenology and hermeneutics and its capacity to give a rich description. However, my research aimed to make sense and explain participant experience to support the construction of this experience and learning into theory, as I propose is needed within this area and which would not be possible with the IPA methodology.

I considered what fitted best with what I wanted to know and achieve, which was to understand what might be happening when clients presented with persistent embodied distress and how therapists involved were trying to support them in their distress.

3.2.1 Grounded Theory

I then explored the use of a grounded theory methodology, which was first introduced by Glaser and Strauss (1967). Different versions of grounded theory have evolved since it was first introduced, as a result of the developments in the different coding paradigms that have been created (McCallin, 2004). I considered which version was most appropriate, given my research philosophy. My final choice of the full constructivist grounded theory method allowed for the construction of ideas (data) into a final theory, which I propose is very much needed to aid therapists in this area of clinical practice. This, I felt, combined a number of key research elements which best fitted my research needs and which I will now explain in more detail.

3.2.2 Deciding on Constructivist Grounded Theory

While considering my research question, I kept coming back to how important it felt to stay close to the participants' accounts and their experiences. I needed to respect their individual approaches and voices which had evolved as a result of their clinical experience with these clients. I also reflected on my researcher position and how important it was for my own individuality and voice as a researcher-therapist to be acknowledged. It was important that my research approach allowed for each participant's subjective experience to be heard, while acknowledging my belief in my own presence and contribution in the research process. Therefore, I opted for Charmaz's constructivist version of constructivist grounded theory (Charmaz, 2014). This choice acknowledged my sensitivity to the data and my presence and influence on all aspects of the research process. This methodology also aligns itself with my relational, intersubjective, reflexive research philosophy.

Grounded theory is an explorative and interpretative methodology and offers a reflexive and intersubjective approach (Charmaz, 2003). It was chosen as a means of exploring the individual therapist's experience, as well as the interpersonal process and reciprocal effects between individuals and the larger social processes within the NHS. This choice of interpretative and emergent methodology offered me the empirical rigour, which is achieved through a systematic, flexible, contextual and, most importantly, co-created approach to data gathering, analysis and the theory construction process. Crucially, grounded theory allowed me the opportunity to describe and understand the experience and meaning of the social process, interaction and psychological phenomenon through direct enquiry with those who experience it (Polkinghorne, 2005; Taylor and Bogdan, 1998) whilst keeping a close and grounded perspective in the data. The theory links with the pragmatic philosophy of symbolic interactionism, exploring, process, action and meaning, and acknowledges the co-created nature of human interactions, including that of the

research process (Charmaz, 2000). It also connects to important elements from my own personal process as well as the relational and scientific aspects of my theoretical framework.

3.3   Research Design and Context

The research design included two stages. Stage one included one-to-one, in-depth interviews with therapist participants, which would be analysed using the grounded theory methodology. The second stage involved a group session with the same participants in order to refine the model under construction.

It was important to me that my research had relevance and application to:

1. My own clinical practice and practice framework within my own development.
2. Contribute to the development and advancement of counselling psychology and psychotherapy as a profession within the NHS.
3. Contribute to an area of clinical practice where a gap/need had been identified, where this study could make a significant contribution.

Therefore, I opted for NHS-based research, which is the context of my own practice, in an area I have found challenging and where professional psychological guidance for practitioners with clients with persistent embodied distress is lacking.

3.4   Choice of Participants using Theoretical Sampling

Recruitment Process

Following the Metanoia Institute and subsequently NHS Ethics Committee approval (see Appendices), I was able to begin the recruitment process. For convenience, I aimed to recruit psychotherapists and counselling psychologist participants, where possible from across England and Wales, to allow for as many face-to-face interviews as possible. The choice to recruit both counselling psychologists and

psychotherapists relates to the gap in both disciplines' contribution to the field, as well as building on my own dual doctoral training, identity and contribution from a dual-disciplinary perspective.

Due to the specialist nature of the research, my primary focus was to recruit participants who were able to offer knowledge-rich data from practice experience and to contribute to the quality, depth and breadth of the theory building and refinement process in the area of persistent embodied distress. Therefore, the inclusion criteria for practitioner-participants were set as follows:

- A minimum of three years' NHS experience working with clients who present with persistent embodied distress across health/mental health services (current or previous experience was considered relevant). Participants needed to have sufficient depth and breadth of expertise with this client group to be able to talk authoritatively about the work and therefore be able to contribute to the data building and refinement process.

- Accredited counselling psychologists and/or psychotherapists who work with a clear therapeutic contract with their clients, with either UKCP or BACP (British Association for Counselling and Psychotherapy) registration, or both, and HCPC (Health Care Professions Council) registration. Participants needed to have achieved a standard of professional training and proficiency to be able to take part in the research process.

- If currently practising, participants needed to be in regular supervised clinical practice (see ethical considerations). If not, they needed to have access to professional or therapeutic support of some kind. This criterion acted as a professional safeguard for the participants who took part should the research trigger any issues with regards to their professional practice and/or personal process.

- Agreement to be involved in a reflective interview and/or be part of a focus group and agree to be audio-recorded for the purpose of transcription and doctoral thesis submission. I appreciate the commitment and contribution involved in taking part in research; therefore, I wanted participants to understand fully what was being asked of them.

There were no specific exclusion criteria that became relevant during the recruitment phase. However, two adaptations were made to the sample selected:

1. One participant who had two years' NHS experience was included in the study. The rationale for changes to the inclusion criteria related to the fact that the participant specifically self-selected to the research study as she felt she had something to contribute to the research question specifically. As I was at the beginning stages of the recruitment process, I initially intended this to be a pilot interview. However, following the interview and coding process, I found that the particular participant had a data-rich experience to contribute and I concluded that the relevant case experience with this client group was more pertinent than the precise number of years/months of service. What came into focus was the importance of the depth of professional process and reflection of the work with this client group and whether the participant was actually able to answer the research questions. On this basis, I decided to include her interview data in the analysis and final model.

2. Related to the use of theoretical sampling, initially I was focused on recruiting counselling psychologists and psychotherapists with NHS experience but, following my second participant interview, I realised that those who worked specifically with the body and embodied presentations to the NHS (as opposed to generic NHS psychology) were able to offer more

focused responses in both breadth and depth. Therefore, my recruitment approach shifted to those who specialised in working with body processes and embodied somatic distress in their day-to-day work.

Participants were recruited using a variety of sources, which included contacting professional governing bodies and associations:

- The Counselling Psychology Division of the British Psychological Society - online network eletter and NHS special interest group.
- BACP online research message board.
- Metanoia supervisor/therapist list and message board.
- Direct contact with specialists within NHS somatic/pain/mental health teams.
- British Pain Society conference delegate list.

Participant expressions of interest were followed up with an email and scheduled phone call within one week, where participants were screened to ensure they met essential criteria for inclusion (outlined above). Research information sheets were then sent out, and verbal consent was gained before the initial meeting, where written consent was then gained (see Appendix E).

In total, I recruited ten psychological practitioner-participants. However, I only interviewed eight before reaching a level of data sufficiency (Dey, 1999). All participants who showed an interest in the study were female and, interestingly, seven out of the eight were of foreign descent. Although all were qualified psychotherapists or counselling psychologists, they all practised from different theoretical positions, and I feel this is relevant to mention due to the breadth and diversity of both cultural and theoretical representation and orientation to the profession and to the particular research which I discuss further in my findings. Interviews took place between December 2016 and April 2017, in both NHS sites and participants' homes/private offices for their convenience.

Table 1 - Participants

Therapist Code	Gender	Cultural background	Title/training	Years NHS experience/ speciality	Described theoretical orientation
A	F	White South African/ Dutch/ Austrian	Integrative psychotherapist	2 years Mental health (adult)	Integrative
B	F	Jamaican	Counselling psychologist	18 years Mental health (child and adult)	Integrative
C	F	German	Counselling psychologist/ psychotherapist	15 years Mental Health & Clinical Health/ Women's health (infertility/pain)	Integrative/ existential/ Yoga therapist
D	F	Indian	Integrative arts psychotherapist	5 years Mental health (asylum seekers/refugees	Integrative Arts
E	F	French	Counselling psychologist	8 years Mental health/addictions Pain/ fibromyalgia	Psychodynamic/ Person-centred Transpersonal/ EMDR Aztec Shamanic Healer
F	F	Australian	Clinical and counselling psychologist	6 years Pain/weight management	ACT/CBT
G	F	Greek-Cypriot	Psychotherapist	12 years Mental health/MUS	Integrative
H	F	English	Integrative arts psychotherapist	24 years Research/MUS	Integrative Arts/dance movement

3.5   Data Collection and Analysis Process

3.5.1   *Choice of Data Collection – Practitioner in-depth Interviews*

The purpose of the research and data gathering process was to obtain information

to develop our understanding of the actions of the therapist in the NHS in their work

with persistent embodied distress. Interviews are both versatile and sensitive

enough to respond to the individual 'real-life' experience of the therapists. Experience tends to have a vertical depth (Polkinghorne, 2005) which requires methods such as dialectic or conversational interviews to follow the process of the participant and gather the richness, fullness and depth of an experience or phenomenon. Therefore, I chose in-depth interviews to support the depth and reflective process of exploration of a number of different levels of the therapists' experience.

Including and collating the multiple participants' experiences in the process created a breadth of data to draw from, build on and explore. Interviews therefore allowed exploration of the individual practitioner experience and the individual time and space to explore the 'real world' practical context of the NHS and reflect on the material at different levels of consciousness. The process also allowed me to develop and construct ideas from the collective experience of the therapists who took part (Taylor, 2002).

Interviews lasted approximately 1-2 hours. All interviews were conducted face-to-face, which was my preferred method due to the relational, reflexive and in-depth interview design and ability to capture the essence of the therapists' work fully.

3.5.2 The Interview Process

Interviews were guided by a semi-structured interview schedule exploring the main areas of interest from the research questions without upsetting the conversational and topic flow. The interview questions grew out of the purpose of the study and were supported by prompt questions (see Appendix F for interview schedule/prompt sheet). I am aware that interview questions can be value-loaded with my own bias. To help manage this risk, interview questions/areas were used as a guide only to explore participant experience (Polkinghorne, 2005). The initial focus of the interviews was on building rapport/trust. Interview data was elicited by following the

conversational threads of the participant, and reflexivity was encouraged through the use of minimal prompts and a supportive and interested researcher manner. I made a note of the participants' personal use of words (in vivo codes) to explore meanings. My own ideas, which were raised during the interviews, were noted in my research log for further reflection and analysis at the time of data analysis.

Similar codes began to emerge quite quickly in the participant interviews and, by Interview 6 and 7, I felt a level of data sufficiency had been met. However, I continued with one further interview, making a total of eight interviews, until I was satisfied I had the breadth and depth of data needed to answer the research question. With the refinement of questions following each interview, I was able to focus my questioning and enquiry and develop focused areas for further questioning and theoretical consideration.

3.5.3 Recording and Transcription

Individual interviews were digitally recorded using two audio recording devices to ensure there was no loss of data and to capture the conversational and experiential account for accuracy. Data was transcribed verbatim after each interview by a professional transcriber. First names and initials only were used, with the transcriber being the only other person with access to the recording. The transcriber was debriefed after each interview. The transcription was checked by me for accuracy and sent to the participant for participant checking. I ensured confidentiality of the participants by initially discussing its importance with the transcriber and then asking them to read and sign a written contract of confidentiality (See Appendix H, transcriber details have been removed for anonymity).

3.6 Data Analysis – Coding Process using Constructive Grounded Theory

3.6.1 Stage 1 – Coding and Constructing

Analytic coding included three main phases: (1) initial coding, (2) focused coding, and (3) theoretical coding. The coding process involved multiple levels of abstraction from the data over several months. Data of interest included everything I heard, experienced and observed, including both verbal responses and non-verbal responses during the interview. I also made a note of anything I felt was omitted or implied in line with Glaser's idea 'all is data' (Glaser, 1992).

3.6.1.1 Initial Coding

Initial coding took place directly after each interview was transcribed and checked for accuracy. Initial open coding included reading each transcript line-by-line, naming/labelling and summarising with focus on identifying 'gerunds' (processes/actions) described within the data. I tried to keep initial codes short and succinct, preserving the participants' use of language. It took some time to get used to this process by focusing my attention on what the practitioners were actually 'doing' in their practice. However, it helped me to consider the relevant verb that best described the participants' practices. I focused on identifying processes, incidents, actions and patterns of behaviour. An example, an excerpt from Participant B showing an example of initial coding and memoing, is as follows:

Initial Coding	Participant narrative	Memos
Realising/honing on just their cognition is not	… presenting not just with psychological distress but like very physical distress and me kind of trying to home in on their	Complexity/holistic nature of the work Working with psychological

| enough **(Helping clients** make Links) **Doing something** about that | cognitions and doing something about that (laughs), realising that it is just a bigger thing… | and physical health together -'bigger' nature? |

See Appendix H for a further initial coding example.

3.6.1.2 Memoing

As I read through the transcripts, I also made personal memos of my thoughts, feelings, questions, musings, images or theoretical threads that sprang to mind that could be suggestive for further consideration as possible focused codes. I also took note of possible implicit actions or meaning or tacit assumptions of the phenomenon and gaps or opportunities missed for further questioning, which could be fed into the next interview.

I was aware of the possibility of my sensitivity to code certain concepts from my own preconceived ideas; therefore, it was useful to make memos of the process as I went along to refer back to when needed for checking. It was impossible to remember all connections, so the memo section also allowed me space to make comparisons and connections and build upon ideas throughout the analytic process as an aide-memoire.

3.6.1.3 Cutting

After I had coded and made my initial memos for each transcript, I physically cut the scripts up and began tentatively to group/organise the initial codes (ideas) into piles. This physical grouping process of the descriptive codes felt a more manageable way to begin to organise and make sense of the data.

3.6.1.4 Constant Comparative Analysis

Charmaz's guidance allowed me to pay attention to physical or mental actions or states of being, meanings, process, agency, situation, self, identity and gaps (Charmaz, 2014). I moved actively between data collection and data analysis, which included searching the transcribed data for emerging tentative codes and then comparing them to subsequent codes to check for frequency and significance to check and refine in subsequent interviews, becoming increasingly more focused and theoretically substantive.

As I became more practised in the interviews and more grounded in the comparative back and forth process, I was able to be more focused in the subsequent interviews as they progressed, as was evident in the interviews becoming longer in duration and my own process of feeling more engaged, more relaxed and more excited and sensitive to the possibility of new categories emerging in the data.

3.6.1.5 My Additional Step – Grouping Initial Codes

Due to the sheer number and breadth of initial codes, I felt the need to include an additional step of grouping the initial codes to help organise the data and begin building a picture of more focused codes. This was a naturally emergent process, with codes and grouped initial codes emerging from the data. As these ideas began to take shape, this additional step made it easier to compare new data with my developing codes and explore their interaction and how they might potentially fit together into more focused codes.

3.6.1.6 Focused Coding

Focused coding included selecting the most frequent and significant groups of initial codes identified and testing them against the subsequent and previous data, to begin to integrate and formulate analytical categories and their properties. Testing further data on emerging categories acted to validate and refine these emergent categories (Charmaz, 2014). Deciding on focused codes included condensing codes

into groups which made the most sense of the data and checking they accounted for all the data and what they potentially revealed theoretically (Charmaz, 2014). I tried to keep as tight a theoretical fit with the codes as possible to stay grounded (Thornberg et al., 2013). This approach helped me to begin to speculate about the therapists' experience and begin to build the 'analytical frame' of my grounded theory. This part of the analysis felt more interactive, comparative and immersive, where I was able to get to know the data well, establish a level of theoretical sensitivity to it, and therefore more easily be open to and notice new categories emerging, as well as data that did not necessarily fit with my existing emergent ideas, capturing the phenomenon in its full complexity.

By the end of the eight interviews, I was able to organise the 16 groups of initial (grouped) codes into eight tentative focused codes which subsumed all the initial codes and began to represent a sense of the type of work practitioners were 'doing' with their clients. This process allowed the data to feel more manageable, and I gained a sense of connection to the work and the underlying processes involved between client, therapist and context and within and between the categories (see Appendix K for Focussed Coding).

3.6.1.7 Theoretical Coding and Constructing - Building Links and Relationships in the Data

The grouping of the initial codes emerging into focused codes allowed me to explore and map (visually) how the ideas might potentially integrate into a theoretical framework and tell the participants' stories of their experiences of the phenomenon. As focused codes began to take theoretical shape, relationships within and between these categories also began to emerge (see Appendix L for Theoretical Coding). Glaser (1978) suggested theoretical coding as a way of conceptualising the relationship between substantive codes to be brought together into an integrated theory. While Glaser explores the necessity of prior knowledge for the researcher to

have a level of 'theoretical sensitivity' to appreciate the relationships in the data, I agree with Charmaz (2014), who suggested that understanding of the relationships emerges from the sense-making process of integrating with the codes and the phenomenon itself. As I immersed myself in the codes, theoretical codes began to stand out as I began to consider 'what is the practitioner doing within this' at a conceptual level. Therefore my experience is in line with Charmaz, who explained that 'a significant theoretical insight' can occur 'when you enter an interactive space with your data' (Charmaz, 2014, p.146). From the focused codes, I was able to build inductively a picture of three theoretical areas of the work in the therapists' practices from which one core concept which was inherent within all of the codes/categories emerged from the data. My memoing and research journaling process shows where these analytical decisions, and leaps considered, were eventually made.

3.6.2 Stage 2 – The Refinement Group

Once the tentative model under construction had been brought together and discussed with my supervisor, all participants were sent the grounded theory under construction for their consideration and feedback, with an invitation to a refinement group session to consider/reconsider the findings together. Three of the eight participants were able to attend on the day of the refinement group. Within the group, I gently encouraged reflective exploration; this felt particularly relevant in this stage of the research process when the participants were part of a group and co-researcher process (DeVault & Gross, 2012).

Participants were briefed that the collected data from their individual interviews would form part of a model/theory that would be discussed in a group session. Participants were aware that some verbatim data would be taken directly from their interview process but would not be identifiable at any time. Participants were able to comment or disclose this in the group session if they so wished.

This group acted as a validation exercise, as a means of bolstering the trustworthiness of the model so that participants felt it was an accurate reflection of their practice and research process. This discussion group also acted as part of an ongoing interaction and refinement process with the data between the 'viewed' and the 'viewer' (Bryant, 2003). The group was then able to reflect on the potential implications and real-life application of the theory/model constructed from the data to refine its clinical/practical use. Prompt questions were used to facilitate the group discussion (see Appendix G).

Of those participants who could not attend the group, four out of the five participants offered their feedback via email and one did not respond. Their feedback was fed into the group session and, together with the group feedback, was transcribed, coded and brought together in the final grounded theory. This process required a reflective look at the coding process and memos for reconsideration of the categories, taking figure or ground positions in the final theory and write-up.

It is clear to me that the refinement group was a crucial stage of the research process and it led me to reconsider and reconfigure what categories became figural and ground within the final grounded theory presented.

The interviews and refinement group alerted me to the high energy and passion 'out there' of the participants, and the professional field from the challenge the interviews and group offered for further exploration of the research questions. However, it felt important to gain a sense of the response to the model, and therefore the group allowed me an active space to test its fit, relevance, workability and modifiability to become even more applicable to clinical NHS practice.

3.7   The Ethical Journey

I very much relate to the quality of ethics being referred to as a 'practical wisdom' (Levine, 1998; Aristotle, 1994). I employ a pragmatic, value-based and contextualised approach to the ethical/moral decisions made in relation to research. If ethical considerations did arise, I reflected on my own morals and values and common sense in consultation with my 'research community' (Krale & Blinckman, 2009), comprising primarily of my research supervisor, local Research and Development Department, Health Research Authority (HRA) and relevant ethical research guidelines.

I consider ethics as a process, from prior to the ethics application and at various stages through to consideration of the dissemination of my results of the research process; from my decision-making around the focus of my research and in relation to the relevant ethical guidelines outlined by (1) Metanoia Institute and Middlesex University, and (2) BPS code of research ethics (BPS, 2014). The ethical approval process was completed in liaison with Metanoia/Middlesex University and with the NHS HRA (see Appendix C & D for approval outcomes).

Throughout the ethical research process, there were four main areas which required my ongoing ethical consideration and attention (Krale & Blinckman, 2009):

(1) **Briefing, consent, and the right to withdraw**. My intention, aim, design, potential risks/benefits of the study including plans for dissemination and potential publication was made clear and explicit to the participants from the outset to allow for mutual understanding and fully informed engagement in the research process. This approach allowed me to gain full, informed verbal and written consent. Full written information on the study was provided beforehand and discussed on an individual basis allowing for voluntary, considered participation. Participants were given the opportunity to ask any

questions and informed of the right to withdraw from the study at any time. However, no participants exercised this right.

(2) **Participant/researcher interaction and well-being**. I aimed to approach my interactions with participants in the same way I do my clinical work; considered and with respect. While reflecting on the importance of the research process, and the potential benefits of a grounded theory approach to elicit rich data from the perspective of the practitioner, I acknowledged that the nature of in-depth interviews might create closeness similar to the therapeutic or supervisory relationship. I aimed to balance rigour and depth with what is viewed as respectful and ethically acceptable (Bor & Watts, 1999). Participant needs were prioritised over research goals and attention was paid to these changing needs of the participant(s).

There was the possibility of the participant experiencing a level of unexpected distress, either through the in-depth interview or group process, where practitioner vulnerability may come to the fore; however, this did not appear to occur during the interview process. Nevertheless, the design of the research, allowing for a second meeting (of the refinement group) created a sense of increased closeness to the participants and their practice, which allowed for an emotional depth I was not expecting in a research interview process. For example, one participant recounted her experience of working with a particular client with persistent embodied distress. The story moved me to tears. In some ways, it supported my belief in the importance of the work with these clients and the research as well as my connection to it, but also to the importance and significance of the therapist contributions and my powerful learning experiences through the research journey.

The refinement group session seemed to serve both as a reflective and debrief opportunity and space for both participants and me as the researcher. I shared how invested I was in really learning from their experience and representing a true account of their experience and voices in the NHS; this felt crucial to my research design, intention and researcher-participant relationships.

(3) **Confidentiality, data protection and participant and client anonymity.**
Consent to audiotape the interviews and group session was gained from participants prior to each stage of the data-gathering process. Participants were asked to use client pseudonyms throughout the process to ensure client confidentiality and ensure that participants felt they were in a safe enough environment to attend and discuss their experience openly and honestly. For instance, some participants who currently work for the NHS may have considered the risk of information leaking if the literature reached the public domain for fear of reprisal. Therefore, no personal information was disclosed to anyone else, apart from my research supervisor, throughout the research process. No safeguarding/risk issues arose which would need confidential information to be disclosed.

A confidentiality contract was agreed and signed between the participant and the researcher. The data was stored securely on a password-protected memory stick between locations and on a password-protected computer during the research process until research completion, when it would be destroyed.

(4) **Participant feedback, debriefing and after-care.** The constructed theory was sent to the participants before the group session for their feedback. Debrief time was protected at the end of the interviews and group session to

discuss any issues and answer any questions or concerns in relation to the research. A follow-up phone call and one-off individual session were available (if needed) for those participants who were unable to attend the group session; these were offered but not requested/needed by any of the participants. All participant expenses were reimbursed, and the least disruption to the participant was prioritised.

3.8   Trustworthiness

3.8.1   Researcher Reflexivity

With my own clinical background of working within the NHS, with my own individual integrative stance, I acknowledge the subjective and intersubjective nature of being involved in the construction of this particular research, which influenced my questioning, choice of design, data collection, participant selection, data selection, interpretation, and theory construction. To address this insider/outsider position, I was interviewed both before and following the data gathering stage, as part of a reflexive process, by one of my doctoral peers. This step was taken with the intention of identifying my prior clinical interests, underlying assumptions and theoretical proclivities that may have coloured my analysis of the data (Bulmer, 1969). The self-interview process was therefore helpful to me, as it made me aware of what I already knew and thought about the research area. Although this data from my own reflective interview and the pilot interview was not used directly in the finalised model, this awareness and recognition allowed me to identify and therefore bracket 'extant' theory, thus foreseeing possible favoured categories in the data.

During the last two years of my research process, I was also supported by a fellow student on the doctoral programme at a similar stage of her research. We would

hold weekly Skype sessions and discuss issues of the personal-research process, issues of feeling stuck, or the need for reflection.

The most ethically important moment was triggered by one of the participants during the refinement group, who fed back that the model presented did not fit and resonate with her experience of working with this client group. I had potentially missed something important about her embodied experience of what it meant to be a therapist working with these clients. My ethical dilemma related to how to respond and allow her voice to be fully represented in the refined model. This incident reminded me that it was important for the individual therapist's voice to be heard and for them to feel that the model reflected their experience, as well as representing the collective group and remaining true to their experience as it emerged from the data.

Within the refinement group process, I asked for their feedback as to what they felt I might have missed; this led to a fruitful, high-energy open conversation and to my decision to go back to the data and spend time with each participant again. I listened to their recordings and read their transcripts, and I thought about how they practised. What was the essence of them as therapists? What was important in their work with these clients? What was unique to them? But also, what was common to them as a group? This new data led me to the refined finalised grounded theory presented in Chapters 4 and 5.

Ironically, from the group process, I realised what was essential and missing from the model was that the voice of the therapist, both collectively and individually in the context of their experience, which needed to be honoured. Therefore, going back to the material, along with the data from the refinement group, allowed me to honour their embodied experience and learning journey as therapists in the NHS, which became central. Due to the breadth and wealth of experience and diversity of the participants, this was not an easy process, but I hope the final model more fully and

authentically represents all of the therapists as individual participants and as a collective voice in their entirety.

This tension created the opportunity to go back into the data and explore what I had potentially missed in the earlier analysis that was relevant and to explore why I had potentially missed this aspect of the therapists' experience in the intersubjective process. On reflection, this particular participant felt most familiar to me, and I soon realised that a lot of our past professional values, training and clinical experiences and interests were aligned. I wonder now whether, in bracketing my own beliefs, I had in some way inadvertently bracketed some of hers.

This moment refocussed me to my ethical commitment to the research process and the participants themselves and the relationships I had built with them, to truly represent their experience and their understanding of the work and the process. To remain true to the data and participants' voices so that they felt heard and that their contribution as individuals had been valued.

3.8.2 Credibility

Due to the grounded theory data-gathering and analytic process, multiple participants acted to triangulate the data, until new categories emerged sufficiently, thus reflecting and validating the idea of multiple realities. The variety of sources of information including my observation, interview data and other written reflections offered by the participants add credibility to the research findings. To avoid the 'anecdotal' examples potentially given by participants, I attempted to access participant knowledge about contrary cases (Silverman, 2000) as well as cultural and contextual elements by asking explicitly about these areas. In addition, a second researcher/critical friend blindly coded and cross-checked the coding for the first two interviews (see Appendix I) for her codes and memos.

3.8.3 Dependability and Confirmability

I wanted to ensure the research findings and analytical process (from research design through to completed theory) were made transparent and were grounded in verbatim quotes and a paper trail available to increase dependability/confirmability. I wanted to follow the key aspects of grounded theory methods as advised by Charmaz (2014) to increase the 'analytic power' of the qualitative process, whereby the finished product will have 'a close fit with the data, usefulness, and conceptual density, durability over time, modifiability and explanatory power' (Glaser, 1978, 1992).

The reflection/refinement group session acted as a form of participant checking and allowed participants the space to expand, reconsider or finish incomplete pieces started in the individual interviews, as well as give their feedback and contribute to the refinement process if they wished. My main intention was to ensure the interview data fully represented participants' views and voices as accurately as possible and that they were accurately represented in the final model.

4 FINDINGS

4.1 Introduction

In this chapter, I consider my key findings which, together, form the basis of my grounded theory and response to my research question: **counselling psychologists and psychotherapists in the NHS: What can be learnt from their work with clients experiencing persistent embodied (somatic) distress?**

I begin with an overview of my findings, including my grounded theory. I offer a breakdown and more detailed description of what emerged from the data in relation to each of the sub-categories identified, paying particular attention to the context of the research within the NHS. I offer excerpts from the participants themselves, to evidence the practitioners within the final grounded theory and the voices behind the categories to illuminate what I believe to be their significant contribution to the research and practice field. Table 3 (Appendix P) shows an example of how in-vivo codes were used to form each initial code for the sub-category, 'Connecting Client-Therapist-Organisation'.

I have offered full visual representations of my step-by-step analytical coding process in the Coding and Categories table (see Appendix N). I have included a summary of my reflections, experience of the data gathering process, and changes made to the theory after the refinement group, which also contributed to the grounded theory process and the final theoretical framework proposed.

In considering the above research question, I set out to understand how counselling psychologists and psychotherapists within the NHS work with clients experiencing persistent embodied somatic distress. My aim was to develop this understanding and knowledge into a theoretical framework that could guide future clinical practice within this practice area in the NHS.

The findings were drawn together from therapist interviews, feedback from a refinement group and grounded theory analysis with eight experienced NHS therapist-participants, reflecting on their clinical work with clients experiencing persistent embodied somatic distress. The model constructed from these sources is shown in Figure 1.

4.2   Overview of my Findings

The three main practice areas (core categories) highlighted as central in the work were:

(1) Providing an embodied therapeutic experience.

(2) Managing connection tensions between client-therapist-organisation.

(3) Making connections between context-mind-brain-body.

Each of these categories identifies actions and processes involving the therapists and reflects the complex relationships between the different components within each category and between these three practice areas Table 2 (Appendix O) shows which participant contributed to the development of each focussed and grouped initial code.

The main codes identified have also been described to show the nature of the work undertaken within each of these practice areas (see Appendix M for a table showing how initial codes were grouped into categories). The theoretical framework proposed was constructed from the analysis of the interview data and the actual words used by the participants.

The findings highlight the complex areas of the work with these clients in the NHS and the key considerations and challenges/tensions in the different areas of work. The overarching core category that emerged was what I have termed, 'The

embodied therapist as a bridge in the NHS', through which all work, connections and tensions are held.

Overall, therapists suggest making connections for the client through the use of attachment-informed practices, working holistically with the body and contextually, providing individual consideration and treatment planning for each client. The influence of the cultural roots on therapists' attitude and approach has also been highlighted. The findings bring the individual clinical practice elements of the work to the foreground and highlight the difficult tensions arising in the work within the NHS for the therapist. The model also suggests our unique contribution to this client group and the NHS as a therapeutic profession.

The table in Appendix M shows the sub-categories (4), focussed codes (3), and groups of initial codes (2), and their related properties (1) which emerged from the data. Codes which emerged in the earlier stages of analysis helped develop codes and categories in the subsequent stages, and a core category was developed from my understanding and interaction with the data at each of these stages of analysis.

THE EMBODIED THERAPIST AS A BRIDGE

(Making Connections and Managing Tensions)
IN THE NHS

CONNECTING CLIENT-THERAPIST-ORGANISATION

- Offering as a professional discipline

- Bridging organisational complexity

- Managing power processes

CONNECTING (INTEGRATING) CONTEXT-MIND-BRAIN-BODY COMPLEXITY

- Meeting the client in their complexity

- Formulating and contextualising distress

- Integrating body and non body based interventions

PROVIDING AN EMBODIED/ THERAPEUTIC EXPERIENCE

- Providing a therapeutic attachment informed relationship

- Using self of the embodied therapist in the work

Figure 1. Grounded Theory Model of 'The Embodied Therapist as a bridge in the NHS'

4.3   The Grounded Theory

The grounded theory, entitled 'The embodied therapist as a bridge in the NHS - making connections and managing tensions', suggests three interconnected areas of work with clients experiencing persistent embodied distress. The model (Figure 1) highlights these three areas and the complex set of tasks and tensions that exist in the therapeutic work between them.

The main premise of the theory is that the culturally embodied presence of the therapist supports the provision of a therapeutic and attachment-informed relationship which together creates a connection (bridge), through which all other aspects of the work are then possible. This connection is achieved through the therapist's dynamic relationship with both the patient and the organisation and their capacity to help the patient make connections across context-mind-brain-body and manage tensions which exist within and between these elements.

The initial area of the work consists of the therapist providing a therapeutic foundation through the provision of a therapeutic and embodied experience for the patient; this connects with the therapist's own capacity to remain culturally embodied in the work. Together, these elements develop a connection between therapist and patient that allows a bridging to other streams of the therapeutic work. This initial stage suggests a structural element to the therapeutic work. These initial aspects of the work are pivotal to be able to hold and manage the levels of complexity within the work at both an interpersonal and organisational level.

By establishing a connection and bridge in the relationship with the client, it becomes possible for the therapist to begin to bridge other elements of the patients care; connecting complex organisational elements within the NHS, as well as beginning to integrate the complexities of the patient's experience (across mind-body-brain and context). These two streams support and interact in a number of

ways (see Figure 1). An example of the interconnectedness of the different areas of the work is as follows.

The therapist helps the client make connections by formulating and contextualising their distress. For the patient, this also connects and helps bridge a number of organisational complexities; for example, by helping them manage power processes and relationships. In this example, the therapist helps connect client and organisation by using themselves as a bridge to help manage any tensions. As a result, connections are made at mind-brain-body and contextual (organisational/systemic) levels. This suggests interactive and dynamic elements to the model and components within it. Further elements and their relationships within the model are now discussed in more detail.

4.4   The Grounded Theory - Key Findings

It was evident from all eight interviews that the therapists' unique integrative perspective, approach and capacity to make connections with the client was central. This connection was achieved through (1) providing an embodied therapeutic experience, (2) making connections between the client and organisation (with the therapist acting as a bridge), and (3) connecting all aspects of the client's experience at multiple levels. These findings were shared with the participants for refinement. It was one participant's clear feedback that, 'it's all there, it just doesn't connect with me', that allowed me to go back to the data and establish what was missing, which was the significant contribution of the embodied experience of the therapist as a bridge in the work. Within this context, the therapist's role included making a number of different connections, holding and managing a number of tensions through the person and body of the therapist. One participant (Participant E) described the process of being an embodied therapist:

Somehow, we embody the institution as well because when we are
with patients we are completely ourselves. In a way, we create a
bridge through our body, through our way of being part of the
institution and yet relating to them through touch, through love,
whatever, and it could be that is the most healing part… this is what
is healing because the therapist embodies the institution, and all of
this we've got in our body as well on some level… And so, you create
a kind of total holistic integration in that moment.

By being present, authentic and embodied in the work, the therapist is able to provide the therapeutic foundations needed to address the need to make connections and manage the tensions that exist between client, therapist and the organisation. The therapist can also begin to manage the complexity of the therapeutic work, connecting the client to the mind-body-brain-context processes.

4.5   The Three Core Categories

4.5.1 *Providing an Embodied Therapeutic Experience*

There were two focussed codes which emerged from initial codes, which led to the development of the first core theoretical code and category, 'Providing an embodied therapeutic experience'. This category very much describes the foundation of the work undertaken with these clients and the connections made through the embodied nature (values, attitude and presence) of the therapist, connecting with the client by providing a therapeutic and attachment-informed relationship.

Interestingly, all eight participants agreed they did not feel the NHS affected their relationship or how they engaged with their clients.

4.5.1.1 Providing an Attachment Relationship

All eight participants were clear that treating the client as a human being with individual needs was crucial in their work and in building a therapeutic alliance. This process was supported by a number of elements related to a person-centred approach and their work being informed by a number of attachment ideas.

Working with the client as a person

This idea relates to the participants speaking about the need to individualise client care and treat the client as a person first, listening to them, validating their experience, believing them, and not seeing them as a diagnosis or label. One therapist (Participant G) highlighted how she aligned herself with her client as a key principle in her practice:

> *There was one principle in my experience of working with patients*
>
> *with these presentations where I felt it was constant and I applied to*
>
> *all patients with this condition, and that was to believe them that they*
>
> *suffered in their body, that the pain was real and it wasn't all in their*
>
> *head, and that was the beginning of the alliance… They were not*
>
> *interested in the source of it, they were interested in being believed*
>
> *by the professional, okay… not to challenge that sense of there may*
>
> *be a psychological component to it, until I believed them, until I*
>
> *listened to the story of their body.*

While Participant G emphasised fostering an alliance with the client, Participant C reflected on this idea in terms of personalising care around the needs of the client:

> *It needs to be personalised, it needs to be flexible, and it needs to*
>
> *come from people who are… err… I think, who have an*
>
> *understanding of distress and an ability to work with distress. So that*
>
> *would be the three bottom criteria, I think, to just be able to create a*

84

service that works, but pain is such a, or any physical... is such a

personal thing, that everybody is slightly different, and everyone has

slightly different needs.

While Participant C explored the need to flex in response to patient needs, other

aspects of the idea of treating the patient like a person related to considering the

interconnected nature of the patient's life, where difficulties in one area may have a

knock-on effect on other areas, as highlighted by Participant A's account of her

client becoming a new mother:

How much is the baby resting and, I think for mental health, that is a

key factor… why would you not ask a little bit more about the

patient's life instead of just the fact of... How are you feeling? Are you

having hallucinations? Well, actually, if you've not had sleep for three

days you might be having some hallucinations whether you're

psychotic or not (laughs) was kind of my, that's why I was like, but

hang on, you need to ask this lady how is the baby doing, yeah, all of

these yeah, it seems to get missed. The patient is a human being.

Providing Attachment-Informed Structure

It was apparent that all eight therapists (whether explicitly or implicitly) were

practising with the attachment history of the client in mind. The structure in the work,

in the context of the client's NHS journey over time (lifespan), was mentioned by the

majority of the therapists. Therapists talked about the time needed to establish trust

in the early therapeutic relationship, pacing and flexibility, an agreed focus for the

work, and the relationship and managed endings in therapy. For example,

Participant G spoke of the importance of trust in the early work:

It varied from patient to patient and their relational patterns, really. Some

patients can attach quite easily and trust quite easily. So, it wouldn't take

more than 2-3 sessions, whereas with other patients who have rigid

defences, it would take them much longer because they had the kind of

mentality of suspicion… So, I had to find a way around that basically, and be

patient and wait until that individual was ready to loosen up his mentality of

suspicion of the professional, engage in a more trusting kind of dialogue with

me.

She went on to discuss the importance of attachment-informed structure in the NHS
and the associated tensions in practice related to this:

The answer is resources and treating each case uniquely and not just be

wedded to this notion of six sessions for all or one year for all… open-ended

therapy. Again that's a luxury these days in the NHS and I think that's partly

why the NHS is failing these patients who need the continuation and the

constancy to develop that alliance so that you can go to the depth of their

problem… You're just scratching the surface and then you're sending them

away, someone else scratches the surface and it's a cycle, repeated cycle

and they become institutionalized in the end.

Participant G highlights the structure needed and the iatrogenic risk attached to
current practices, and Participant A suggested an additional consideration as to how
therapy could be offered in the NHS. While working within an IAPT service, she
stressed that client needs are central:

 …they viewed six sessions as six sessions (referring to other counsellors/

therapists), whereas I often viewed six sessions as an opportunity to almost

support patients that were in crisis and then hopefully get them longer-term

support if that's what they needed.

Thus suggesting that the therapy could be considered as part of a bridging or transitional and longer therapeutic journey, instead of continually focusing on how to discharge the patient at the earliest convenience.

Providing Attachment-Informed Care

Areas highlighted by many of the therapists were; the need for containment and soothing, empathic attunement, understanding and managing expectations of the relationship, and the therapist role and boundaries of the relationship. One therapist (Participant E) highlighted the importance and difficulties of establishing trust with these clients in the context of the NHS:

> *…building a relationship with this patient is not the solution but it's often what fails because they are so complex.*

This view suggests that complex trust issues exist for these clients. The complexity of this area of practice was further supported, with all eight of the participants clearly describing their practice and difficulties in terms of the attachment and the therapeutic alliance. For example, many therapists spoke about the attachment history of the client and/or their adult patterns of relating in the work and their associated attachment or therapeutic needs, expectations, deficits or expectations of the therapist and of the relationship. One therapist (Participant G) clearly considered the quality of the therapeutic alliance and persistent care-seeking in terms of the client's early attachment history:

> *I wonder whether these patients who are in the system for many many years are the patients who actually developmentally have a deficiency in attaching themselves or entrusting themselves in the hands of another… So I think that fear of the catastrophic disappointment keeps them at a distance from fully engaging, fully revealing, fully opening up to exploration and collaboration. So if you like to describe it in terms of the alliance, the alliance*

> *is always temperamental. It's never stabilised with these patients, but they will not give up the hope that they will find the ideal parent, so they are on a quest so moving from one therapist to the next.*

Psychological defences were further considered by a number of the therapists' observations. Some, such as Participant A, outlined the tensions of working clients' attachment difficulties and defences in the NHS and the need for a 'continuity of care' approach:

> *…because the patients build up a relationship with you… they don't want to see somebody else, they will wait to see you. They were often also, the ones that ended up coming back into the service because they were having one session and then not another session for another 4 weeks so it's not, in my experience, it wasn't effective as a therapeutic treatment because there was no continuity of care for the patients.*

Participant A went on to explain the importance of continuity for the client in relation to their developing sense of self and the sense of being known by the therapist to support the client's sense of growth:

> *Continuity there seemed really important to patients, because they would say, I saw so and so last week, now I have to rehash the whole story when I don't really want to be talking about that, I want to talk to so and so about what I was talking to them about because they will know whether… will also be able to help gauge whether I am any better because they've gotten to know me.*

Again, this view highlights the desire to support the client's individual needs for consistency and continuity in the NHS.

4.5.1.2 Using Self in the Work

There were a number of ideas (codes) that emerged and came together in the sub-category of 'Using self in the work', which involved various ways in which the self of the embodied therapist connects with the client in the therapeutic work.

Transmitting the (cultural) values/attitude/presence of the therapist

It emerged that the attitude (and behind that, the cultural values which underpin this attitude) was central in engaging with these clients and guiding the practitioners in the work. This attitude seemed to translate into practice by therapists being above all respectful, open, and honest with themselves and their clients. Feeling able to speak freely and directly about the body was very much described in relation to their own way of being in the world, embedded in their cultural upbringing and history, with seven out of the eight therapists being of foreign descent. Several therapists talked about this explicitly; Participant G said:

> I'm Greek, I'm Greek and we're sort of tactile and physical and expressive you know… I grew up with a mother who was running around naked in the house doing the housework…

While Participant G emphasised the influence of her Greek upbringing, another therapist (Participant E) shared the freedom she felt as a 'foreign' therapist:

> …as soon as you're a foreigner, in a way, you have the freedom that you don't have if you're not. So it allows us to reach patients directly because we're not caught in the structure of you know, middle-class, upper-class…

The freedom she felt and expressed had helped her reach (connect) with patients, transcending culture and class difference and divides.

The other way in which cultural attitude and values were conveyed in the therapists' approach was through the way they talked about their connection and relationship

with their clients. Several of the therapists felt comfortable to use the word love or passion and commitment in relation to their clients or client work or their wider sense of love towards humanity that drew them to the profession. This spirit seemed to resonate throughout all the therapist interviews, with a general expression of openness towards the client; for example, one therapist (Participant E) openly stated:

> *I usually work with an open heart, so I work more with my heart than with my mind, but because I am a psychologist, I have to be able to formulate to assess to ask questions.*

This view reflected my experience more generally of the therapists I interviewed as passionate, authentic and congruent; for example, Participant G went on to say:

> *…everything I said to you, what I do is love. Why would I commit myself, why would I put myself there to suffer and tolerate... love for the other person, love for humanity.*

This point reflected the therapist's connection to her clients and to humanity. The therapists' general approach appears embedded within their cultural experiences and history of the therapists themselves, which is embodied, offered and communicated through their attitude, presence and therapeutic style.

The Embodied Therapist

All eight of the therapists spoke in some way about their personal contribution in their work and the embodied impact of being a therapist. This very much related to their embodied experience, either in the intersubjective exchange or in relation to working creatively with the use of self. Therapists mainly described feeling overwhelmed, challenged or fatigued in the work with clients in embodied distress.

One participant (Participant G) spoke about the importance of the use of self in the work and the tensions this creates for the therapist:

> *The extent of the clinician's own ability to be open, like a sponge and absorb. Because some clinicians themselves are so defended and rigid that they only use their cognitive function. They don't go into the affective function. I say to myself, I must allow myself to be infected by my patient for me to fully understand what it feels like to suffer from this infection. So it's like opening myself but that drains your resources, it's very tiring.*

Participant G highlighted both the importance of affect in the work and the importance of the openness of the therapist to working with this emotion, while another therapist (Participant E) warned about maintaining boundaries around the use of self in relation to the use of self-disclosure:

> *I've got this patient, it was funny, and I was so unwell… I looked at myself in the mirror, I had some really powerful stuff happening inside… I can't see her, and she's going to see everything. And you know, it's true, some patients are so attuned to who we are that actually if we disclose too much then it overspills on their own field and they can't remain a receiver… so I'd be careful with possible, with very sensitive patients, to be careful with that.*

Participant E carefully highlighted the tension of her own embodied process material in the intersubjective space. She went on to suggest:

> *Sometimes, if we have been through it and we fought it, it gives us a voice or a right to say, 'you could do this'. If we haven't been through it, what right do we have to say that, you know.*

This point relates to the other aspect of the use of self, which was considered by most of the therapists in the study and which related to their connection and

understanding of embodied distress in the work. This view was supported by another therapist (Participant C) who shared her own view of distress and the use of self-experience:

> *You cannot come in from a medical vantage point thinking that you can tell people how to be and what to do... rather than it being relational… I think to be able to put oneself into somebody else's shoes you just need some sort of similar experience, it doesn't have to be the same… So I think it's more the overall ability to understand distress… it's more, it's a bit more like having a therapist who never had any problems let's say, they don't understand the idea of distress at all physically or psychologically and then having somebody who has... in whatever shape or form struggled with life… but I think there needs to be understanding of what distress on a physical level looks like.*

As Participant C reflected on her own embodied process and its use in the work, Participant B reflected on her own prior experience with her daughter and how she allowed this to facilitate the client work:

> *As a clinician, that's probably what made me choose counselling psychology over clinical because I feel like, as a counselling psychologist you always keep yourself in the therapy room just a little bit more, not too much so that it's not contaminating the session, but very aware of what is pulling up for you… Yes, I allowed it to come through and I allowed it to be used in a really effective way.*

In doing so, Participant B was open to working creatively with the use of self and to using her prior personal experience to strengthen the client-therapist fit in work with her client.

Working with Unconscious Process (Embodied Relating)

Most therapists talked about their embodied countertransference or embodied empathy as overwhelming, and the need to consider self-care as a result. For this reason, it felt important to distinguish and categorise 'unconscious process' as a separate sub-category, instead of including this experience under 'the embodied therapist' sub-category. An example of a strong unconscious embodied process was described by Participant D as she spoke about a particular case:

> *I have very strong empathic and counter-transferential response to that, um, to the point of feeling actually quite physically sick when there's been a history of violence in particular… but that's not part of my history, so I know it's not my own stuff at play, um, because I don't have violence in my history but there's something about clients who had violence as children, um, that really make me feel quite nauseous and so I will, um, take crayon to paper and I will do some mark making and some urghhhhhh, you know.*

This example given by Participant D felt very important because of my reaction to her response. In the interview I began to feel similar symptoms to the therapist as she spoke; I mirrored her experience on me as the researcher, suggesting the power of the unconscious process of these clients and further supporting the existence of this category. At the level of unconscious, symbolic, embodied relating, Participant G hypothesised about the process of embodied relating as a way of communicating with the therapist:

> *And I started to notice and think in terms of whether there was some kind of disassociation or whether I acted as the container for carrying her own bodily distress and this is a kind of cathartic process for her, okay, where she leaves me carrying that distress… I think that's another level of relating with patients.*

Participant D developed this idea further, suggesting that embodied communication communicates a number of different things at different levels; for example, the voice of the client and voice of the organisation, and what we are therefore able to offer:

> *We're working with unconscious processes and so often we're holding the voice of the unconscious on behalf of the agency or the organisation… and then all kinds of things can happen dynamically within the organisation… I think we have that to offer.*

This point highlights the unconscious connections being made through the embodied use of the therapist, and the dynamic tensions that exist as a result between client, therapist and organisation.

4.5.2 Connecting Client-Therapist and Organisation (NHS)

The second sub-category which emerged from the data was 'Connecting client-therapist-organisation'. Here, the therapist acts as a bridge to connect the client to the organisation and the organisation with the client through the therapist's embodied relationship with both.

4.5.2.1 Contributing as a Professional Discipline

It was clear from their experiences that the therapists in the study felt that our profession had a role and made a unique contribution to the NHS; something I have come to term as 'Working at the edge'. Most of the therapists compared their professional skills to clinical psychology within the NHS in favour of counselling psychology and psychotherapy. They considered that our unique contributions with these clients included working holistically and integratively and with the capacity to work with the unconscious process, as well as working creatively, reflexively, individualising client care, and with a relational focus. For example, one therapist, Participant G, noted:

Psychotherapy has brought the relationship at the centre of what we offer, that's the healing component.

Participant G's view was echoed by another therapist (Participant F) with a clear sense of the worth and contribution to the NHS:

I think in the health care environment, um, psychology and counselling have something very special to offer, in the sense that patients can feel heard and valued and listened to and hopefully have a bigger picture understanding of how things fit together.

While Participant F considered the conditions of the therapy and the connections made in the work, the other aspects of our contribution relate to therapists 'working at the edge' of the profession and at the edge of the NHS. At least half of the therapists spoke about working differently or taking risks and working at the edge of their professional boundaries for their clients. Participant C demonstrated a beautiful example of how the therapists I spoke to were willing to work at the forefront of helping, taking risks and trailblazing for what they believe:

I get a lot of flak... you can't do this, you can't do that, and I'm like... well why not? I mean, I set up this therapeutic knitting group and people like, say... oh there's no evidence of that, of course, the evidence then came out two years later where people said... yes actually, it is a very valid intervention but I'm of that opinion that, you know, you meet people and if you're attuned you find out kind of what they need you to give to them… I'm sorry, that just really winds me up and it's just another shied of saying, I'm not going to give you what you need. I can see what you need but the research says you shouldn't be having this right now.

Importantly, Participant C highlighted the attunement to the client's needs. A number of participants shared their diverse breadth of professional skills. An example of this

was described by Participant E, who was also a shamanic healer, who spoke about working at the edge of the profession:

> *I've taken risks … So that's the privilege of really being a psychologist, that you do what you want in the four doors, so in a way, they are our guidelines but, you know, some people follow guidelines and others are a bit more wavy, you know… I suppose I'm the second category.*

Participant E went on to give a culturally relevant example of her practice, which demonstrates the importance of our contribution as a diverse profession, continuing to offer a wealth of knowledge and diversity as well as creating tensions for the therapist to hold:

> *One day I was doing shamanic work, and one day we received letters from commissioners, saying to my boss, could you explain to us what we have heard that actually this woman has been asked to put eggs under her pillow during the night. We have commissioned you to do CBT. I don't ask people to put eggs under their pillow but sometimes it's a bit strange what I do. And actually, it was amazing to have the boss I have because you know, work for BPS and transpersonal psychology, and demonstrate that actually my work was within the NICE guidelines…*

This example highlights the lengths professionals are willing to go to (the commitment) to address and respond to clients' diverse needs with cultural attunement and sensitivity. The example also highlights the real tensions that exist for the embodied therapist as a bridge between client needs and the NHS.

4.5.2.2 Bridging organisational complexity

Here, the therapist bridges the client's understanding and connection to the organisational complexity involved in their care, through embodying the different aspects of the system. For example, one therapist (Participant E) described how

through being embodied ourselves, we connect to the organisation and the client to create a process of integration:

Somehow, we embody the institution as well because when we are with patients we are completely ourselves. In a way we create a bridge through our body, through our way of being part of the institution and yet relating to them… touch, through love whatever and it could be that is the most healing part… this is what is healing because the therapist embodies the institution and all of this we've got in our body as well on some level. So, when you show yoga posture you're not just one evening yoga class cut off from the system… your yoga posture in the middle of the institution has both helped the patient, made them ill, misunderstood them and etc. etc. And so, you create a kind of total holistic integration in that moment you know.

Whilst Participant E explains the complex relationship between the embodied therapist, institution and client, other aspects of this bridging that take place through the person of the therapist include: working across health and mental health presentations and services, various specialities and hospitals, medical language, working with uncertainty and unknown aspects of the presentation, and organisational uncertainty. There are multiple levels of complexity for the client and therapist to be held and integrated through the person of the therapist.

Participant F considered the general lack of holding for these clients in the NHS and the tensions this creates, and which impact the client's experience of care and the therapist's frustrations with system restraints:

You're like, where can I put this person, anywhere but on my list, you know what I mean and it's like… uhh, you would be better off there, I know that they don't do anywhere as much as they should but, you know, and they're ping-ponging around and hopefully when they're done with a piece of work

that's helped… it's like right you're off my list and you're gone… somewhere else, and hopefully you're going to land (shoo-in sign)… Yeah it's just like maybe they'll magically land in from this list on the list that was intended but you don't know, that's another service.

Participant G supported the experience of service in relation to lack of communication and holding of these clients and the area of research needed, adding support for this study:

There isn't that kind of continuation or communication between services, okay, to follow these patients through (yes) and holding of these patients… So it's the lack of that basically… I don't think anybody has actually looked at the dysfunction of this model of servicing people with bodily problems.

4.5.2.3 Managing Power Processes

Working with the Client's Power

There were a number of codes identified in relation to the client's power. Most of these ideas relate to persistent embodied distress and the client's use of services. Several therapists suggested the client's fear of loss of care or hospital bed or medication, or the client's previous experience of NHS care in some way influences the client's power in relation to their persistent use of services. Two therapists also mentioned the power of the client in relation to the threat they pose as a result of complaints made against staff. Participant B reflected on who holds a more powerful position:

Mmm… it kind of makes me think, you know, who the power lies with because… these families, they've been through the system time and time again, and I think they use complaining as a way of power, to get seen, to get their voices heard, you know.

The same participant further deepened my understanding of these clients by explaining their context and narrative in relation to power:

A lot of them have that family narrative of… We're fighters, we fight the system you know, until we get what we want… And I think if you look at that narrative, it makes you realise… why people do that, not because they are horrible, you know… they're doing that because they really do feel that's how you get your voice heard.

A number of considerations for therapeutic practice were raised by therapists, including understanding the reasons for persistent care-seeking and requests for investigations, exploring coping and dependency on NHS services, and developing the client's sense of agency, responsibility and self-management.

Participant A offered her experience of the NHS context to better understand the client's persistent distress and care-seeking in relation to the client's needs:

They had quite a few patients that the staff used to know as almost regular visitors of the service because they knew exactly how to get in… they were working very hard to keep them out… and they would try and give them other options, but they did not want anything else, they didn't want to stay out because… they have a bed, they're warm, there's somebody to look after them, somebody to ensure they take their meds. They might know some other inpatients, so they have friends around them.

This example highlights the complex needs of these clients, but also the tensions between patient and therapist in having different goals and agendas. This tension may also highlight the wider cultural use of NHS services by patients in the UK, as Other therapists also implied that previous positive care from within the NHS might contribute to a client's persistent care-seeking. Overall, therapists felt that exploring coping and dependency on the NHS and related fears were important parts of the

work with these clients, to shift from dependency to responsibility, agency and self-management.

Therapists reflected on the fact that these clients can elicit strong feelings, potential enactments and countertransference responses. This sub-category suggests the client holds power through their intrinsic vulnerability.

Working with the Therapist's Power

The therapist's sense of power or lack of it was raised by several of the therpaists, as therapists began to consider their own position of power and limitations in relation to working within the NHS. The issues of resource and the capacity to work freely and do things differently in line with what they felt the client needs were raised. Several therapists talked about their frustrations with power in relation to responding to the client needs and the associated tensions in the NHS. Participant E highlighted the tensions with clients in persistent embodied distress and the level of trauma present:

> *…there is relentlessness about it, and because there's so much trauma with no power to offer proper trauma work like EMDR with pain, you know…*

She noted that the vast majority of these clients had unresolved trauma (PTSD) and went on to discuss the tensions within this complex work and our own sense of power/powerlessness:

> *With very complex patients we're faced with our own mortality, we're faced with our limitation, we're faced with our powerlessness you know. So potentially we're pissed off at them because they're putting us in front of our vulnerability and our lack of power and that creates tension, yeah. So particularly with very complex, relentless patients, in a way they come with something and they keep telling us you don't know how to help me, and for*

people who devote their lives to help it's not the message that you want to

hear so there's tension.

This view highlights the tensions for the therapist as a bridge in the NHS in this work. In contrast, two of the therapists offered an alternative perspective, challenging the need for long-term work and resources, suggesting that much can be done with a few sessions. One participant stated that we have the training and skills and power to do deep work with these clients but considered managing this responsibly with the reality of the time we have and in line with what the client wants.

From a slightly different angle, Participant A discussed her lack of power in relation to her own self-care when working with these clients, due to lack of resource:

In the NHS I didn't have a choice… I didn't have control over who I would

see, when… and I couldn't necessarily give myself an extra half hour of

space here because perhaps I needed time to go and have a coffee and

breathe. I might have two really tricky presentations back-to-back… Whereas

I won't do that to myself here… that's the big difference for me, being able to

factor my own wellbeing in the terms of the clients I see.

In contrast, two of the therapists talked about their power to use the NHS as a shield from difficult clients, sharing the responsibility with the organisation. Participant B openly considered managing the tensions of getting a complaint and our loss of power and voice:

But I think a lot of the parents of these children that we see do hold a lot of

power because, you know, people in the NHS are afraid of getting a

complaint. So they give them what they want, but actually, it might not be

what the child needs. So they'll send them off to how many tests they ask for

and how many blood tests they want and how many painkillers they want,

and they'll feed into that… and they say they don't like this therapist, so they

give them another one... and they say they don't like that therapist... I'll give

them another one.

This view reflects the need to address issues of power in the work with these clients and the tensions that exist in the work within the NHS context.

Working with Organisational Power

The codes which emerged here tended to relate to the organisation's power and structure embedded within its history and medical model. Participant A stated clearly and simply:

The focus tends to be on the symptom, not the patient.

This inherent power and dominance of the medical approach in the NHS provides and manages resources and supports clients (or not) and puts constraints and boundaries on the practices of therapists practising within the NHS. The therapists also mentioned the power of the organisation to both protect and support the therapist. Participant A highlighted the decision-making power of the NHS:

Yeah, well for the patients that I came across, for them what it did, it meant

the service holds all the authority, the people that they interact with, all the

professionals, they have the authority, they make the decisions... on yes or

no, you're well enough to be here, or actually 'no we're going to discharge

you'… that's what it did, it was very much this patient-doctor relationship.

This suggests a lack of mutuality. Participant G considered the wider organisational power and tensions that exist between organisation, practitioner and client:

Medical practitioners are not patient with them, because these patients drain

resources, so that perpetuates the negative attitude towards patients with

symptoms and non-organic causes… and they end up going on a journey

alone basically because the resources that we need to invest in helping them are not there. The commitment to understanding their unique condition, situation is not there… so unless those of us who are working with them put our souls into helping them and effecting change on a much wider level, social, political level in terms of resources, then this phenomenon will carry on happening for ever and ever.

This suggests the organisation holds power in a number of different ways, embedded within the culture of the medical model and doctor-patient power structure which will potentially influence the client's experience and the therapist's practices. This situation conflicts with more relational perspectives on the client-therapist relationship in which all of the therapists had first-hand experience and were able to reflect on in some way.

4.5.3 Connecting Mind-Body-Brain-Context Complexity

This category outlines the connection and integration taking place at a number of different levels in the therapeutic work in relation to the complex and inter-related human experience between context-mind-body and brain. This category relates to how our experience in the world, our psychological health, embodied experience and biological chemistry interrelate in the work.

Three main areas emerged to consider within the area of mind-body-brain-context complexity.

4.5.3.1 Meeting Clients in their Complexity
It was agreed by all the therapists that a client with persistent embodied distress is a complex clinical presentation and that there is a general lack of training and understanding from general clinicians and the medical professions as to how to work with this level and type of complexity.

Being Open to the Whole Person (at all Levels of Experience)

This relates to the therapist holding all of the person in their complexity. All therapists in the study showed the capacity to work with the client at a number of different levels of experience, including the capacity to work with physical and psychological health in parallel and the relationship between. Participant C considered the connections between different areas of functioning as having a genuine knock-on effect, highlighting the key connection between mind and body interaction:

> *As practitioners, we are like...'well they are not putting in the work or they resisted or whatever'... and not truly understanding that if you don't sleep because you have pain, or your mood is low because you have pain, then this is really hard… really hard.*

This view was supported by Participant B, who gave an example of the interrelated nature of distress, often leading to misrepresentative diagnosis in the NHS as a smokescreen for the underlying origin of the client's difficulties:

> *One ran into another because her anxiety was so high, so she couldn't concentrate at school, and when she dropped out of school, she didn't have any social interaction, so then she became depressed… Then her sleep was disturbed, so because her sleep was disturbed, she had no energy the following day… So they thought, this looks like something else is going on. It could be ME. Then they said it is chronic fatigue syndrome and all these different things... but I think one was causing the other. She had lots of anxiety, she had poor sleep, she had a dreadfully poor appetite, she was worried all the time, she wasn't socialising, wasn't leaving the house... so it all just contributed to the overall symptoms. And it started to look like something very different.*

Participant B highlighted the need to address the client's understanding of how different aspects of their life are interrelated. Therapists considered it important to work at the behavioural, physical, emotional and cognitive levels, as well as with unconscious process. Participant E considered the need for a model to bridge the powerful divide between mind and body of the client and integrate the client's emotional story in the work:

> *I had a model… it created a bridge extremely powerful to engage people while at the same time as honouring the physical condition, slowly getting them to a new narrative that could take in the psychological emotional story… that ability to make a bridge so that they can start exploring their own emotional lives without feeling threatened, without feeling that we reject them or that we deny their physical pain. I think it's very powerful.*

While Participant E highlighted the importance of working with emotion and building a new narrative, Participant G considered working with emotion at the embodied level, using the self of the therapist to bridge the complex work:

> *Trying to get access to the emotional path, the emotional path has always been a challenge with this group of patients. Because as I said, it's the body that does the talking, it's the body that does everything, and it's like de-coding and helping them symbolize… So it's both a challenge, it's fascinating, interesting. But I'm a mother, so I've seen raising two sons… I have seen what it feels like, starting with communication, which is just facial because they don't understand language, to evolving into language.*

Participant G reflected on her own personal contribution and how this informed her approach. In line with this view, the way the therapists approached their work depended on their core training; for example, Participant H gave a perspective from the creative arts psychotherapy approach:

From my side, I sometimes feel helpless to help them because they present

with such complexity. It's difficult sometimes to know where to start. I find to

start with the body is the best place. Where do you feel that in your body you

know? Try to get them to connect with the body, little body awareness things

or some breathing exercises, or something that just takes them into the

body, into making that connection.

Participant H shared the feeling of helplessness these clients often evoke in the therapist and creative ways to make connections with the client and invite the body into the work.

Working with the Client's Sense of Self

All therapists spoke about these clients struggling with some aspect of their sense of self. The case examples therapists discussed covered a wide array of loss, identity, shame, the body, agency and other existential questions which can all be considered under the premise 'sense of self'.

It was clear from all the therapists that with clients in embodied distress, integrating and connecting the clients with their embodied experience in the work was central; for example, Participant H said:

Acknowledging the subjective experience in the body. That's essential.

That's essentially what the work's about. It's not objectifying the body, they

don't have a body, and they are a body. You are a body or body-mind. And

also, they are their symptoms in some ways. You know it's part of them and

what does it represent?

The need for acknowledgement of the body and normalising the embodied process and what it means to be human at the embodied level was further highlighted by Participant B's existential perspective:

I think the main thing that… as human beings, we just don't like distress and this goes back to a very philosophical basis that we should always be okay and we should be well… and I find it kind of fascinating by now that distress is such an abhorrent thing, that we don't easily allow ourselves to be not okay, and I often say to clients, you know, that my kind of model in life is that I'm okay even when I'm not okay… it's a very powerful thing because it makes us resilient but we don't do that… it's not the end of the world, it's just how life functions.

I also gained an implicit sense that integrating loss was figural for these clients in the work, as a result of their loss of health or loss of control of their body as directly related to their sense of self. This point was exemplified by Participant B in a case description:

She felt that she was broken, and when she said that to me about feeling broken and we thought about that in context of being ill all the time… So if you're broken you go to the doctor, they give you medicine, they fix you, they make you better, and she was saying that she'd gone to all these different doctors… she's had stomach scans and all sorts of x-rays and they've injected dye in her and x-rayed her and all sorts of things and they couldn't find an explanation… And she said nobody could fix me… So, every time the doctors referred her back to CAMHS she saw another therapist, but they couldn't repair her.

Participant B also highlighted another iatrogenic factor, as her client was offered yet another therapeutic relationship. Relationships were considered key in developing the client's sense of self. One example that became prevalent was the use of groups and reconnecting to others, the world and their future; as Participant F noted:

Often it comes from people reconnecting with a sense of humanity and caring about each other, because what I think happens a lot to pain patients is that in there, in their strive to kind of take care of themselves, they isolate and protect themselves… If she can do it maybe I can do that, so it motivates.

Continuing to reflect on the benefit of the group process, Participant F went on to connect to the importance of building a future sense of self:

But a lot of the work that we do in the groups is about rediscovering who we wanna be.

These findings support the evidence for self and others in relation to the client's developing sense of self in the work.

Working with Extreme Stress/Trauma and Risk

Most therapists considered that stress and unresolved (complex) trauma were central to their understanding of clients with persistent embodied distress, which may or may not include the presence of mental health risk, which only adds to their level of complexity. Participant E made a very clear argument for the presence of unresolved trauma with this client group:

In my experience, I had never seen anybody who's got what you call it... embodied symptoms, where there's not trauma full stop, you know… So it's all around trauma, how do you deal with trauma. So, unfortunately, in the NHS we had very little space to do proper trauma work. So we always ... it's a pain in the arse basically, you don't have to call it that, but the fact is that actually if we could do proper trauma all these, such research wouldn't exist... full stop.

In naming the prevalence of trauma with clients in persistent embodied distress, she acknowledged the tensions in relation to the therapeutic needs and lack of resources to meet these needs. Participant F also supported the unresolved trauma connection, offering an alternative take on service provision:

> *…for some of the patients that come through they definitely have got trauma that's just never been supported, they've never had any kind of skill development to handle or no, no support to normalise that what they've been through… But I think also there's a lot of patients that have come through that have had it thrown at them, they've had lots of therapy, they've had EMDR thrown at them a couple of times… they've been to the IAPT service, they've been to mental health maybe, or maybe that hasn't happened but… if you've seen your friends die next to you… umm, I don't think any amount of treatment or therapy or EMDR is going to… you've got to learn to carry this with us and so I think we just need to learn the skills to bring it with us to not fight so much with what we've got.*

As Participant F reflects on the existential elements of working with trauma, and the importance of psychoeducation and normalising the distress in its context, Post-Traumatic Stress Disorder (PTSD) seemed to raise further tensions for the therapists:

> *They're the ones I end up calling GPs about; I don't tend to call GPs about anyone else. It's the ones I see that are like, like I've got a gentleman at the moment who is 34/35, he's from Iran, he is Kurdish, he is a refugee and he has fibromyalgia and the most significant PTSD that I have ever seen… I mean, I saw this gentleman twice because I couldn't get to the end of the story, and he told me all about his life, how he came to the UK, all of the trauma that he experienced and so, you know, and then he's really happy*

coming to see me, but I'm not a trauma specialist and that's… his trauma is

not something that a trauma specialist in our team would focus on because

it's not directly related with his pain, okay… because we're not allowed to

just kind of go willy-nilly treating everything… (Participant F)

Participant F highlighted the cultural needs and trauma training and experience required to work with this type of complexity. Participant D further developed this category by identifying the client's immediate psychological and wider needs in the context of cultural trauma:

Trauma is very immediate, very in their bodies, and needs a kind of first aid

kit, a bit like, you know, if somebody is bleeding I'll stick a plaster or bandage

around it… and that actually felt really helpful before you explore… often with

refugees, asylum seekers… you can't go to the trauma and explore it in that

way that I was describing because they're not ready for that, you know…

they need a house first, and a job, and learning to speak English and IT skills

and whatever… and food on the table and whatever… and to be reunited

with lost children and whatever else is going on before you can kind of go

into the psychological work around the trauma.

Although it was agreed among all the therapists that trauma was prevalent with this presentation, two therapists suggested that personal trauma was not always present with these clients, but in the absence of personal trauma, cross-generational trauma was likely to be present; for example, Participant H said:

Not assuming it's trauma because it could be… I've had people with histories

of, for example, family members having ill-health… That doesn't mean that

they've been through trauma, but they have got an MUS. But there's

something around the script of health, the schema that they've got around

health, that's meant that's the best way they can deal with whatever… So it's

not necessarily that everybody's got trauma.

Importantly, Participant H highlighted that we cannot assume individual personal trauma is present with every client in embodied distress. Therefore, this possibility should be approached with consideration of other possibilities in mind. Participant F considered the tensions working with trauma and how this is communicated and may be interpreted by the client:

This is a risky kind of area in the sense that you are basically kind of treading

this line now where you're saying to people… there's a whole lot of people

with pain that's biopsychosocial, but maybe yours is really just psychological

you know, and that it's just the manifestation of your trauma… it's just the

manifestation of your psychological pain.

4.5.3.2 Formulate and Contextualise Distress

It was generally agreed by the therapists interviewed that formulation was a key component of the work with this client group. This view was in relation to both the client's individual and culturally embedded/family history, and in relation to their NHS experience, often involving multiple investigations and diagnoses over a period of time. Formulation was described as an opportunity to collaborate with the client, normalise, organise, map and connect with the client's experience; for example, Participant F stated:

Sometimes, just that assessment and that formulation are reassuring that

they're not losing their marbles and that what they're experiencing is

perfectly understandable… like for me, I think the number one thing is that

they leave a little closer to understanding that, maybe, they've got enough

information already to get on with it… to move on with their life. They don't

need more investigations…

Considering the Client's NHS Journey

A number of therapists stressed the use of formulation to help contextualise distress and help the client make connections in their lives, for example of the client's NHS experience, often being seen for multiple diagnoses, by different professionals, across specialities for different investigations, which was considered to create fragmented experience and confusion for the client.

Different therapists varied in the way they considered introducing the mind-body connection. Participant B shared the view that she felt this was important in the early stages of the work:

> *… the interesting bit about it initially was to help people understand why, when you have a physical issue you would see a psychologist, which is of course a big problem, and you have physical pain and then you're sent to see a psychologist… especially if there's no obvious reason for the pain, that people get very distressed about that, and that again for other practitioners… so I would spend a lot of time just getting people to understand that everything is connected… And so that was kind of my starting point…*

Other therapists considered that a strong alliance needed to be in place first before this idea could be introduced. Participant G discussed how she included the client in the process and encouraged the client to engage in the formulation, activating agency and responsibility from the beginning of the treatment:

> *I even give them a written copy of my formulation, inviting them to read it and then for us to discuss it, and then I will incorporate their own reaction to my formulation, which then enriches the formulation because the agency of the patient is integrated into the formulation… It's not just me on the outside looking at my patient as an object… I turn them into a subject, so they actually give of themselves and their thinking… doesn't have to be defined*

as accurate thinking, true thinking, because for me the healing happens in that collaboration and in that connection.

While Participant G highlighted collaboration as a key aspect of formulation, Participant E suggested that the key task of formulation in the beginning is to construct a new narrative:

So… in a way, these patients are constructed around their physical illness for years, and then two services are trying to make a formulation, you know, just because so the patients themselves, they believe their pain needs to be sorted by the pain consultant, the psychiatrist will sort their… so they're constructed like that. So, there's energy that is put into that, and our job is to deconstruct and create a new narrative.

Finally, in the same vein, Participant C highlighted the importance of helping the client understand and connect with others' (professionals) perspectives, decision-making and thinking process, to form a bridge in the work between those involved in their care:

… I think there's often the sense like, you know, the psychologist believes it because it's a psychological issue. So for me, an important part in actually getting the other (the client) to see that it's not that simple, that it's not just me personally who understands them because I'm the psychologist and I'm different from everybody else… it's about being able to explain why people, why the medics can't see pain on the x-ray for example. So psychoeducation, to say, we can't see it, we can't measure it… we can only know it from what you tell us, and you told us this, and this, and this, and therefore we assume this is what it is…

A number of these factors suggest formulation needs to take into account a number of NHS factors to bridge the clients' understanding of their experience in the NHS context.

Considering the Client's Personal Journey

As therapists spoke about their client work, the importance and content of their formulations were implicit in the recollections of their cases. Therapists in the study tended to pay attention to the systemic role and context of the embodied distress, integrating ideas of the clients' personal, attachment, familial, intergenerational, spiritual and embodied life and experience. Particular attention and sensitivity were paid to the cultural components of embodied distress, with several of the therapists making particular reference to their clients' presentations in a cultural context. For example, Participant D talked about making sense of distress in Somali culture, and the difficulties faced by therapists in the NHS by the added complexity of having to use the client's uncle as a translator due to resource issues:

> *When I think about my work, particularly with young Somali, um, men… and I'm talking men predominantly, what does being in this culture… what's available to them… So, at one point I think I… I used the term, um, you know, does it make you feel distressed or something I use that phrase, um? … the uncle, he said something, blahluddlelah and he did this (finger rolling, pointing to head area)… and so for me, this action in my culture here in Britain is a derogatory way of suggesting someone's mentally ill… you know, gone crazy in some way, and I thought, what… what does this mean to them? What does distress mean, and it's really hard to get underneath that, it's very hard to.*

This example highlights the impact of the NHS on formulation and client care and the need for translators in the work to fully understand ('get underneath') the client's

distress in the work. In considering the role of the illness in the particular cultural context, Participant G stated:

> *What matters is that each culture is different. The way they relate to physical symptoms would be peculiar to that culture. I don't expect myself to read about and understand every culture. But my client can tell me how their culture relates to that, responds to that. So then I can understand the gains in being physically ill, ok, if there are any, and the dynamics in the culture which impact, because when we internalize cultural elements dynamics… But again, I wouldn't say that this would be specific to patients with somatic complaints. The culture is part of a person's identity.*

While Participant G talked of culture as part of identity, which she felt could be learnt through exploration with the particular client, Participant B developed the idea of individual context, outlining the importance of the personal, attachment, family and the cultural and emotional atmosphere of the family:

> *They were just so angry with everybody else because they felt that no one was listening, nobody understood how difficult things were. So I allowed them to tell me how difficult things were... what's good about your family... what's bad about your family? And actually, the more we dug with that family, they were quite a resilient family. They struggled because they both had... mum had a learning difficulty; dad had a learning difficulty, so they struggled. But they were very resilient... they held it together. They had absolutely no money, but they found a way to pay their bills, children were clothed, they were all fed.*

As Participant B reflected on making sense of a client's story and her family's distress in context, several therapists discussed the importance of the context of the

story of the embodied distress over time, behind their diagnosis. This idea was vividly described by another participant, Participant D:

> *…so it's useful to, to help the client explore that, because it might help them to… to take them to something about an original unmet need before that got labelled as, or mislabelled as 'You're hungry' or 'You've got IBS', you know, depending on where in their lifespan they are! Before it got labelled, there was a distress, and it might help them to identify the original distress, to explore that, and I think that's sometimes useful especially when people have been labelled or mislabelled over time.*

Participant D went on to give an example and map the journey and evolution of how the embodied distress develops in context, across the lifespan:

> *…there's a thing that's trying to be expressed, and over time it's come up as… in teenage it came up as eating disorder, later on in life, it came up as chronic fatigue, then it became post-natal depression, then became this, then became that… and you might have somebody at the age of fifty, you know, sitting in front of you who presented in so many different ways, and has been labelled in so many different ways… so I don't look at those labels… just a kind of map.*

This point highlighted the importance of recognising embodied distress and how it manifest and changes across the lifespan and what it means for that client (beyond the diagnosis).

4.5.3.3 Integrating Body-Based and Non-Body-Based Approaches in the Work

This category has been divided into body-based and non-body-based interventions. It was evident that the therapists interviewed had a depth and breadth of training and experience to offer across a number of theoretical approaches. From the initial

codes, I identified that the majority of these approaches were centred around a number of particular approaches:

- Humanistic-existential.

- Psychoanalytic (more contemporary/relational than traditional).

- Constructivist, such as narrative, transpersonal, and creative arts approaches.

- Third wave cognitive behavioural (acceptance and commitment and compassion-focused therapy).

All the participants either explicitly stated, or implied, that they draw from a number of approaches, practising more integratively with this client group. Interestingly, the non-body-based interventions outlined in Table 4.1 (see Column 4) could also be considered a list of generic therapeutic inventions not specific to this particular group of clients or modalities. This point was noted by two of the therapists, who stated they were unsure if their approach to working specifically with this client group was any different to working with other complex clients.

Incorporating Non-Body-Based (Generic) Interventions

There were several elements of practice which were raised by the majority of the therapists; which can be categorised into the following: (1) facilitating expression and building a narrative, (2) integrating emotion and working with affect, (3) developing insight and future-orientated work, (4) psychoeducation around making connections and, (5) working in a flexible, individual and creative way. I will now explore some examples of these elements, as shared by therapists in the study.

One therapist (Participant G) considered that her primary task working with this client group is on building a narrative:

> *…the patient's story that is absent and needs to be constructed… and I think*
> *that is basically the treatment because patients who present with this*
> *condition often are concrete, they have difficulty symbolizing, they have*
> *difficulty mentalising, their reflective function is often limited or non-existent,*
> *and it's building and developing the reflective function… their ability to*
> *symbolize and find words to describe the psychological pain so that the body*
> *is not the carrier of the psychological pain.*

This narrative is built by helping the client to develop their reflective/mentalizing function.

Common approaches emerged, regardless of the preference of orientation; for example, most of the therapists talked about the importance of psychoeducation in the work and helping the client develop insight and understanding into their difficulties. Participant G stated:

> *There's a lot of education involved as well… I think that when people*
> *understand what's happening and how things are happening, and then you*
> *give them an alternative way of kind of dealing with the problem, then they*
> *can often make the switch themselves quite easily.*

The therapists also shared a number of more creative ways of working with these clients which included mapping, writing or drawing, using art or timelines; Participant B stated:

> *It works really well, because it takes that pressure away of just using the*
> *verbal. Because when we're anxious, visual thinking is easier to access and*
> *so, yeah, I tend to go to the visual when I've got anxious patients, even my*
> *adult patients… I tend to get the pen and paper out and make it very visual.*
> *It's also something they can take away if they want.*

These approaches seemed more common in those trained in creative arts psychotherapy or therapists who had worked therapeutically with children.

The creative use of metaphor was very common amongst all the therapists, to help clients create or visualise things in a different way. Participant F described their usefulness in working with complexity:

> *A lot of metaphors, um, help to distil really complex kinds of ideas into something small.*

The use of **embodied** metaphor seemed particularly relevant to this group of therapists and clients. An example of the use of embodied metaphor was offered by Participant B, whose metaphor offered a way of connecting physical and psychological struggles and allowed the therapist to communicate she had been heard and her struggle understood:

> *I kind of gave that analogy of a packhorse carrying lots of bags, and your legs are getting tired, but people are still putting more bags on top and eventually you crumble, and you can't move and everybody's wondering you know... why has she stopped... why's she ill? But actually, all the stuff that you were carrying, nobody saw what you were carrying, and it feels really heavy, and I think at that time I kind of saw this vulnerable little girl carrying loads and loads of bags, and her little arms couldn't carry the bags any more, and she just walked into my therapy room and put them down... and that's fine, and then she had her energy back, and her shoulders went back because she wasn't carrying these bags anymore.*

Overall, the use of metaphor seemed incredibly powerful in the work. My initial focus of the research was speaking to therapists about their experience of working with clients one-to-one in therapy experience persistent embodied distress. However, what emerged was that most of the therapists felt that significant change was

usually a result of the client joining a group. Therefore, although this was not the initial focus, I have included some practice considerations here, as summarised clearly by Participant E:

> *My gut feeling is that it is the most powerful way of working with people... If I just summarise and, you know… and it is often the combination of individual work and group, but I think it's through group work.*

Therapists talked about a variety of individual and group interventions that they felt facilitated the change process with this particular client group. For example, one therapist, Participant F, reflected on the process of change and the tensions working with clients with complex and chronic distress in the slow progress:

> *…one small change can then affect something else, and so we have to start small and just keep chipping away at it and so… sometimes it's a physical healthy thing that will a bit, but most of the time with our patients, by the time that they come and see me, all the easy ones have been done...*

Participant F highlighted the journey clients have often been on before they present to psychology, and the 'chipping away' approach to support their process.

Incorporating Body-Based Interventions

Seven out of eight participants explicitly discussed body-based interventions. The majority of these interventions came from those who practised more psychodynamically, creatively using metaphor or movement, the arts, breath or touch.

There was also an interesting presence in the data where the therapist's culture became figural in relation to the therapist's relationship to the body and embodied role within the therapy, as in this example given by Participant C:

…I'm quite active, so I will get up a lot and I will do extreme role play. I'm not just standing talking at them, I will get up and I will show them something, how I'm dancing with the pain, you know, something that will grab them… there's a bit of luring people into going with this approach, and if we are not enthusiastic, and if we don't say this is possible and we believe in it, then actually we have lost the cause.

Other ways these body-based approaches were integrated were through the work with spirit and the body:

So, working with the idea that when people are traumatised part of their energy leaves their body… which is disassociation in a way, but instead of formulating as being you know, in the brain, it's like a part of our consciousness leaves the body, and in traditional societies they have no problem with that because everything is spirit and there's some, you know, traditional techniques that in traditional societies are used to bring somebody's spirit back into their body.

Importantly, Participant E highlights the minority voice in the NHS, the spirit in therapy. Yoga was also named by four out of the eight therapists as a strategy they incorporate themselves or refer clients on to. Participant C stated:

I'm much more practical and focused, and it's just much faster and you get results much quicker… Within a few sessions, people shift… something, and that's just amazing to see where… I'm still gobsmacked and why don't we do more of this.

Integrative arts therapists were also convinced by the importance of their specific therapeutic approaches and what it offers these clients. One of these therapists (Participant D) suggested slowing client movement down to reflect on the detail, the

intentionality of the body, which she suggested was crucial to understanding what informs the body at a biological level:

> *When we took the label of IBS aside, and we took even the idea of diarrhoea aside… we looked at the physicality of holding in or letting go and explored that in the room literally… holding in, letting go as physical movements.*

While Participant D described the holding in/letting go response and the function of embodied distress. Participant E raised a very important point about touch and communication at the embodied level:

> *…there is something about the body saying something that nobody can hear, including us, you know that's mysterious… how the body speaks, and that actually we don't know how to read that language, and certainly our society has not invented that way of speaking to the body… and I mean, the fact that in the pain clinic there's not a masseur… I mean it's surreal; this patient needs to be touched. The greatest power I have in the healing work I do, my shamanic work where I, you know, where I rub patients with eggs, is touch. I can see people that are craving to be touched, you know.*

This question of embodied narrative or communication was central for seven of the eight therapists. All of the therapists considered the actual or symbolic/functional meaning of the physical distress.

Most of the therapists felt that touch was important, but only two out of the eight interviewed were trained and insured to use touch in their work as a result of additional training and most felt that it served as an important boundary in the NHS. Touch was clearly an area of tension and divide, as shown by Participant G's comments:

You can touch someone without actually touching them, yeah… So I wouldn't want to turn ourselves into carers, because what makes our service therapy with the work, is the professional relationship without the touch, yeah. If someone benefits through touch they can go to a masseur or an osteopath… If I start engaging in that touch, then I lose the sense of what I'm trained to do. Do you see what I mean? It's like everything has its own place, and an element of touch would be allowed in my model of working but I don't want to turn myself into that kind of soothing mother that holds the baby, okay… and through touch soothes it. That's the job of someone else.

Participant G highlighted again the idea of touch, boundaries in the NHS, and connecting experience and the body in the work. Participant E insisted the bottom line is:

You know if your job is to touch… you know physios, they do touch… but you know they touch to assess, they don't touch to transmit love… and that's what heals, it's love, full stop, full stop, nothing else. And so in a way, practitioners, you know, are not given the opportunity to share their love… if we're talking very bluntly, that to me is one of the main problems, that the models we have don't let love flow… and these people are desperate and maybe that's what's relentless… is that actually they are bringing suffering that has taken an embodiment of the body and the boundaries of our model don't allow us to really heal them in a way that makes sense.

Touch and love were two terms used by several of the therapists as central in the embodied work with these clients.

Reflective Summary of the Findings

What became figural from the findings was the importance of the embodied person of the therapist, as a bridge between client and organisation. Within this, the therapist acts as a medium to make connections, hold and manage tensions within the work in the NHS, connecting mind-body-brain and context with and for the client. Therefore, the findings suggest the person of the therapist is central in the work and their way of embodying this process is crucial for therapeutic success. Interestingly, the cultural presence of the client, the therapist and the organisation remained inherently present across all three core categories.

The framework and grounded theory presented go some way to begin to organise and address the complexities of the work with these clients in their embodied distress within the context of the NHS and offer considerations for future clinical practice.

5 DISCUSSION

5.1 Introduction

This research looked to develop our understanding of how therapists work with clients experiencing persistent embodied somatic distress within the context of the NHS, through speaking and reflecting with therapists about their work. The findings and grounded theory proposed offer therapist considerations for future clinical practice.

In this chapter, I discuss the major findings and answer the research question: **counselling psychologists and psychotherapists in the NHS: What can be learnt from their work with clients experiencing persistent embodied somatic distress?**

I discuss the key findings which emerged from the research:

(1) The importance of the provision of an embodied therapeutic relationship.

(2) The role of the therapist in bridging the connection between the client-therapist and organisation (NHS).

(3) The importance of connecting mind-body-brain and context of the client's distress.

These sub-categories come together to form the core category of, **the embodied therapist as a bridge in the NHS** – making connections and managing tensions.

I move on to discuss the clinical implications and potential contributions of the research, limitations, and ideas for future research. I conclude with a summary of the research findings in the wider context, the grounded theory proposed and implications/recommendations for NHS practice.

5.2   The Therapist's Voice

The grounded theory design and process drew together the common threads among the therapeutic practices of the therapists interviewed. However, I wanted to ensure I did not lose the individual voice and essence of the individual practitioners. The fear of potentially missing the essence of the induvial therapist's voice in the research propelled me to another level of connection with the data. This consideration challenged me to see things I had previously missed. Through discussion in the refinement group and with my research supervisor, I was able to identify the importance of the therapist's voice. Through reflection, I realised that I was, in fact in parallel, one of those therapists whose voice previously had not been heard and had been silenced as a result of the NHS power structure. This felt like an important ethical moment in the research process, and it allowed me to connect with the data in a very different way. Therefore, I have attempted to reconcile the individual versus collective voices by choosing specific excerpts from the transcripts that not only exemplify the particular category which emerged but also best reflects the essence of the individual therapists.

5.3   Core Category - 'The Embodied Therapist as a Bridge in the NHS'

The core category which permeated across all sub-categories suggests that the therapists use self as a bridge in the NHS, through which a number of connections are created and a number of tensions are held and managed by and through the person of the therapist. This situation occurs within the context of their relationship with both the client and the organisation (NHS). A therapeutic model is created from the person of the therapist and what they are holding, as everything goes through them as the bridge.

As discussed in Chapter 2, the therapist may serve many different functions and roles. Frankland and Walsh (2005) highlighted the role of the counselling psychologist in the NHS as a 'negotiator', acknowledging the management and holding of the tensions between the contrasting philosophies of the medical and humanistic paradigms. However, the findings from this study suggest this is only one aspect of the role.

Another important part of the therapist's role was illustrated in the sub-category of mind-body-brain-context, which supports Lipowski's (1974) findings that the therapist is an 'educator'. Pittu (2004, p.201) developed this educator role further to describe the therapist's role 'as that of a facilitator, a catalyst – a clarifier of confusions, conflicts and conundrums.' This implies that the therapist has a regulatory and guiding function.

In contrast, Lemma (2014) conceptualised the body of the analyst as part of the 'embodied setting', which is made up of (1) the analyst's presence and, (2) the analyst's somatic countertransference, which creates a 'structure in the mind of the analyst'. This internal setting of the therapist is theorised to make up part of the therapeutic frame, which provides the containment for therapy.

The various aspects and functions of the therapist's role and the findings from this study have been considered. My findings are most in line with Sexton's view, that the 'self of therapist' is more than a list of personal characteristics and core skills. In his description, the therapist has a complex multi-layered function which extends previous ideas (Sexton, 2007). He suggested that the therapist is both the 'moderator and mediator in successful therapeutic change'. Sexton posited the 'self of the therapist' as a potential bridge to unite both common factors and the therapist's therapeutic model. This view suggests the self or person of the therapist is not enough for successful therapy. He outlined the therapist's central role as (1) a

'moderator' variable in therapy - bringing certain characteristics, techniques, style and abilities, and (2) a 'mediator' - within the particular therapeutic interaction. The findings from his study support the notion that the therapist is part of a larger dynamic change process. However, allow me to develop Sexton's ideas further - that the person of the therapist, as well as what she does and how she does it, acts as the 'unifying thread'. In this way, I am suggesting that everything goes through the embodied person of the therapist, as a bridge, a mediator, a medium.

Therefore, I posit that the therapists themselves are the critical element in therapy, supporting Sexton's view that, 'It is only through the person and actions of the therapist that therapy works' (Sexton 2007, p.105).

These findings were further supported by Simon (2006), who said that the common factors versus specific model debate misses the core element of the 'self of the therapist', and their commitment to a model that is congruent with the therapist's worldview (cultural values) is pivotal for successful therapy. Bringing together this model and findings from my study, each therapist can be considered to provide a personalised approach through the use of themselves, in their individual relationship with both the client and organisation. The therapist, therefore, holds a central function and task.

Having suggested that models and therapy work through the person of the therapist, I now address an additional complexity which is that one size does not fit all (Lebow, 2006). Therefore, the therapist needs to be open to a model which allows flex around several models and worldviews (Blow et al., 2007) to be able to meet the client in theirs and maintain an equal and balanced relationship with the client and organisation. This requirement was highlighted from a number of focused codes which emerged, namely 'working with the client as a person' and the individual attachment history and needs. The body of the therapist, therefore, has to act as a

dynamic medium which flexes and accommodates the different variables and needs in the specific and unique client-therapist-organisation relationship and context. However, these connections exist in the midst of a number of tensions within the different areas of work, which I will now discuss further under each category.

5.4 Providing an Embodied Therapeutic Experience

5.4.1 Attachment-Informed Practice

This sub-category is made up of three key findings from this research:

(1) Working with the client as an individual/person.

(2) Providing attachment-informed structure.

(3) Providing attachment-informed care.

Firstly, it was found that providing this type of therapeutic relationship and experience requires a certain type of attitude, quality and style as a therapist. The codes which emerged suggest ways in which the therapist connects with the client in the relationship; these codes are all interconnected around the attachment premise. The findings from this study suggest practising in a way that considers the attachment history of the client, including the need for a trusting working alliance, time, pacing, and continuity of care in the supportive milieu of the relationship. These findings support a number of existing attachment-based models, as discussed in the literature review (Luyten & Fonagy, 2016; Engel, 1977; Stuart et al., 2008). I will now discuss this category in more detail.

The emergence of the sub-category 'Working with the client as an individual/person' supports a number of existing authors and theories. For example, McCluskey (2005) in her book, *To be met as a person: the dynamics of attachment in professional encounters*, suggested that care-seeking/caregiving dynamics are complex and rooted in infancy. She highlighted the profound potential influence of the

professional (care-giver) in their response to the client (care-seeker) through careful attention to the provision of 'goal-corrected empathic attunement'; this type and level of attunement are achieved when the biological goals of both care-seeking and care-giving parties are considered and met. McCluskey suggested that meeting these goals includes both a learnable skill and the attitude of the professional. These findings support two of the three codes around 'meeting the client as a person' and 'attachment informed care'. She commented on the attunement or misattunements of professionals, who may 'drop' or 'back off' emotionally from a client and what this may represent. She moved on to suggest that clients need a professional response that helps them reconnect with their own capacity and agency at all levels of functioning. The importance of the attachment structure is less evident from her model. Therefore, the results from this study extend ideas around attachment structure in the work with this particular client group.

Entwistle and Watt (2013) make the case from an ethical position in favour of person-centred care. They raise the issue that a patient should be treated as a person and their individual needs responded to, irrespective of the contribution this makes to the individual's health.

My findings develop the application of attachment models to clients in persistent embodied distress by considering the corresponding tensions that exist in providing attachment-informed care in the NHS. Tensions identified from this research include the need for our approaches and models to flex in response to the client's attachment needs (one size does not fit all), and this should be in line with the client's stage of their therapeutic journey and individual pace. The importance of providing 'continuity of care' was also highlighted for this client group, as well as management of the professional-client attachment relationship around expectations and boundaries of therapy.

Overall, the findings from this study support the research relating to the need for empathy, reassurance and supportive/continuity of care approaches with these clients, which reinforces theoretical ideas of the therapist as temporary attachment figure (Holmes, 1993). I conceive that an awareness of these important connections and tensions allows an element of anticipation and forward planning, supporting both the structure and containment in the therapeutic work and supports the argument for relationally trained therapists and approaches in NHS therapy practice.

The need to provide a therapeutic relationship was evident across all focused codes in support of the 'common factors' model such as, empathy, openness, respect that contributes to positive outcomes (Sexton, 2007). With attachment playing such a significant role in the work with these clients, I propose that an open dialogue approach similar to those used in interpersonal integrative approaches could be beneficial. This idea also supports Luyten and Fonagy's (2016) first area identified in their model with these clients' attachment issues and offering support to the integrative interpersonal focus of their model.

My research findings extend existing attachment theories by emphasising the importance of attachment structure with these clients while considering the tensions that may arise in the context of the NHS work.

5.4.2 Using Self in the Work

This sub-category is made up of:

(1) Transmitting the cultural values/attitude/presence of the therapist.

(2) The embodied therapist.

(3) Working with the unconscious process.

These focused codes describe various ways in which the therapist makes connections with the client in the work through the embodied use of self as a bridge.

5.4.2.1 Transmitting the (Cultural) Presence/Values/Attitude of the Therapist

The first code to emerge centred around 'the cultural attitude/style/presence of the therapist', embedded within their own cultural values and upbringing and how these were utilised by the therapist in the work. This attitude and style seemed to encapsulate the core conditions or atmosphere of the therapeutic relationship, with some additional key components including: speaking openly about the body and being passionate about the work, and being open to communicating or transmitting love, both of which the therapists felt added to the quality of the interaction. Interestingly, seven out of the eight therapists who self-selected for the research study were of foreign descent, and I myself am of mixed descent. This fact may suggest a relationship between certain cultures and embodied experience or somatic focusing.

The prevalence of this code was surprising and something which I had not anticipated. There is already a considerable amount of literature around the cultural relationship between client and therapist, which adds support to these findings. For example, Beutler et al. (2004) found that the therapist's cultural attitude is a variable for therapist efficacy, a view which has also been supported more recently by Baretto (2013), who found that a therapist practising in a foreign country is both beneficial for a client-therapist relationship and positive outcomes. At least five of the therapists spoke openly about the contribution of their foreignness or differences within the work with these clients.

From my findings, the contribution of the therapist's foreign culture suggests a great benefit to these clients in the work. Pittu (2014) suggested the reason for this is that the therapist operates from a 'euro-centric model' which suggests a 'horizontal' and 'non-hierarchical' relationship, thus supporting the therapeutic alliance and power difference. I hypothesise that by the therapist embodying their individual cultural

experience, this acts to balance the inherent power imbalance that exists within the context of the therapeutic relationship in the NHS.

Cheng's (1991) study also supports these findings, related to 'the personal quality of the therapist as a key element in therapy'. More specifically, in the case of foreign (minority) therapists, Cheng suggested that language, values and cultural background amongst therapists can be 'acculturated'. Through this 'acculturation', the therapist is able to orientate to these values which create 'cultural objectivity', which supports the therapist to help the client see alternative ways of coping. Interestingly, Mahalik (1999) found that across 301 therapists, all had similar value orientations and worldviews despite variations in race and ethnicity. Cheng (1991) suggested that, although Western medicine and psychotherapy are culture-bound, the minority therapist can remain 'culturally neutral'. In line with my findings, these studies suggest culture is embodied and assimilated in the person of the therapist and therefore contributes to our understanding of the embodied therapist's presence in the work. My findings, therefore, support the existing theory. These findings further support the welcome inclusion of diversity among therapists in the UK, to the profession and training programmes.

On reflection, this code came into focus following the refinement group, when one participant highlighted the common foreignness among those in the room. This comment led me to consider the foreignness and diversity across all eight of my participants working with these clients and, beyond that, to consider the diversity across the counselling and psychotherapy profession. This moment felt incredibly powerful in the group, and it was highlighted by an energy shift noticed in the recording of the group process; I noticed that all the therapists had begun to laugh and talk at the same time in a celebration of their underlying connection in the foreignness (or differences) that connected them. Although culture was not figural in

133

the initial interviews or data, it was one of the emergent factors undeniably present in the room among us (including myself) and in the demographics of the participants themselves, which only became clear in the refinement group process. This refinement process, therefore, was central in deepening my understanding of the important contribution of the cultural presence, attitude and diversity of the therapist population becoming figural within the profession and is thus presented as one of the key codes.

5.4.2.2 The Embodied Therapist

In addition to the cultural presence of the therapist, there were a number of codes that emerged and came together to form 'the embodied therapist'. This category was developed from all the therapists speaking in some way about the personal contribution they felt they had made and their embodied experience in their work with these clients. This code very much related to them working creatively with their own body (using embodied attunement, embodied empathy) or utilising their own experience in the work, either implicitly or explicitly, e.g. through self-awareness or self-disclosure. Contributions from body psychotherapy support these findings, suggesting that 'a body therapist must have access to their own deep embodiment and relate to the client in a deeply embodied way' (Kepner, 2003, p.9).

In Chapter 2, I discussed Lemma's idea of the 'embodied setting'. Here, it was suggested that 'the body of the therapist sets a particular sensory tone to therapy'. Lemma (2014) conceptualised the therapist's presence and physical appearance in the room as crucial, implying many of the aspects of the setting are, in fact, embodied by the therapist. This view was reflected in the variety of ways the therapists in the study described their use of self, ranging from being flexible with their boundaries to considering their intersubjective contribution and thus supporting the notion of the embodied experience and presence as a bridge in the work.

Tensions created for the therapists in relation to working in an embodied way included the impact of closeness to the distress from their own experience, the embodied impact of the work with these clients and the need for structured self-care within the NHS. Despite these tensions, many of the therapists demonstrated an embodied commitment and passion for these clients. Eisler (2006, p.30) stated, 'doing something we are wholeheartedly committed to must surely be more effective than something we only half believe in.' One of the therapists in the study (Participant G) offered advice on the embodied use of self:

> *I'm opening myself to the patient in that I'm receptive to them, I*
> *receive them in my soul okay, but I don't give my soul away to them.*

Findings from this study reiterate the findings from Shaw (2004), that 'psychotherapy is an inherently embodied process.' Both studies highlight the importance of the therapist's body experience in the therapeutic encounter between client and therapist where 'embodiment rather than the body is central to psychological life and social relationships' (Radley, 1998). Shaw (2004) suggested that this embodied experience is a valuable source of knowledge and communication in the intersubjectivity of the therapeutic encounter, ideas strengthened by the findings here relating to the importance of the culturally embodied presence of the therapist.

Touch can also be a contentious subject when it comes to psychotherapy practice, depending on what model you are trained in. Shaw added that one of the ways to bring the body into the work without involving touch is through the idea of embodiment and the use of somatic experience (Ibid).

Lemma (2014) added that an advantage of conceptualising the body of the therapist as part of the setting in this way is that. Just as changes to the therapeutic frame can affect the therapeutic process, changes to the therapist's body can also impact the process. I can conclude that the therapist's body, therefore, holds both constant

and dynamic functions for the interactive regulatory experience between client, therapist and organisation, further supporting the presence of the core category.

5.4.2.3 Working with Unconscious Process

There were several codes that fed into the category of 'unconscious processes' from both the clients' and therapists' perspectives, with most therapists speaking of their strong embodied countertransference or embodied empathy (Rowan, 1998) in relation to these clients.

As discussed earlier in the literature review, Lemma (2014) conceptualised the body of the analyst as a 'feature of the therapeutic setting', where the patient relates to the body of the analyst through the use of somatic countertransference (or non-verbal narrative). Messler (1994) considered transference and countertransference as a vehicle for expressing traumatic experience. Both suggest clients in somatic distress evoke powerful countertransferential processes, which suggest the unconscious communication through the use of the therapist's own body (Lemma, 2014). This view was reflected in my findings, with all eight participants suggesting strong countertransferential reactions to these clients. Therefore, the body of the therapist can be considered part of the dynamic variable which exists as part of an interconnected communicative process between client-therapist and the wider organisational context, while simultaneously holding a containing function (Bergner 2009).

In Chapter 2, I discussed how environmental failures to adapt (by the mother) lead to a disintegration of 'self'. Winnicott (1945) proposed a re-living or re-experiencing of this early gap in continuity through acting out in the transference process (mirroring the early disruptions in healthcare interactions), whereas, from an object relations perspective, Malin (1990) suggested the request for further support from the client indicates the self-object bond is still intact. Findings from this study

suggest that therapists felt that the NHS was not in a position to respond to individual needs and provide a level of 'good enough' and attuned 'continuity' of care. Findings also highlight that therapists who work with these clients need to be trained and experienced enough to consider complex unconscious process (Bachrach, 1981).

Luyten and Fonagy (2016) suggested that these clients are not 'difficult to treat' as much as 'difficult to reach', reminding us of the unconscious defensive quality/structures present which, I suggest, need our constant reflexive management, time and attention.

I suggest that the therapeutic conditions relating to the first sub-category, connecting therapist and client need to be in place before a bridge connecting client-to organisation through the therapist, can begin to take shape.

5.5   Bridging Client-Therapist-Organisation

This sub-category is made up of:

(1) Contributing as a professional discipline.

(2) Bridging organisational complexity.

(3) Managing Power processes.

These focused codes which emerged suggest ways in which the therapist made connections with the client through the work.

The categories 'our contribution as a professional discipline' (or 'working at the edge') and 'bridging organisational complexity' closely overlap with literature relating to the core category, 'the embodied therapist as a bridge in the NHS' which I have discussed earlier in this chapter. There were a number of codes which emerged outlining the complexity of this work and the therapeutic role with these clients in the

NHS. These codes included the need to create a bridge with other professionals, specialities and hospitals, the consideration of multi-diagnoses or medical uncertainty, and working with complex treatment programmes. One key aspect of the role related to the professional contribution and the therapist's position in the NHS, which I have come to term 'working at the edge'.

5.5.1 Counselling Psychology and Psychotherapy in the NHS - 'Working at the Edge'

A code of conceptual interest which emerged from the data was the lengths that the therapists I interviewed will go to in their practice as professionals. Their willingness to go that extra mile and work beyond their boundaries and work brief. Their passion, their care and their commitment, their understanding of their client's needs, often extends far beyond their role in the NHS to meet the human needs of the individual in front of them. I consider now whether this is a determining factor that leads to the success stories the therapists shared as part of their interview process. I consider whether this differentiates counselling psychology and psychotherapy from other disciplines as several of the therapists in the study suggested. For example, participants shared practices such as hiring a minibus and picking up clients to attend groups in times of hardship, practising in ways that their managers or supervisors may not support but that are in line with a client's spiritual or cultural beliefs and needs and the therapists values, and doing management courses just to ensure they, as therapists, were in powerful enough positions to pilot services they knew would meet their clients' needs. Most felt that practising at the edge of the professional boundaries in this way came from a passion, what they felt was right, and what their clients needed (despite working outside of organisational guidelines). These were new findings in terms of existing research and the literary field and therefore of interest and warrant further study.

5.5.2 Managing Power Processes

Power was raised as an emergent category for all parties involved, clients, therapists and the NHS organisation.

5.5.2.1 The Client's Power Process

Therapists described clients as exercising their power through persistent care-seeking and, in some extreme cases, expressing through complaints against staff the wish to have their needs met where the client may fear a loss of care. This view supports Stuart and Noyes (1999), who proposed that somatisation is a maladaptive communication to elicit care. They suggest these patterns of behaviour directed towards healthcare providers are often met with apathetic responses, which lead the patient to feel rejected and reinforce their belief that care is unavailable and further increases the patient's demand for care (Stuart & Noyes, 1999).

In transactional analysis terms, Johnstone (1989) illustrated the positions of power in the case of a patient feeling in need of help (rescue). For example, if the patient does not respond as expected or hoped to treatment, the rescuer (healthcare professional) may feel anger and switch to a punishing or persecutory position. In this case, Johnstone suggested that the patient cannot find an equal position. Johnson made the case that in taking up either rescuer or persecutor position, the professional continues to hold a more powerful position. Proctor (2017) suggests this is a common dynamic in mental health services, particularly in cases where patients are diagnosed with borderline personality disorder. These ideas are also in line with statistics outlining the prevalence of the comorbidity between borderline personality disorders and somatic disorder diagnoses (van Dijke, 2012).

Approaches advocated by the therapists in the study outline a process whereby clients are supported to develop their own power and agency and sense of responsibility, by addressing their fears and developing their coping methods and

responsibility with the health professional. Johnstone (1989, p.55, cited in Proctor, 2017, p.7) usefully reframed how power can be shared:

> *It is not enough to tell people they are responsible for their own problems and dismiss them, as tends to happen in persecution. Clearly, they are genuinely distressed and in need of some kind of help. What is needed is recognition that people suffering mental distress are responsible, capable agents and in need of help as well.*

5.5.2.2 The Therapists and Organisation's Power Process

Findings from this study show that therapists feel a sense of power as well as limitations to their power as counselling psychologists and psychotherapists within the NHS. Findings also reflect their professional values in terms of how they view power between client and therapist in the relationship. Therapists frequently discussed the limitations of their position and the tensions created in their work due to time, lack of resource, having to work within certain professional models or boundaries, and the limitations of their own language or understanding or approach. They described their power as being exercised through the sharing of knowledge, their access to resources, and through the decisions they make to work with clients, while using the NHS to protect them if they choose not to work with a client.

Proctor (2017), a key author in the area of power in counselling psychology and psychotherapy, suggested several issues which are relevant to these findings. Firstly, she argued that power is determined by the immediate relational context and the wider socio-political environment of roles/status. An individual's power position in society is related to their level of psychological distress. Secondly, Proctor further claimed a link between psychological distress and issues of power, abuse, and mental health diagnosis. This model considers the potential contribution from both interpersonal relationships and the wider social context. These ideas allow us to

consider our embodied power as a therapist as we form part of the NHS institution and clients' wider system.

Proctor's theory was supported by the emergence of the code 'power', suggesting a relationship between power and 'persistence embodied somatic distress', which has implications for the consideration of power within the client-therapist-organisation interaction. Again supporting the 'mediating/bridging roles' of the profession, Gabinet and Friedson (1980) suggested that psychologists may have enough authority and status (power) to get the attention of medical doctors and yet not enough to alienate them from nursing and other members of staff. Therefore, psychologists are objective enough to spot and work with the inherent medical power process and the impact on the patient.

My understanding of power is that it is dynamic and exists and is shared across levels as suggested in the findings (across client-therapist-organisation). The literature tends to focus on it as negative and abusive and as some separate construct. However, therapists who were part of the study spoke about their power in terms of the relational, transferential, dynamic and embodied process. There are of course times when power can become abusive. However, I conclude that if we continually work towards person-centred practice and mutuality with our clients in mind, the inherent inequality that exists due to the historical and cultural context of the NHS can begin dynamically to change shape in the relationship.

While the therapist bridges relationships between client and organisation, connections can also begin to form between the client's context-mind-body-brain within the work.

5.6 Connecting Mind-Body-Brain-Context Complexity

It was unanimous among all the therapists I interviewed that integration of mind-body-brain processes and their relationship to the clients' lived-experience (in context across the lifespan) was central in the work. This sub-category was made up of:

(1) Meeting clients in their complexity (at all levels of experience).

(2) Formulating and contextualising distress (in both personal and NHS context).

(3) Integrating body-based and non-body-based interventions.

These focused codes support the process of understanding the complex layers of experience with clients towards integration. From this information, I conclude a subsequent treatment model/approach needs to reflect these three key elements.

5.6.1 Meeting Clients in their Complexity

'Meeting clients in their complexity' included a number of psychological aspects of the therapeutic work such as, 'being open to the individual at all levels of experience' which, in turn, included working with emotion/affect, cognition, behaviour, embodied experience, spiritual experience, across the lifespan, unconscious process and symbolic representation.

'Working with the client's sense of self/identify' included working with loss, pain/distress, shame, purpose, existence, the body, culture, power and agency, beliefs/values and self-compassion.

'Working with extreme stress/unresolved trauma and risk' included psychoeducation, managing/treating stress/anxiety/unresolved PTSD, normalising, resourcing, connecting mind-body-brain-experience within context and supporting wider professional understanding of the embodied distress.

5.6.2   Formulating and Contextualising Distress

This sub-category included both personal contexts (attachment, familial, intergenerational, cultural, spiritual, over time and in the context of their NHS journey (across their experience of multiple professionals, diagnosis, appointments, and treatments, over time).

Findings from the study suggest we need to ask the questions: How do we adapt our NHS practices to work with clients of different cultures that may have a different understanding of their persistent embodied symptoms and expectations of help? How do we incorporate the client's culture and country of origin and their usual source of help and support who might be a parent, a grandparent, a tribal doctor or a spiritual leader?

5.6.3   Integrating Body-Based and Non-Body-Based Interventions

These have been considered as more generic (non-body based) therapeutic skills, e.g. facilitating expression and building narrative and more body-based interventions, e.g. attending to somatic narrative or grounding exercises.

5.6.4   Integrating the Body and Body Psychotherapy (into the NHS)

Integrating the body into healthcare almost seems like an obvious statement, and all eight of the therapists interviewed as part of the study discussed different ways of working with the body in therapy. However, body psychotherapy (Reich, 1943) is still considered rare practice within the NHS (Stickley & Wright, 2014). The holistic philosophy assumes that naturally occurring systems are interrelated and mutually dependent (Walach, 2007). Findings from this study are consistent with the extensive research base that supports the need for body-based practices and the interrelated nature of the embodied process (Reif & Hiller, 1999; Ogden, 2014; Highland, 2011). Van der Kolk (2006) explained the particular importance of working

with the body with traumatised patients. In contrast, Koelen et al. (2014) found that body-focused therapies may not, in fact, be effective at improving functioning and emphasised emotional awareness, emotional exposure and emotional expression as more effective.

Further tensions were raised when discussing issues of touch in the NHS as a general rule. Therapists believed the NHS operates a 'no-touch' policy in psychotherapy; however, Sumner and Haines (2010, p.354) explained the significant importance of touch:

> The client can experience touch as an anchor, a sense of holding, container, a boundary to facilitate safe expression of emotion, conveying the message 'I am present with you', contributing to the integration of an embodied mind-body process.

Montague (1986) considered identity to develop from touch as a result of a feeling of contact with the body, and Chang (2001) noticed the impact of touch on the stability of the body-mind and its connectivity as a system.

Although most therapists appreciate the significance of touch, six out of eight therapists did not feel this was part of their psychotherapy practice. Ogden (2014), however, suggested that touch does not have to be physical. The practice of self-touch can be used to facilitate communication between different self-states (Ogden 2014, cited in White, 2014). Kolnes (2012) described the therapist's own embodied movement and presence and awareness which, in turn, lead to changes in contact and relationship and help the patient's awareness of their embodied and others' process, which itself leads to integration.

5.7 Circular Models - Mind-Body-Brain-Context

Therapists from this study appear to have found their own ways of explaining and formulating mind-body-brain mechanisms, including how this connects to stress, trauma and pain-processing mechanisms. This was evident from the different ideas discussed and the various concepts and materials they use in their practice.

I have focussed on reviewing the existing integrative models which show application to practice. Although there is no current agreed or unified approach to working with these clients, many local models and programmes have been created to respond to NHS service/client need.

In Chapter 2, I discussed contributions from Stuart et al. (2008) who offered for consideration the integration of IPT and CBT. This integration of methods is particularly well suited to the NHS context because of its strong evidence base, equally promoting both prior approved models. Due to the emphasis on interpersonal elements of therapy, the model aligns itself with the importance of attachment findings which emerged from this study. However, it fails to address the mind-body-brain-context complexity conundrum which was raised as a fundamental requirement of therapy from the findings from this study. It attends to the interpersonal/emotional and cognitive elements but fails to address the distress at the embodied and complexity level (education around the understanding of how these dimensions are interconnected). For me, this approach again identifies the gap in existing models more generally and practice approaches as a way of explanation for clients of the complex interactions of mind-body-brain-context processes involved. I propose the need for models that support therapist-client dialogue of these complex interactions in simple language with which clients can engage.

Earlier in Chapter 2, I also discussed the integrative, evidence-based attachment framework proposed by Luyten and Fonagy (2016), who emphasised the relevance of a number of key issues such as attachment, embodied mentalizing and epistemic trust with clients experiencing functional somatic disorders. Although there appears a lack of critique or support for their model from the field, their ideas correlate well with certain findings from this study, suggesting the attachment relationship and the embodied experience for both client and therapist, is crucial in the work for patients experiencing persistent embodied somatic distress.

Their model is particularly relevant as it explains functional somatic disorders as a result of severe stress and dysregulatory functioning of neurobiological systems and neural circuits affecting allostatic load (McEwan, 2007). This, in turn, affects immune system functioning, pain processing gateways and fatigue, which activates attachment-seeking behaviours to help regulate the system (individual). They explain how co-regulation between client and professional can fail when professionals are not in a position to meet client needs and the impact on the mentalizing function, leading to further interpersonal difficulties and ultimately epistemic trust issues. As a result, Luyten and Fonagy (2016) successfully brought together, formulated and contextualised the complex mind-body-brain-context mechanisms and elements illustrated as central in the work. However, they referred to '(embodied) mentalizing' as the capacity to reflect on one's own embodied self as well as others. Despite the majority of participants in this study not explicitly naming 'mentalising' as a key component, results do suggest that the significance of the embodied therapist is not just about their capacity to be present and reflect but also about how they are present, i.e. the qualities, the attitude needed for the therapist to be present and the therapy to be transformative.

Therefore, aspects of my findings which further develop Luyten and Fonagy's framework relate to the importance of the person of the embodied therapist, and the creative use of self in the work embedded within the therapists own cultural embodied experience. Their model also fails to address important power dynamics. I acknowledge that power process issues may have emerged in this study as a result of the contextual dynamics which occur in NHS-based research, which may not be so relevant to Luyten and Fonagy's framework.

Rappoport's (2016) work supports the view that educating patients in the structural and biological realms of their symptoms of distress embedded within their survival mechanisms creates an opportunity for healing and agency. He too advocated an attachment-informed somatic psychotherapy approach in the work with transference-countertransference phenomenon, with the important element of bridging the psyche-soma divide.

Another promising theoretical and practice-based model to extend our own and our clients' understandings of a more circular, multi-dimensional perspective which addresses the mind-body-brain-context complexity findings is offered by Hyland and his colleagues.

Hyland et al. (2016) offered an alternative narrative to clients with functional disorders, namely fibromyalgia and chronic fatigue syndrome. Their metaphor-based narrative imagines the body as a 'very, very clever computer', where functional disorders (such as fibromyalgia) are considered a software problem (as opposed to a hardware problem) of the body. Whereas the body may respond to medical intervention, Hyland and his colleagues suggest modern medicine cannot detect software-related problems, leading to a MUS.

They propose the body as a network of mechanisms with emergent properties to adapt/learn/self-organise in the face of conflicting factors and demands on the

system (individual). Symptoms such as pain and fatigue act as the bodies 'stop signals' when demands become excessive. The biological and psychological events that cause stop signals include a number of things, e.g. infection (biological) or frustration (psychological). If these signals go continually ignored, the body cleverly adapts, and the stop system becomes fixed ('stop signal' to 'stop programme') which manifest as pain, fatigue or both. The intention of the body's response is to stop the individual from further behaviour and activity.

Hyland (2017) proposed that there are no current biological or psychological theories that fully account for functional disorders. He suggested that these disorders require a theory based on a third paradigm. In doing so, he drew from algorithms from artificial intelligence, biological systems and complexity theory of the interconnectivity of functioning. He posits that symptom-causing mechanisms are part of a larger network in the body (part of the psychoneuroimmunology framework) which includes the nervous system, immune system, endocrine system and epigenetic programming (Ibid) all of which are interconnected. Hyland's framework rests on the premise that the patient's conceptual understanding of their distress is central, and the explanation needs to be accepted by both client and therapist (Coastronguay & Hill, 2007). This 'explaining pain' approach includes an individualised 7-week psychological and exercise group treatment programme (including relaxation/mindfulness/exercise/diet/lifestyle changes).

This model holds strong explanatory power, addressing the mind-body-brain-context complexity area of the work needed as highlighted by my findings. Despite using a particular computer-based metaphor in their narrative of bodily distress, this study showed that fibromyalgia patients respond well to the technology-based analogy of the body as a computer. Thematic analysis of 25 participants over three programmes led to clients feeling the model was believable and informative,

empowering, and gave them hope, instigating positive lifestyle changes. Hyland considered the model useful for a number of reasons. First, for its positive approach to the patient as someone who has managed to keep going in spite of adversity and gives hope for healing by potentially changing their lifestyle. Secondly, the model explains complex presentations and clients with multiple symptoms by introducing psychoneuroimmunology and complexity theory. And finally, the software analogy also explains why the medical professionals cannot find anything wrong with the patient. This addresses a number of factors, including 'treating the client as a person' and 'bridging client-therapist-organisation' as discussed earlier in the discussion.

While Hyland acknowledged that the components of the course are not anything new or novel, his software/hardware analogy offers a fresh approach for those clients who may be resistant to accepting psychological formulations. They suggest that 'body reprogramming' is likely to be relevant in the treatment of other functional presentations. Hyland and colleagues have addressed issues of formulating and contextualising embodied complexity with their clients through developing a more circular understanding of mind-body-brain-context processes. After reviewing the findings from this study, I suggest this client education and understanding of the circular nature and connectivity of the human system are central to the work with clients in persistent embodied somatic distress.

A number of models exist acknowledging at least one of the three key areas (sub-categories) drawn from my findings; however, there is no current model that fully encapsulates all of these levels to give an overview of the work within the context of the NHS.

My findings suggest that a framework addressing all three areas, including attachment dimensions and power processes is needed to fully support clients on their NHS and embodied journey.

5.8 Implications – Applying these Findings to the NHS

The research adds to the field from a knowledge, practice and research perspective, offering an explanatory account of working with clients in persistent embodied distress. It adds to the professional contributions to the NHS with this client group specifically and potentially to other complex presentations. The research offers a framework to consider several relevant clinical practice issues with these clients.

The findings and framework proposed directly support my own clinical understanding and those to whom I offer consultation. I anticipate this knowledge has the potential to do the same for other psychologists who act as consultants to multidisciplinary speciality colleagues working with clients in persistent embodied distress.

5.8.1 Clinical Implications/Recommendations

Further consideration of my grounded theory model led to the development of a number of practical and clinical recommendations for therapists working with this client group to consider. These clinical guidelines were derived from the analysed data from the eight interviews with therapists working with clients in persistent embodied distress in the NHS. The diagram in Appendix N demonstrates the grounded theory process from initial codes to clinical recommendations (below). These guidelines highlight the connections to be made and tensions held and managed by therapists in the different areas of the therapeutic work.

(1) **Support/invite an open dialogue about body process**. It may be useful for the therapist to develop a dialogue and relationship with the client about their

body process in an open, direct and honest way, without being overly intrusive or cautious. This can be facilitated through the attending to time, pacing and trust in the developing working alliance.

(2) **Address power issues as they arise.** It will be useful for the therapist to openly explore expressions, positions and use of power in terms of behaviours, the client's history and experience (in and outside of the NHS context) and associated fears. The therapist can model expressions of their own sense of power in relation to the relationship and work in the NHS, and how power can be negotiated towards establishing equality/mutuality. This process can be supported through the exploration of coping towards developing a sense of agency and shared responsibility.

(3) **Utilise your own embodied process in the work.** It is important that the therapist allows their own experiential/embodied into the process in the work. This may be an opportunity to practise more creatively, by being more authentic, and express your own passion/belief or embodied experience in the work. A warning note: try to ensure structured self-care is in place in this type of client work.

(4) **Provide a 'flexible structure' to the work**. Both structure and flexibility are important in the work with these clients. Consider the scope within the NHS to practise from an attachment-informed position, e.g. are we able to provide weekly sessions to begin with, or open-ended sessions to provide a sense of continuity of care? If not, how might you be able to address these needs openly with the client? At the same time, the treatment plan needs to be based on individualised need and real life, tailored to the particular client's life struggles, trust issues and stage of their therapeutic alliance and therapeutic journey.

(5) **Meet the client as a person first**. This relates to the person of the therapist meeting the person of the client. It is important to believe, respect and validate their personal experience as well as their experience of professionals and NHS systems and processes. Although formulation may be a useful tool in the work, it is not necessary to hurry and suggest the problem has a psychological component. Change can come from working with the physical but mostly from aligning ourselves to where the client is in the work.

(6) **Understand the cultural/spiritual relevance of the distress**. It is important to approach the cultural/spiritual meaning of the symptoms, no matter how foreign they are to us. We can facilitate understanding by exploring personal, socio-cultural and spiritual contexts to the distress in the context of the individual's history. Who might they go to 'back home' if they were in distress and 'what might that individual advise you?' What do they expect or hope from you as a therapist? Work with an interpreter if needed (preferably not a family member) to understand what the persistent embodied distress or symptoms mean to them.

(7) **Enhance client understanding of mind-body-brain-context**. It is helpful to have your own way of explaining how physical health, mental health and pain are connected to life experience and our neurobiology in layperson terms. Highlight how pain and distress cannot always be seen on scans or evidenced medically but that we know it exists and is connected to stress and lifestyle and they can therefore take some control and make changes themselves that can help.

(8) **Include body-based interventions**. Developing body-based skills as therapists may be particularly useful in the work with these clients. Even if a therapist is not trained as a body psychotherapist, body-based methods can

be used safely to model for the client a variety of body-based exercises which can be helpful, such as movement (in the form of role-play or sculpting), a variety of breathing exercises including yoga-based breathing, safe place or grounding exercises, deep muscle/progressive muscle relaxation (the letting go response), paying attention and working with body-based sensations, behaviours, movements, gestures or posture.

(9) **Bridge client and professional understanding of embodied distress**. It can be very helpful for the professional network involved to understand the client's embodied distress in the context of their individual history and related needs. This includes understanding the stress response and what happens when the individual experiences something traumatic. This psychoeducation supports both the client and the professional team with understanding and managing the complex health-mental health interactions and presentations. It may also support the emotional transferential-countertransferential dynamics which may present within a clinical setting and how these dynamics can arise and be understood and better managed by the individual as well as by the multi-professional team. Educating the key professionals in context-mind-body-brain mechanisms including attachment behaviours, psychological defences, possible triggers for the patient and learnt patterns of behaviour as well as how to respond therapeutically is likely to be very useful for the patient, professional network and the ongoing relationship between them.

5.9   Research Contributions

The research has the potential to contribute at a number of different levels; for the individual and family, at a practitioner and organisational level, and at a public health

policy and cost/benefits level for those clients who sit in limbo, at the interface of physical health and mental health services across their lifetime.

I have proposed several gaps in the existing literature relating to the therapeutic relationship in the NHS and the client's therapeutic needs. I believe that as individual practitioners and as an organisation, we form part of a co-created process and have a responsibility to continually reflect upon these encounters. The research, therefore, has the potential to enhance the knowledge, awareness and competencies of psychological practitioners working with embodied experience across services, and improve therapeutic outcomes for our clients.

The lived embodied experience of the therapist in the work with these clients offers an important disciplinary perspective. I hope the research helps professionals anticipate the work ahead and manage the various tensions of working within this environment with complex clients.

The research was approached as an integrative endeavour; therefore, implications for professionals trained or aspiring to practise integratively, as well as those in related disciplines, may find this research useful. Wider use may apply across both health and mental health services and contribute within primary and secondary care.

Due to the focus and motivation for the research, it has the potential to impact in a very useful and applied way, to draw from practice-based evidence and wisdom and make a very much needed contribution to the area of persistent somatisation in the NHS, from a counselling psychology and integrative psychotherapeutic perspective (Shahar, 2013).

Through the research process, I started to consider the need for NHS mind-body link workers, specifically trained to work and track clients across departments and services, skilled in formulating complex, in-depth and unconscious processes to

support clients, professionals and services in the work with clients in persistent embodied distress.

Therapists I interviewed as part of the study worked across primary, secondary and tertiary services, and across both health and mental health services. They discussed a wide variety of embodied presentations and distress, including pain, fatigue and paralysis, numbness, and diagnosed and undiagnosed conditions. Therefore, I hope the findings from the research have the potential to inform a number of professionals and benefit a variety of clients in a variety of settings/specialities.

5.10 Research Limitations

The main limitations of the study relate to the grounded theory process methodology. This approach speaks to the therapists' commonality in the work and fails to pick up on their individuality and essence of them as practitioners. This felt particularly important following the emergence of the first codes, 'Communicating the (cultural) values/attitude of the Therapist' which highlighted the importance of the presence and way of being of the therapist. Therefore, I would suggest further study is needed to look at the individuality and, in particular, the cultural presence of the therapist with clients in embodied distress.

From an intersubjective standpoint, the research also focused on the therapist's voice and, therefore, has not given space for the client's voice in the construction of this theory. Although the participants included in the study came from diverse backgrounds, both culturally and clinically, and offered a wealth of experience contributing to the grounded theory, the gender of the sample (being all-female) may suggest it is not representative. There could, therefore, be gender bias in the grounded theory, which could be considered a limitation of the model. Interestingly, only female participants self-selected for the study, which could suggest something

else; for example, female therapists are perhaps more drawn to working with the body therapeutically or more drawn to talking about it. These thoughts are purely speculative at this stage, and further studies could explore this further.

In addition, due to the single researcher design, independent checking of the full data set was not possible and is therefore considered a further limitation. However, the analysis did benefit from being scrutinised by a sub-group of the participants in a focus group exercise, which further refined the model presented.

5.11 Future Research

To test the parameter of my grounded theory, I considered testing the theory with professionals from other disciplines outside of the counselling psychology/psychotherapy arena to test the transferability of the theory. Future research could assess the transferability of this model to other disciplines in the NHS. However, throughout the research process, my practice continues to evolve and the ideas I now integrate into my own practice have developed. My clinical practice context within a clinical health psychology team within a hospital allows me to work with a number of medical specialities, and I have already offered some of my learning less formally through psychological consultation that I offer to a number of other consultants and specialities within the hospital setting. Although it is early days to see the fruits of the research, as a psychological practitioner within the NHS I feel more able to offer guidance confidently to other disciplines and feel the guidance I give is anchored in something that applies to the NHS, is evidence-based in practical wisdom from within profession, and relevant to these clients in particular.

At this stage, it would be useful for the findings and framework from this study to be tested against other integrative and psychological models and be developed and

tested with a client population. Clients' accounts of this therapeutic approach within the NHS could also further elucidate the findings from this study.

With the feedback from participants that some elements of the proposed framework did not differ greatly from their work with other complex clients, the integrative framework for persistent embodied distress presented here could be trialled with other complex client presentations, e.g. clients with persistent/chronic depression, to compare outcomes and transferability.

Whilst considering the limitations of this study, it is possible that the patients as well as male therapists, as discussed in the limitations section, have a different concept of the field or different experience of working within it. Although it is hard to generalise, future research could look to address and incorporate these different perspectives into the model and address any possible gender bias within the model itself.

5.12 Discussion Summary

In this chapter, I have addressed the research question: counselling psychologists and psychotherapists in the NHS: what can be learnt from their work with clients experiencing persistent embodied (somatic) distress? I have addressed how therapists work with persistent somatic/embodied distress. What can be offered by counselling psychology and psychotherapy as a profession to these clients, and the ways in which the practice setting of the NHS impact the work?

'Persistence' as a phenomenon did not arise as a separate category/construct, as I may have expected from the data, but was embedded within the understanding of embodied and functional distress supporting the more recent classifications of somatic/functional disorders (DSM-5 and ICD-11).

My research contributes to the wider field by re-approaching the theory and existing models of embodied distress with an up-to-date lens of the cross-disciplinary sciences. There are currently very few integrative contributions from counselling psychology and psychotherapy that fully address the complexity of these clients and their associated therapeutic psychological needs in context. The research, therefore, offers an important practice-based disciplinary NHS contribution to the field. These findings have affirmed the need for an integrative, attachment-informed NHS practice model. It also supports the need for practice models that can be shared with our clients that offer a dialogue to begin to facilitate their understanding of the mind-body-brain-context complexity involved.

The findings also suggest clear elements of this work relate to more generic principles of psychotherapeutic practice, whereas other aspects of the findings highlight aspects with particular relevance to this group of clients.

6 CONCLUSIONS

6.1 Reflective Interview 2

Overall, the research process has been a very enjoyable experience, mostly because of the therapist-participants I met as part of the process. I felt privileged to listen as they reflected on their learning through their practice experience. As a result, I have grown in confidence both at the research and a specialist practice level. However, I was also interested to know how the learning from this research process would affect my own practice framework and practice approach. I, therefore, underwent a second reflective interview post-analysis of the data.

From this interview, I considered where I sit in the NHS as an IPT; I work for an organisation but sit 'on the edge' as a non-medical member of staff. In being part of the NHS and embodying the institution in many ways, I inherently embody its tensions as well. The embodied voice of the therapist was therefore important to me because it reflected my own experience and position within the NHS. I leant that therapists are central in the work; fundamentally acting as a bridge to all areas. The therapists in the study were important because the individual voices made up the collective voice. Therefore, each individual needed to be represented fully in the model, not only to capture the breadth and depth of knowledge and the diversity of experience, but also to express their powerlessness as a result of their embodying aspects of the institution and client process. I realised that I am content to bend the rules; I understand it is part of my unique role as a counselling psychologist and psychotherapist at the edge of the NHS. I am happy to offer something different, not necessarily better than any of our colleagues, but something important to our clients nevertheless.

6.2   Bringing Two Professional Identities

As a result of my own dual training and the selection of participants in the study, the model also addresses the ongoing task of bridging two professional identities, counselling psychology and psychotherapy within the NHS. The influence of this over the model may present in a number of ways. From a psychotherapy perspective, the participants and myself as the researcher offered the relationship (in the form of attachment ideas) as the foundation of the practice model. Complex relational dynamics were discussed and considered in terms of the patient's unconscious past and in terms of using our own embodied experience as the therapist.

From a counselling psychology perspective, the participants presented from diverse cultural backgrounds and, as a result, attended to the socio-cultural sensitivities in the work with these patients. This included attention to the patient and the therapist's own relationship with the body in the context of their own culture as well as the relationship with the NHS context and NHS culture. Their integrative training also presented itself in the model by considering the patient holistically and systemically in relation to the evidence-based and interconnected nature of experience across mind-body-brain and context across the lifespan.

Although the design of the study encouraged practitioner reflexivity, the level and depth of reflexivity were evident across both professions. The diverse training, openness and creativity of the participants across both professions were also evident and reflected in the final model constructed. My personal integration and awareness of my dual roles and task within the NHS bridging both identities continues to evolve and develop as a result of the research process and the research findings I have discussed.

6.3 Review of the Study

This research study set out to explore what could be learned from counselling psychologists and psychotherapists in the NHS reflecting on their work with clients experiencing persistent embodied somatic distress. Within this, I answered how NHS therapists work with this presentation, what can be offered by counselling psychology and psychotherapy as a profession, and how the NHS impacts the work.

The overall findings suggest that this is a complex area of practice, where the embodied therapist acts as a bridge between the client and the NHS organisation, making connections and managing tensions through the embodied use of self.

New and surprising findings from the study include counselling psychologists and psychotherapists 'working and at the edge' of the helping professions and the edge of the NHS in order to support these clients. In addition, the cultural presence of the therapists and their attitude to working with the body found to be key factors in the work.

At the beginning of the research process, I held a particular curiosity about persistent, embodied distress as a phenomenon. However, 'persistence' did not emerge as a separate phenomenon in the data but was understood by therapists as part of a larger relational/attachment process within this clinical presentation.

I was particularly interested in what tacit knowledge and wisdom potentially existed in the professional field based on my past experience with these clients. I attempted to capture this understanding by conducting in-depth, reflective interviews with eight NHS therapists who had a particular interest and specialist experience working with clients in persistent embodied distress within this therapeutic context. This approach proved fruitful, and a wealth of experience and data was captured which was developed using full constructivist grounded theory analysis into a finalised model:

The embodied therapist as a bridge in the NHS. However, it was the second group

stage of the data gathering and refinement process that was pivotal in developing

my model to something that was both valid and useful to future NHS

psychotherapeutic practice.

This refined model highlighted three key practice areas in the work with these

clients:

(1) Providing an embodied therapeutic relationship.

(2) Managing connections and tensions between client-therapist-organisation.

(3) Supporting connections in the mind-brain-body-context.

These findings add support for person-centred, attachment-informed, body-based

practice in the NHS, highlight the role of the profession in the NHS, and support

models that connect and communicate mind-body-brain-context complexity in ways

that facilitate clients' understanding without alienating them. These three sub-

categories and practice areas were developed further into clinical recommendations.

Difficulties that I experienced as part of the research process included getting

caught up by 'squeezing' the data of eight very skilled, articulate, passionate

therapists into some type of theoretical structure/model. This proved a quite

challenging task. I was intent on capturing the essence and experience of meeting

these skilled therapists and their practices, and I consider now whether it is fully

possible to reduce the data and their practices and what may have been lost as part

of the analytical process. As Participant E stated:

> *…the fact is that your journey of being a yoga person is*
>
> *indescribable, it's not manualised you know… your history your*
>
> *relationship with the land, with Greek, with food. This is not*
>
> *manualised. It is embodied in one person and so in some way may*
>
> *be the way is to create a model from the person and what that person*

is holding, the therapist, their relationship with the institution, their

relationship with their research model, with the academy, their

relationship with spirituality, because everything goes through us.

I also understand my findings are likely to be part of a larger systemic picture which changes in relation to time, context, therapist and client (Taylor & Francis, 2013). My perspective, therefore, offers only one contribution; however, in this case, I believe the combined skill of the eight therapists and my own relevant experience in this area offered depth to this particular research process.

6.4   The Future

Part of the problem of working with embodied (somatic) distress is, I believe, embedded within the ongoing false dichotomy between psychological and physical health that exists in the NHS (Stuart et al., 2008). The mind-body Cartesian split is embedded within the origin and history of the NHS and medical origins of the psychotherapy profession. In other languages, there are terms for the subjective self; for example, in German, they call the body-mind together 'Liebe', and in Chinese Taoist philosophy of profound unity there is considered to be an indiscernible essence of wholeness, evident from one's aliveness. However, in Western philosophies, we have not yet found or created our own language for the process of being one being that integrates and helps us understand and accept these two aspects together.

As I discussed in Contributions (Section 5.9), we could begin to bridge this gap another way by introducing (mind-body) link workers in the NHS across various services that work and are trained to work with both mind and body together to support these complex clients. In the meantime, until we create a language and model that encompasses both mind and body together (as one), we will continue to

be drawn back to our old understanding and use of language. I would go as far as to suggest that we make the shift by drawing from (or borrowing) one of these terms, or similar, from our foreign colleagues. In this way, we would be able to begin to think, talk and practise in ways that allow openness and understanding, not necessarily of illness and disease but begin to understand oneself as a fragmented whole. Some working across the divide, for example the introduction of mental health liaison, is evidence that treating people's needs together can lead to improved outcomes and costs (Stickley & Wright, 2014). A relook at how supportive psychotherapy models can be reintroduced into the NHS to better support these clients' needs may be useful, as well as the evidence for 'social prescribing', which shows the benefits of addressing the long term and holistic needs of these clients (Kimberlee 2015).

I agree with Fink (2017) in working towards finding some recognition of an underlying multi-function disorder; we may be able to unify our research and practice efforts and our practice models and focus our funds in a way that finds the best outcomes for these clients.

6.5   Final Thoughts

As I think about endings, I become aware of several points. I have been assuming that persistence to the NHS has a regressive function or quality. I am able to consider now that not everyone is able to work through therapy or distress in one smooth motion. It may not be the right time for some clients as life issues arise, it may be too much for others, or the therapist/client match or cultural fit may not be right. My understanding of persistence is very different from what I first assumed. I now understand that the phenomenon is dynamic and clients' need NHS support over a period of time.

The research has also allowed me to move beyond my own personal experience and invite new and diverse ideas and perspectives into the work with these clients. Of course, how each therapist integrates these findings will be open to their own interpretation and integration into their own framework and embodied process and presence in the work. I hope the research welcomes new ways of bridging the mind-body-brain divide in the NHS, as this complex area of practice does not currently appear as part of our traditional counselling psychology training programmes. Promisingly, Interventions directed at educating physicians in this area has already shown an impact on healthcare utilisation (Dickinson, 2003).

Despite rapid developments in research in this area, the Cartesian split is still very much alive reflected in our healthcare systems. Our understanding of multi-dimensional issues and a more circular model of understanding of embodied experience in the NHS still have some way to filter down. However, I believe we have an ethical responsibility to reflect continuously on our practice with each client and to be open to all aspects of the embodied individual and new ways of trying to support their understanding.

This research has deepened my understanding of persistent embodied distress, the centrality of the person of the therapist, the importance of the context of the NHS, and the contribution of counselling psychology and psychotherapy. It has also deepened my understanding of the uniqueness of the therapist to provide diverse, reflexive, socially-culturally sensitive practice at different levels of being. These research findings suggest that this profession has the capacity to work with this level of complexity and the multi-faceted role of the therapist in the NHS. However, I propose additional training in models of mind-body-brain-context complexity needs further consideration in our future training programmes.

Importantly, the research also highlighted the areas of tension within the work in the NHS and further consideration for how these are managed by the therapist in relation to the organisation and the client may be useful in future work.

By virtue, the embodied therapist is someone who bridges the client and NHS relationship and divide. Embedded within their own embodied experience and steeped within their own layers of training, values, roles, beliefs and cultural history. Simultaneously making multiple connections and holding and managing multiple tensions both in and outside of their conscious awareness. Interpersonally, intersubjectively, they hold multiple relationships; the role is vast yet fundamental, at the same time complex and specialist. The embodied therapist is all of these things as a bridge to both client and organisation in the work.

RESEARCH REFERENCES

Ablin, J.N., Buskila, D., Van Houdenhove, B., Luyten, P., Atzeni, F. and Sarzi-Puttini, P. (2012) 'Is fibromyalgia a discrete entity?' *Autoimmunity Reviews 11*(8), pp. 585-588.

Addis, M.E. and Mahalik, J.R. (2003) 'Men, masculinity, and the contexts of help seeking', *American Psychologist, 58*(1), pp. 5-14.

Almond, R. (2013) 'Varieties of psychoanalytic experience lessons from returning patients', *Journal of American Psychoanalytical Association,* 61(5), pp. 957–976.

Alvesson, M. and Deetz, S. (2000) *Doing critical management research.* London: Sage.

American Psychiatric Association. (2013) *Diagnostic and statistical manual of mental disorders: DSM-IV-TR.* 5th edn. Washington, DC: American Psychiatric Association.

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D. and Gilies, W. H. (2006) 'The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology', *European Archives of Psychiatry & Clinical Neuroscience*, 256 (3), pp.174-186.

Anderson, F. (2007) *Bodies in treatment.* New York: Routledge.

Aron, L. and Harris, A. (2005) (*Eds.) Relational psychoanalysis volume 2: Innovation and expansion.* Hillsdale N.J: The Analytic Press.

Axelman, M. (2012) 'Chronic conversion disorder masking attachment disorder', *Journal of Psychotherapy Integration*, 22(1), pp. 14–18.

Bachrach, L. L. (1981) 'Continuity of care for chronic mental patients: A conceptual analysis', *American Journal of Psychiatry*, 138(11), pp. 1449-1456.

Barreto, Y. K. (2013) 'The experience of becoming a therapist in a foreign culture', *Journal of Humanistic Psychology*, *53*(3), pp.336-361.

Bayer, B. M. & Shotter, J. (1998) (Eds.) *Reconstructing the psychological subject.* London: Sage.

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

Barsky, A.J., Orav, E.J. and Bates, D.W. (2005) 'Somatization increases medical utilization and costs independent of psychiatric and medical comorbidity', *Archives of General Psychiatry*, *62*(8), pp. 903-910.

Beebe, B. and Lachmann, F. (2005) *Infant research and adult treatment.* New York: The Analytic Press.

Bensing, J. M., and Verhaak, P. F. M. (2006) 'Somatisation: A joint responsibility of doctor and patient', *Lancet*, 367(9509), pp. 452–454.

Bergner, S. (2009) 'The analytic environment in times of bodily dysfunction: the effect of psychoanalytic psychosomatic theories', *Psychoanalytic Psychology*, 26(4), pp.362-378.

Bermingham, S.L., Cohen, A., Hague, J. and Parsonage, M. (2010) 'The cost of somatisation among the working-age population in England for the year 2008–2009', *Mental Health in Family Medicine*, *7*(2), pp.71-84.

Beutler, L.E., Malik, M., Alimohamed, S., Harwood, T.M., Talebi, H., Noble, S. and Wong. E. (2004) Therapist variables. *Bergin and Garfield's handbook of psychotherapy and behaviour change* (5th ed). New York: Wiley, pp. 226-306.

Bleichhardt, G., Timmer, B., and Rief, W. (2004) 'Cognitive-behavioural therapy for patients with multiple somatoform symptoms: a randomised controlled trial in tertiary care', *Journal of Psychosomatic Research*, 56(4), pp. 449-454.

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

Bor, R., and Watts, M. (1999) *The trainee handbook: a guide for counselling and psychotherapy trainees.* London: SAGE Publications.

Bowlby, J. (1979) 'On knowing what you are not supposed to know and feeling what you are not supposed to feel', *The Canadian Journal of Psychiatry*, *24*(5), pp.403-408.

Broom, B. (2013) *Transforming clinical practice using the mindbody approach*. London: Karnac Books Ltd.

Brown, R. J. (2004) 'Psychological mechanisms of medically unexplained symptoms: an integrative conceptual model', Psychological Bulletin, 130(5), pp. 793–812.

Brown, R. J. and Ron, M. A. (2002) *Conversion and somatoform disorders, in Ramachandran, V.S. (Ed.) Encyclopaedia of the human brain (Vol. 2).* Diego, CA: Academic Press, pp. 37-49.

British Psychological Society (2014) *BPS code of human research ethics. 2nd edn.* Available at: https://www.bps.org.uk/news-and-policy/bps-code-human-research-ethics-2nd-edition-2014 [Accessed 27 Aug. 2018].

Bruner, J.S. (1990) *Acts of meaning* (Vol. 3). Cambridge: Harvard University Press.

Bryant, A. (2003) A constructive/ist response to Glaser. *Qualitative Social Research* (Vol. 4). 1:15. Available at: http://www.qualitative-research.net/index.php/fqs/article/view/757/1642 [accessed 27 Aug 2018].

Caouette, L. (2013) 'Self-emergence, embodiment, and presence in eidetic psychotherapy: Integrative bridges to the existential-humanistic perspective and beyond', *Journal of Mental Imagery*, 37(1-2), pp. 112-123.

Carr, D., and Springer, K. W. (2010) 'Advances in families and health research in the 21st century', *Journal of Marriage and Family*, 72(3) pp. 743-761.

Coastronguay., L. G. and Hill., C. E (2007) *Insight in Psychotherapy*. Washington, DC: American Psychological Association.

Charmaz, K. (1995) 'Grounded theory', in Smith, J.A, Harre, R. and Van Langenhove, L. (eds) Rethinking methods in psychology. London: Sage Publications.

Charmaz, K. (2000) 'Constructivist and objectivist grounded theory', in Denzin, N.K. and Lincoln, Y. (eds) Handbook of qualitative research. 2nd edn. Thousand Oaks, CA: Sage Publications, pp. 509-535.

Charmaz, K. (2003) '*Grounded theory'*, in Lewis-Beck, A., Bryman, A. and Liao, T.M. (eds.), *The sage encyclopaedia of social science research methods*. London: Sage, pp. 440-444

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

Charmaz, K. (2014) *Constructing grounded theory*. London: Sage Publications.

Cheng, L.Y. and Lo, H.T. (1991) 'On the advantages of cross-culture psychotherapy: The minority therapist/mainstream patient dyad', *Psychiatry, 54*(4), pp.386-396.

Ciechanowski, P., Russo, J., Katon, W., Von Korff, M., Ludman, E., Lin, E., Simon, G. and Bush, T. (2004) 'Influence of patient attachment style on self-care and outcomes in diabetes', *Psychosomatic Medicine*, *66*(5), pp.720-728.

Colmenares-Roa, T., Huerta-Sil, G., Infante-Castañeda, C., Lino-Pérez, L., Alvarez-Hernández, E., and Peláez-Ballestas, I. (2015) 'Doctor–patient relationship between individuals with fibromyalgia and rheumatologists in public and private health care in Mexico', *Qualitative Health Research*, 26(12), pp. 1674-1688. Available at: http://qhr.sagepub.com/content/early/2015/06/01/1049732315588742. [Accessed 22nd September 2015]

Cornell, W.F. (2002) Body-centered psychotherapy, *Comprehensive handbook of psychotherapy: Interpersonal/humanistic/existential, Vol. 3.* Hoboken, NJ, US: John Wiley & Sons Inc, pp. 587-613.

Creswell, J. W. (2012) *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks: Sage.

Croicu, C., Chwastiak, L. and Katon, W. (2014) 'Approach to the patient with multiple somatic symptoms', *Medical Clinics of North America*, 98(5), pp.1079-1095.

Crombez, G., Beirens, K., Van Damme, S., Eccleston, C. and Fontaine, J. (2009) 'The unbearable lightness of somatisation: A systematic review of the concept of somatisation in empirical studies of pain', *Pain*, 145(1), pp.31-35.

Cryer, P. (1996) *The research student's guide to success.* Berkshire: Open University Press

D'Andrea, W., Sharma, R., Zelechoski, A.D., and Spinazzola, J. (2011) 'Physical health problems after single trauma exposure: when stress takes root in the body', *Journal of American Psychiatric Nurses Association*, 17(6), pp. 378–392.

De Gucht, V., and Maes, S. (2006) 'Explaining medically unexplained symptoms: toward a multidimensional, theory-based approach to somatization', *Journal of Psychosomatic Research*, 60(4), pp. 349–352.

Den Boeft, M., Claassen-van Dessel, N. and van der Wouden, J. (2017) 'How should we manage adults with persistent unexplained physical symptoms?' *BMJ*, 8(356), p. 268.

Denzin, N. and Lincoln, Y.S. (2000) Handbook of qualitative research. 2nd edn. Thousand Oaks, CA: Sage, pp. 509-536.

Descartes, R., Haldane, E.S. and Ross, G.R.T. (1911) The *philosophical works of Descartes* (Vol. 1), Cambridge: University Press. p. 224.

DeVault, M. and Gross, G. (2012) *Feminist qualitative interviewing: experience, talk, and knowledge, i*n Hesse-Biber, S. (Ed.) Handbook of feminist research: Theory and praxis. 2nd edn. Thousand Oaks, CA: SAGE Publications, Inc, pp. 206-237.

Dey, I. (1999) *Grounding Grounded Theory*. San Diego: Academic Press.

Dey, I. (2004) 'Grounded theory', in Seale, C., Gobo, G., Gubrium, J.F. and Silverman, D. (Eds), Qualitative research practice. London: Sage, pp. 80–93.

Dryden, W. (2007) *Dryden's handbook of individual therapy (Ed.) 5th edn.* Los Angeles: Sage.

Dryden, W., and Reeves, A. (2014) *The handbook of individual therapy.* London: SAGE Publications.

Dunbar, H.F. (1935) *Emotions and bodily changes. A survey of literature on psychosomatic interrelationships.* New York: Columbia University Press, pp. 1910-1933.

Dunleavy, P. (2003) *Authoring a PhD: How to plan, draft, write and finish a doctoral thesis or dissertation.* London: Palgrave/Macmillan.

Edelstein, L. (1943) *The Hippocratic oath: text, translation and interpretation.* Washington, DC: Johns Hopkins Press.

Eisler, I. (2006) 'The heart of the matter–a conversation across continents', *Journal of Family Therapy*, *28*(4), pp.329-333.

Engel, G. L. (1977) 'A need for a new medical model: A challenge for biomedicine. *science*, 196(4286), pp. 129-136.

Entwistle, V.A. and Watt, I.S. (2013) 'Treating patients as persons: a capabilities approach to support delivery of person-centred care', *The American Journal of Bioethics*, *13*(8), pp.29-39.

Etherington, K. (2004) *Becoming a reflexive researcher: Using ourselves in research.* Jessica Kingsley Publishers: London.

Farnell, B., & Varela, C. (2008) 'The second somatic revolution', *Journal for the Theory of Social Behaviour*, 38(3), pp. 215-240.

Field, K.E., Cohler, B.J. and Wool, G.E.(eds) (1989) *Learning and education: psychoanalytic perspectives.* Madison, CT: International Universities Press. pp. 209-243.

Fink, P. (2017) 'Syndromes of bodily distress or functional somatic syndromes - Where are we heading'. Lecture on the occasion of receiving the Alison Creed award. *Journal of Psychosomatic Research* (Vol.97), pp.127-130.

Finlay, L. and Ballinger, C. (eds) (2006) *Qualitative research for allied health professionals: challenging choices.* West Sussex: John Wiley & Sons.

Finlay, L. and Gough, B. (2003) *Reflexivity: A practical guide for researchers in health and social science.* Oxford: Blackwell Publishing.

Flick, U. (2014) *An introduction to qualitative research. 5th edn.* London: Sage.

Fonagy, P. (1991) 'Thinking about thinking: Some clinical and theoretical considerations in the treatment of a borderline patient', *International Journal of Psycho-Analysis*, 72(4), 639-656.

Fonagy, P. (1999) 'Psychoanalytic theory from the viewpoint of attachment theory and research', In Cassidy, J. and Shaver, P.R. (Eds.), Handbook of attachment: Theory, research, and clinical applications. New York: The Guilford Press, pp. 595-624.

Fonagy, P., & Luyten, P. (2016) A multilevel perspective on the development of borderline personality disorder, in Cicchetti, D. (Ed.), Developmental psychopathology: Maladaptation and psychopathology. Hoboken, NJ, US: John Wiley & Sons Inc, pp. 726-792.

Frankel, S., Bourgeois, J. and Erdberg, P. (2013) *Comprehensive care for complex patients.* Cambridge: Cambridge University Press.

Frankl, V.E. (1994) *Logotherapie und existenzanalyse: Texte aus sechs Jahrzehnten.* Berlin: Quintessenz.

Frankland, A. and Walsh, Y. (2005) 'Counselling psychology in the NHS', *Mental Health Review Journal*, 10(3), pp.31-34.

Freud, S. (1914) 'Errinern, wiederholen und durcharbeiten (weitere ratschläge zur technik der psychoanalyse, II)', *Internationale Zeitschrift für ärtztliche Psychoanalyse,* 2(6), pp. 485-491.

Freud, A. (1936) The ego and mechanisms of defence. London: Hogarth Press.

Frie, R., Ries, B., Thompson, M.G., Frederickson, J., Giovacchini, P.L., Giovacchini, P., Summers, F., Zeddies, T.J., Downing, D.L., Nissim-Sabat, M. and Langs, R. (2005) *Relational and intersubjective perspectives in psychoanalysis: A critique*. Oxford: Jason Aronson.

Gabinet, L. and Friedson, W. (1980) 'The psychologist as front-line mental health consultant in a general hospital', *Professional Psychology*, 11(6), pp. 939-945.

Garralda, E. (2004) 'The interface between physical and mental health problems and medical help seeking in children and adolescents: A research perspective, *Child and Adolescent Mental Health*, 9(4), pp. 146–155.

Garza, M.C. (2017) A culturally sensitive psychological treatment plan for immigrant Mexican-American women diagnosed with somatic symptom disorder with predominant pain. *Dissertation Abstracts International*, 78, 5-B(E).

Gergen, K. J. (1982) *Toward transformation in social knowledge.* New York: Springer-Verlag.

Gergen, K.J. (1985) 'The social constructionist movement in modern psychology', American Psychologist, 40(3), pp. 266–75.

Gergen, K. J. (2009) *Relational being: beyond self and community.* Oxford: Oxford University Press.

Glaser, B. G. (1978) *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory.* Mill Valley, California: Sociology Press.

Glaser, B. G. (1992) *Basics of grounded theory analysis.* Mill Valley, California: Sociology Press.

Glaser, B.G. (2003) The grounded theory perspective II: Description's remodelling of grounded theory methodology. Mill Valley, California: Sociology Press.

Glaser, B.G. and Strauss, A.L. (1967) *The discovery of grounded theory: strategies for qualitative research*. Chicago: Aldine Publishing.

Gold, M. (1999) (*Ed.) The complete social scientist: A Kurt Lewin reader.* Washington, DC: American Psychological Association.

Goodwin, I. (2003) 'The relevance of attachment theory to the philosophy, organisation and practice of adult mental health care', *Clinical Psychology Review*, 23(1), pp. 35-56.

Goodwin, I., Holmes, G., Cochrane, R., and Mason, O. (2003) 'The ability of adult mental health services to meet clients' attachment needs: The development and implementation of the Service Attachment Questionnaire', *Psychology and Psychotherapy: Theory, Research and Practice*, 76 (2), pp. 145–161.

Goss, S. and Rowland, N. (2000) *Evidence-based counselling and psychological therapies*. London: Routledge.

Gottlieb, R. M., and Levy, S. T., (2013) 'A patient returns': Editors' introduction, *Journal of American Psychoanalytical Association*, 61(5), pp. 925–927.

Guillemin, M. and Gillam, L. (2004) 'Ethics, reflexivity, and 'ethically important moments' in research', *Qualitative inquiry*, *10*(2), pp.261-280.

Haglund, P. and Buirski, P. (2001) Making sense together: The intersubjective approach to psychotherapy. *Northvale, NJ: Hason Aronson*.

Hague, J. (2008) 'Improving access to psychological therapies in primary care', *Primary Health Care*, 18(10), pp.18-19.

Hardwick, P. J. (2005) 'Engaging families who hold strong medical beliefs in a psychosomatic approach', *Clinical Child Psychology and Psychiatry*, 10(4), pp. 601–616.

Harris, M. and Bergman, H. C. (1984) 'Reassessing the revolving door: A development perspective on the young adult chronic patient', *The American Journal of Orthopsychiatry*, 54(2), pp. 281-289.

Hatfield, L . (2006) *Working with dual realities: psychological and physical*, *Dual realities: The search for meaning: Psychodynamic therapy with physically ill people*. London, England: Karnac Books, pp. 79-91.

Hayes, J. (2008) 'Review of somatic psychology, body, mind and meaning', *Body, Movement and Dance In Psychotherapy*, 3(2), pp. 133-136.

Helman, C.G. (2000) *Culture, health and illness. 4th edn. UK: Butterworth Heinemann.*

Henningsen, P., Zimmermann, T. and Sattel, H. (2003) 'Medically unexplained physical symptoms, anxiety, and depression: a meta-analytic review', *Psychosomatic medicine*, *65*(4), pp. 528-533.

Herman, J.L. (1992) 'Complex PTSD: A syndrome in survivors of prolonged and repeated trauma', *Journal of traumatic stress*, *5*(3), pp.377-391.

Hilsenroth, M.J., Ackerman, S.J. and Blagys, M.D. (2001) 'Evaluating the phase model of change during short-term psychodynamic psychotherapy', Psychotherapy Research, 11(1), pp.29-47.

Holmes, J. (1993) 'Attachment theory: A secure theoretical base for counselling?' *Psychodynamic Counselling*, 1(1), pp. 65-78.

Holton, J. A. (2007) 'The coding process and its challenges', in Bryant, A. and Charmaz, K. (Eds.) The Sage handbook of grounded theory. Thousand Oaks, CA: Sage, pp. 265-289.

Houtveen, J., Lintmeijer, L. and van Broeckhuysen, S. (2013) 'The clinical effectiveness of a long-term multidisciplinary integrative psychological treatment with a focus on body-related mentalisation for patients with severe somatoform disorder', *Journal of Psychosomatic Research*, 74(6), p.656-664.

Howard, L. M., and Wessely, S. (1996) 'Reappraising reassurance: The role of investigations', Journal of Psychosomatic Research, 41(4), pp. 307-311.

Hunter, J. and Maunder, R. (2016) *Improving patient treatment with attachment theory*. (1st edn) Switzerland: Springer International Publishing.

Hyland, M., Hinton, C., Hill, C., Whalley, B., Jones, R. and Davies, A. (2016) 'Explaining unexplained pain to fibromyalgia patients: finding a narrative that is acceptable to patients and provides a rationale for evidence-based interventions', British Journal of Pain, 10(3), pp.156-161.

Hyland, M.E. (2017) 'A New Paradigm to Explain Functional Disorders and the Adaptive Network Theory of Chronic Fatigue Syndrome and Fibromyalgia Syndrome', Resistance *and Renewal in Theoretical Psychology*, ON: Captus University Publications Concord, pp. 21-31.

Janssens, K.A., Houtveen, J.H., Tak, L.M., Bonvanie, I.J., Scholtalbers, A., van Gils, A., Geenen, R. and Rosmalen, J.G. (2017) 'A concept mapping study on perpetuating factors of functional somatic symptoms from clinicians' perspective', *General hospital psychiatry*, *44*, pp.51-60.

Johnstone, L. (1989) Users and abusers of psychiatry, in Proctor, G, The dynamics of power in counselling and psychotherapy, 2nd edn. Monmouth: PCCS Books, p 7.

Josselson, R. (2011) 'Narrative research: constructing, deconstructing, and reconstructing story', in Wertz, F.J. and Wertz, F.J. *Five ways of doing qualitative analysis: phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry*, pp.224-242.

Kaffman, A. (2009) 'The silent epidemic of neurodevelopmental injuries', *Biological Psychiatry*, 66(7), pp.624-626.

Kamler, B. and Thomson, P. (2014) *Helping doctoral students write. 2nd edn.* London: Routledge.

Katon, W., Kleinman, A. and Rosen, G. (1982) 'Depression and somatization: a review: Part I', *The American journal of medicine*, *72*(1), pp.127-135.

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

Katz, A.W. (2010) 'Healing the split between body and mind: structural and developmental aspects of psychosomatic illness', *Psychoanalytic Inquiry*, 30(5), pp. 430-444.

Kepner, J. (2003) 'The embodied field', *British Gestalt Journal*, *12*(1), pp.6-14.

Kimberlee, R. (2015). What is social prescribing?.Available at: https://doi.org/10.14738/assrj.21.808 [accessed 14/9/19].

Kirmayer, L. J., and Sartorius, N. (2007) 'Cultural models and somatic syndromes', *Psychosomatic Medicine*, 69(9), 832–840.

Koelen, J., Houtveen, J., Abbass, A., Luyten, P., Eurelings-Bontekoe, E., van Broeckhuysen-Kloth, S., Bühring, M. and Geenen, R. (2014) 'Effectiveness of psychotherapy for severe somatoform disorder: meta-analysis', *British Journal of Psychiatry*, 204(01), pp.12-19.

Kohut, H (1971) *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders.* Chicago: University of Chicago Press.

Kolnes, L.J. (2012) 'Embodying the body in anorexia nervosa: A physiotherapeutic approach', *Journal of Bodywork and Movement Therapies*, *16*(3), pp.281-288.

Kools, S., McCarthy, M., Durham, R. and Robrecht, L. (1996) 'Dimensional analysis: broadening the conception of grounded theory', *Qualitative Health Research*, *6*(3), pp.312-330.

Krioukova, Z. (2017) 'The embodied experience of transformation during relational somatic psychotherapy: A phenomenological study from the clients' perspective', *Dissertation Abstracts International*, 78, 6-B(E).

Kvale, S. (1992) Psychology and Postmodernism. London: Sage.

Kvale, S. and Brinkmann, S. (2009*) Interviews: Learning the Craft of Qualitative Research Interviewing. 2nd edn.* Thousand Oaks: Sage.

la Cour, P. (2017) 'Comparison of patients diagnosed with "complex pain" and "somatoform pain"', *Scandinavian Journal Of Pain*, Vol 17, pp. 49-52.

Lacan, J. (1994) *The Four Fundamental Concepts of Psycho-Analysis.* London: Éditions du Seuil, p. 49.

Lambert, M. J. (2013) *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change. 6th edn.* NY: Wiley.

Langdridge, D. (2007) *Phenomenological Psychology: Theory, Research and Method.* Harlow, England: Pearson Prentice Hall.

Lask, B., and Fosson, A. (1989) *Childhood Illness: The Psychosomatic Approach: Children Talking with Their Bodies.* Chichester: Wiley.

Laungani, Pittu & Laungani, Pittu. (2004) 'Counselling and therapy in a multi-cultural setting', Counselling Psychology Quarterly, 17(2), pp.195–207. Available at: http://search.proquest.com/docview/57163339/.

Lemma, A. (2014) 'The body of the analyst and the analytic setting: reflections on the embodied setting and the symbiotic transference', *The International Journal of Psychoanalysis*, 95(2), pp. 225-244.

Levine, P. A. (2015) Trauma & Memory: Brain and Body in a Search for the Living Past. California: North Atlantic Books.

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

Lowen, A. and Watts, P. (1969) *The betrayal of the body*. USA: Macamillan

Luyten, P. and Fonagy, P. (2016) 'An integrative, attachment-based approach to the management and treatment of patients with persistent somatic complaints', in Hunter, J. and Maunder, R. *Improving patient treatment with attachment theory: A guide for primary care practitioners and specialists*. Switzerland: Springer International Publishing, pp. 127-144.

Lyons, E. and Coyle, A. (2007) (*Eds.) Analysing Qualitative Data in Psychology*. London: Sage.

Lyons-Ruth, K., Bruschweiler-Stern, N., Harrison, A.M., Morgan, A.C., Nahum, J.P., Sander, L., Stern, D.N. and Tronick, E.Z. (1998) 'Implicit relational knowing: Its role in development and psychoanalytic treatment', *Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health*, *19*(3), pp.282-289.

Mann, D. (2002) *(Ed.) Love and Hate.* New York: Brunner-Routledge.

Margarian, A. (2014) 'A cross-cultural study of somatic countertransference: A brief overview', *Asia Pacific Journal of Counselling and Psychotherapy*, 5(2), pp. 137-145.

Marmarosh, C.L., Kivlighan Jr, D.M., Bieri, K., LaFauci Schutt, J.M., Barone, C. and Choi, J. (2014) 'The insecure psychotherapy base: Using client and therapist attachment styles to understand the early alliance', *Psychotherapy*, *51*(3), p.404.

Maroda, K. (1999) Seduction, surrender and transformation. Hillsdale N.J.: The Analytic Press.

Maroda, K. J. (2010) *Psychodynamic techniques: working with emotion in the therapeutic relationship.* New York: the Guilford Press.

Marshall, T., Jones, D.P.H., Ramchandani, P.G., Stein, A., and Bass, C. (2007) 'Intergenerational transmission of health beliefs in somatoform disorders', *The British Journal of Psychiatry*, Vol 191, pp. 449–450.

Maunder, R. G., and Hunter, J. J. (2001) 'Attachment and psychosomatic medicine: developmental contributions to stress and disease', *Psychosomatic Medicine*, 63(4), pp. 556–567.

McCann, T. and Clark, E. (2003) 'Grounded theory in nursing research: Part 1– Methodology', *Nurse & Researcher*, 11(2), pp. 7–18.

McCluskey, U. (2005) *To be met as a person*. London: H. Karnac Books Ltd.

McLeod, J. (2003) *Doing counselling research.* London: Sage.

McLeod, J. (2010) *Case study research in counselling and psychotherapy*. London: Sage.

Mechanic, D. (1986) 'The concept of illness behaviour: culture, situation and personal predisposition', *Psychological Medicine*, 16(1), pp. 1–7.

Melidis, C., Denham, S.L. and Hyland, M.E. (2018) 'A test of the adaptive network explanation of functional disorders using a machine learning analysis of symptoms', *Biosystems*, Vol.*165*, pp.22-30.

Melzack, R. and Wall, P. D. (1965) 'Pain mechanisms: A new theory', *Science*, 150 (3699), 971-979.

Merleau-Ponty, M. (1962) *Phenomenology of Perception (trans). London: Routledge and Kegan Paul.*

Merskey, H. (1965) 'Psychiatric patients with persistent pain', *Journal of Psychosomatic Research*, 9(3), pp. 299-309.

Messler, D. (1994) Treating the adult survivor of childhood sexual abuse: A Psychoanalytic Perspective. New York: Basic Books.

Meyers, L.I. (2004) 'Living in ice houses: A poetics of the body', *Contemporary Psychoanalysis*, 40(2), pp. 279-297.

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

Mohan, I., Lawson-Smith, C., Coall, D. A., van der Watt, G. and Janca, A. (2014) 'Somatoform disorders in patients with chronic pain', *Australasian Psychiatry*, 22(1), pp. 66-70.

Montague, A. (1986) *Touching: the human significance of the skin*. New York: Perenial Library.

Morriss, R. (2012) 'Role of mental health professionals in the management of functional somatic symptoms in primary care', *The British Journal of Psychiatry*, 200(6), pp. 444-445.

Morrow, S.L. (2005) 'Quality and trustworthiness in qualitative research in counselling psychology', *Journal of counselling psychology*, *52*(2), p.250.

Mulvihill, D. (2005) 'The Health Impact of Childhood Trauma: An Interdisciplinary Review', *Issues in Comprehensive Paediatric Nursing*, Vol 28, pp. 115-136.

Murray, R. (2009) *How to Survive Your Viva. 2nd edn.* Maidenhead, Berkshire: McGraw Hill/Open University Press.

Nimnuan, C., Rabe-Hesketh, S., Wessely, S and Hotopf, M. (2001) 'How many functional somatic syndromes?' *Journal of Psychosomatic Research*, 51(4), pp.549-557.

Norcross, J.C., Beutler, L. E. & Levant, R. F (2006) (Eds.) Evidence-based Practices in mental health: debate and dialogue on the fundamental questions. Washington, DC: American Psychological Association.

Norcross, J. C. & Goldfried, M. R. (1992) *(Eds.) Psychotherapy integration.* New York: Basic Books.

Ogden, T.H. (2014) *Rediscovering psychoanalysis: Thinking and dreaming, learning and forgetting.* East Sussex: Routledge.

Ono, Y., Janca, A., Asai, M. and Sartorius, N. (1999) *Somatoform disorders.* Tokyo: Springer.

Pain Community Centre (no date) '*Low back pain: The problem*'. Available at: http://www.paincommunitycentre.org/article/low-back-pain-problem#ref6 [Accessed 11/04/16].

Parker, I. (1994) 'Reflexive research and the grounding of analysis: Social psychology and the psy-complex', *Journal of Community & Applied Social Psychology*, *4*(4), pp.239-252.

Parsons, T. (1975) 'The sick role and the role of the physician reconsidered', *Milbank Memorial Fund Quarterly*, 53(*3*), pp. 257-278.

Petre, M. and Rugg, G. (2010) *The unwritten rules of PhD research.* Maidenhead, Berkshire: McGraw Hill/Open University Press.

Pietromonaco, P.R., Uchino, B. and Dunkel, S.C. (2013) 'Close relationship processes and health: Implications of attachment theory for health and disease', Health Psychology, 32(5), pp.499–513.

Pilowsky, I. (1997) *Abnormal illness behaviour.* Chichester: Wiley.

Polkinghorne, D. E. (2005) 'Language and meaning: data collection in qualitative research', *Journal of Counselling Psychology*, 52(*2*), pp.137-145.

Proctor, G. (2017) *The dynamics of power in counselling and psychotherapy*, 2nd edn. Monmouth: PCCS Books.

Prussack, J. (2015) *Chronic pain: An 'emotional' experience.* Available at: http://www.sirpauk.com/pa_referring-practitioner/jim-prussack/ [Accessed 15th March 2016]

Ramchandani, P.G., Murray, L., Romano, G., Vlachos, H., and Stein, A. (2011) 'An investigation of health anxiety in families where children have recurrent abdominal pain', *Journal of Paediatric Psychology,* 36(4), pp. 409–419.

Rappoport, E. (2015) *Dynamic linking of psyche and soma: somatic experiencing and embodied mentalization*, *relational psychoanalysis and psychotherapy integration: an evolving synergy*. New York: Routledge/Taylor & Francis Group, pp. 136-157.

Rao, A.S., Bhutani. G.,Dosanjh, D., Clarke, J., Hacker-Hughes, J., Easton, S., Van Lar, D., Cohen-Tovey, E. (2016) Psychological wellbeing and resilience: resetting the balance. Leicester: British Psychological Society.

Reich, W. (1983/1942) Character Analysis. New York, Touchstone.

Reid, S., Wessley, S., Crayford, T. and Hotopf, m. (2002) 'Frequent attenders with medically unexplained symptoms: Service use and costs in secondary care', *British Journal of Psychiatry*, Vol.180, pp. 258-253.

Rief, W. and Hiller, W. (1999) The psychological treatment of somatoform disorders. Springer: Tokyo, pp. 212-217.

Rief, W., Schaefer, S., Hiller, W. and Fichter, M. M. (1992) 'Lifetime diagnoses in patients with somatoform disorders: which came first?' *European Archives of Psychiatry and Clinical Neuroscience*, 241(4), pp. 236-240.

Rimes, K.A. and Chalder, T. (2010) 'The beliefs about emotions scale: validity, reliability and sensitivity to change', *Journal of psychosomatic research*, *68*(3), pp.285-292.

Robson, C. (2011) *Real world research, 3rd edn.* Chichester: Wiley.

Rogers, C. (1951) *Client-centred therapy: Its current practice, implications and theory.* London: Constable.

Rossi, E.L. (1990) *From mind to molecule: More than a metaphor*, *Brief therapy: Myths, methods, and metaphors.* Philadelphia, PA, US: Brunner/Mazel, pp. 445-472.

Rost, K., Smith, J.L. and Dickinson, M. (2004) 'The effect of improving primary care depression management on employee absenteeism and productivity a randomized trial', *Medical care*, *42*(12), p.1202.

Rowan, J. and Jacobs, M. (2002) *The therapist's use of self*. Maidenhead: Open University Press.

Rowland, N. and Goss, S. (2000) *Evidence-based counselling and psychological therapies*. London: Brunner-Routledge, pp. 3-12.

Rubin, H. J. and Rubin, I. S. (2009) *Qualitative interviewing: The Art of Hearing Data, 2nd edn.* Thousand Oaks: Sage.

Saldana, J. (2013) *The coding manual for qualitative researchers, 2nd edn.* London: Sage.

Sampson, E.E. (1998) 'Life as an embodied art: the second stage - beyond constructionism', in Bayer, B.M. and Shotter, J. (eds), Reconstructing the psychological subject: bodies, practices and technologies, inquiries in social construction. London: SAGE Publications Ltd, pp. 21-32

Schneekloth, T., Arab, J., Niazi, S. and Simonetto, D. (2018) Impact of pre- and post-liver transplant addiction treatment and AA attendance on outcomes for recipients with alcoholic liver disease, *Journal of Psychosomatic Research*, Vol. 109, p.134.

Schore, A. N. (2001) 'The effects of early relational trauma on right brain development, affect regulation, and infant mental health', *Infant Mental Health Journal*, 22(*1-2),* pp.201-269.

Schwandt, T.A. (2000) Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics, and social constructionism. *Handbook of qualitative research*, Vol. *2*, pp.189-213.

Seale, C. (1999) 'Quality in qualitative research', *Qualitative inquiry, 5*(4), pp.465-478.

Segal-Andrews, A. M., Altschuler, S. M., & Harkness, S. E. (1995) 'Chronic abdominal pain: Treating the meaning of pain', *Family Systems Medicine*, 13(*2*), pp. 233-243.

Sexton, T. (2007) The therapist as a moderator and mediator in successful therapeutic change', *Journal of Family Therapy*, 29(2), pp.104-108.

Shahar, G. (2013) 'Where we should be: Introduction to the special section on psychotherapy integration in behavioural medicine (part I)', *Journal of Psychotherapy Integration*, 23(1), 1–4.

Shaw, R. (2003) *The embodied psychotherapist*. Hove: Routledge.

Shaw, R. (2004) 'The embodied psychotherapist: an exploration of the therapists' somatic phenomena within the therapeutic encounter', *Psychotherapy Research*, 14(3), pp.271-288.

Siegel, D. J. and Solomon, M. (eds) (2003) *Healing trauma: attachment, mind, body and brain.* New York: W. W. Norton & Company.

Silverman, D. (2000) *Doing qualitative research: A practical handbook.* London: SAGE Publications.

Simon, G. M. (2006) 'The heart of the matter: A proposal for placing the self of the therapist at the centre of family research and training', Family Process, 45(3), pp.331–344.

Smith, J. A. (2015) *Qualitative psychology: A practical guide to research methods, 3rd edn.* London: Sage.

Solomon, M. and Siegel, D. (2003) *(Eds.) Healing trauma, attachment, mind, body and brain.* New York: Norton.

Spiegel, D., Bloom, J. R., Kraemer, H. C., and Gottheil, E. (1989) 'Effect of psychosocial treatment on survival of patients with metastatic breast cancer'. *Lancet*, 2(8668), pp. 888–891.

Sprenkle, D. and Blow, A. (2007) 'The role of the therapist as the bridge between common factors and therapeutic change: more complex than congruency with a worldview', *Journal of Family Therapy*, 29(2), pp.109-113.

Starčević, V. (1991) 'Reassurance and treatment of hypochondriasis', *General Hospital Psychiatry*, *13*(2), pp.122-127.

Staunton, T. (2002) *(Ed.) Body psychotherapy.* UK: Brunner-Routledge.

Stickley, T. and Wright, N. (2014) *Theories for mental health nursing*. London: SAGE, pp. 344 - 371.

Stolorow, R.D., Orange, D.M. and Atwood, G.E. (2001) 'Cartesian and post-Cartesian trends in relational psychoanalysis', *Psychoanalytic Psychology*, *18*(3), p.468.

Stuart, S. and Noyes Jr, R. (1999) 'Attachment and interpersonal communication in somatization', Psychosomatics, 40(1), pp.34-43.

Stuart, S., Noyes, R., Starcevic, V. and Barsky, A. (2008) 'An Integrative Approach to Somatoform Disorders Combining Interpersonal and Cognitive-behavioral Theory and Techniques', *Journal of Contemporary Psychotherapy*, 38(1), pp.45-53.

Taylor, B., and Francais, K. (2013) *Qualitative research in the health sciences.* Oxon: Routledge.

Sumner, G. and Haines, S. (2010) Cranial intelligence. *London and Philadelphia: Singing Dragon*.

Taylor, G. J. (2002) 'Mind-body-environment: George Engel's psychoanalytic approach to psychosomatic medicine', *Australian & New Zealand Journal of Psychiatry*, 36(4), pp. 449–457.

Taylor, S. J., and Bogdan, R. (1998) *Introduction to qualitative research methods: A guidebook and resources, 3rd edn.* New York: John Wiley & Sons.

Thornberg, R. (2012) 'Informed grounded theory', *Scandinavian Journal of Educational Research*, *56*(3), pp.243-259.

Tinkler, P. and Jackson, C. (2004) *The doctoral examination process: A handbook for students, examiners and supervisors.* Maidenhead, Berkshire: Society for Research into Higher Education & Open University Press.

Trafford, V. and Lesham, S. (2008) *Stepping Stones to achieving your doctorate.* Maidenhead, Berkshire: McGraw Hill/Open University Press.

Tronick, E.Z. (1989) 'Emotions and emotional communication in infants' *American psychologist*, *44*(2), p.112.

Tschacher, W., & Storch, M. (2015) Embodiment und Kommunikation: Der Körper im Fokus von Beratung und Therapie: Embodiment and communication - Focus on the body in counselling and therapy. *Familiendynamik: Systemische Praxis Und Forschung*, 40(2), pp. 118-127.

Ulirsch, J., Ballina, L., Soward, A., Rossi, C., Hauda, W., Holbrook, D., Wheeler, R., Foley, K., Batts, J., Collette, R., Goodman, E., & McLean, S. (2014) 'Pain and somatic symptoms are sequelae of sexual assault: Results of a prospective longitudinal study', *European Journal of Pain*, 18(4), pp. 559-566.

van der Kolk, B.A. (2006) 'Clinical implications of neuroscience research in PTSD', Annals of the New York Academy of Sciences, 1071(1), pp.277-293.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., and Spinazzola, J.(2005) 'Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma', *Journal of Traumatic Stress*, 18(5), 389–399.

van Dessel, N., den Boeft, M., van der Wouden, J., Kleinstäuber, M., Leone, S., Terluin, B., Numans, M., van der Horst, H. and van Marwijk, H. (2014) 'Non-pharmacological interventions for somatoform disorders and medically unexplained physical symptoms (MUPS) in adults'. Available at: https://www.ncbi.nlm.nih.gov/pubmed/25362239

van Dijke, A., Ford, J., van der Hart, O., van Son, M., van der Heijden, P., & Buhring, M. (2012) 'Complex posttraumatic stress disorder in patients with borderline personality disorder and somatoform disorders', *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(2), pp. 162-168.

VandenBos, G. R., DeLeon, P. H. (1988) 'The use of psychotherapy to improve physical health', *Psychotherapy: Theory, Research, Practice, Training*, 25(3), 335.

Vania, A. A., Baliki, M. N., Petre, B., Torbey, Huany, K. M. L, Schnitzer, T. J. and Fields, H. L. (2012) 'Corticostriatal functional connectivity predicts transition to chronic back pain', *Nature Neuroscience,15(8), pp1117-1119.*

Verhaeghe, P. (2004) *On being normal and other disorders.* New York: Other Press.

Walach, H. (2007) 'Mind--body—spirituality'. *Mind and Matter*, *5*(2), pp.215-240.

Walter, S., Leißner, N., Jerg-Bretzke, L., Hrabal, V., & Traue, H. (2010) 'Pain and emotional processing in psychological trauma'. *Psychiatria Danubina*, 22(3), pp. 465-470.

Watson, W.H. and McDaniel, S.H. (2000) 'Relational therapy in medical settings: working with somatising patients and their families', *Journal of Clinical Psychology*, *56*(8), pp.1065-1082.

Wells, A. and Matthews, G. (1994) *Attention and emotion: A clinical perspective*. Hove: Lawrence Erlbaum, p. 402.

White, K. (2014) *Talking Bodies.* London: Karnac Books.

Winkley, K., Landau, S., Eisler, I. and Ismail, K. (2006) 'Psychological interventions to improve glycaemic control in patients with type 1 diabetes: systematic review and meta-analysis of randomised controlled trials' *BMJ*, *333*(7558), p.55-56.

Williams, S. J. (2005) 'Parsons revisited: from the sick role to...? *Health', (London)*, 9(2), pp. 123–144.

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

Willig, C. (2008) *Introducing qualitative research in psychology.* Maidenhead: Open University Press.

Willig, C. (2013) *Introducing qualitative research in psychology, 3rd edn.* New York: McGraw-Hill/Open University Press.

Winnicott, D. W. (1945) Mind and its relation to the psyche-soma, *British Journal of Medical Psychology, 27*(*4*), pp. 201-209.

Winnicott, D. W. (1973) *The child, the family, and the outside world.* London: Middlesex Press.

Woo, C. W., Roy, M., Buhle J. T. and Wagner T. D. (2015) 'Distinct brain systems mediate the effects of nociceptive Input and self-regulation on Pain', *PLOS Biol*ogy 13(*1*).

Woods, S. B., Priest, J. B. and Denton, W. H. (2015) 'Tell me where it hurts: assessing mental and relational health In primary care using A biopsychological assessment intervention', *The Family Journal: Counselling and Therapy for Couples and Families*, 23(2), pp. 109-119.

Woolcott, H. (1990) *Writing up qualitative research.* Sage: India.

World Health Organization. (2018) *The ICD-11 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research*. Geneva: World Health Organisation.

Young, C. (2007) 'Review of relational perspectives on the body', *International Journal of Psychotherapy*, 11(1), pp.81-82.

APPENDIX A – DEFINITIONS

Psychotherapist/therapist/healthcare professional: Has been used interchangeably.

Client/Patient: Individuals tend to be referred to as 'patients' within the NHS setting or traditional psychoanalytic setting, whereas the term 'clients' is used more in psychotherapy literature.

Somatic/somatisation: Refers to the presence of physically embodied symptoms and implies the interconnection between mind and body and the significant distress and impairment in the way it presents, in the absence of any known medical cause (Lipowski, 1988). In this research, I encompass the broad 'psychosomatic spectrum' (Lask & Fosson, 1989) which includes all somatic symptoms and experience, from pain through to fatigue and paralysis.

Somatic symptom disorder: Presentation as above. Previously 'somatoform disorder'. A diagnosis of exclusion. Somatic symptoms may be generalised in four major categories: neurological, cardiac, pain, and gastrointestinal somatic symptoms (American Psychiatric Association, 2013).

Bodily Distress Disorder - Previously 'Functional Somatic Disorder': "Bodily distress disorder is characterised by the presence of bodily symptoms that are

distressing to the individual and excessive attention is directed toward the symptoms, which may be manifest by repeated contact with health care providers. If another health condition is causing or contributing to the symptoms, the degree of attention is clearly excessive in relation to its nature and progression. Excessive attention is not alleviated by appropriate clinical examination and investigations and appropriate reassurance. Bodily symptoms are persistent, being present on most days for at least several months. Typically, bodily distress disorder involves multiple bodily symptoms that may vary over time. Occasionally there is a single symptom - usually pain or fatigue - that is associated with the other features of the disorder" (World Health Organisation, 2018).

APPENDIX B – LITERATURE SEARCH STRATEGY

I have referred to the terms used within each of the individual papers to capture the essence and context of the specific contribution.

I have primarily focused on the last 30 years of research in line with the huge influence of contemporary cross-disciplinary sciences; namely psychoneuroimmunology, bringing closer the mental and physical health divide. However, I have also considered relevance and contribution over date published, so have mentioned several key theorists pre-dating this time.

Search Strategy

I followed the literature search guidance for NHS researchers (2015).

I first searched CINAHL and Cochrane library.

I then used Middlesex University Summon Search tool to do an initial search on the following key terms and then individual searches in several of the following databases online: Ahmed, Base, Cambridge journals, Medline, NICE, Ovid, Oxford Journals, PubMed, Pep Web, ProQuest Natural Sciences collection, Psych articles, Psych Info, Sage journals online, Science citation index, Social Science citation index, Web of Science and Wiley online.

Search terms included:

- NHS and therapist and Counselling Psychology and Psychotherapy and role.
- Counselling Psychology or Psychotherapy or Counselling or health professional or therapist or psychologist or psychotherapist or practitioner.
- Soma* or psychosomatic or functional, medically unexplained symptoms (MUS) or pain.

- Persistent or chronic or returning or revolving or frequent attenders or relapse or recurring or long-term or high frequency users or help seeking or illness behaviour or sick role.

Following data analysis, I further searched the following terms up to July 2018:

- Therapist as a bridge or the embodied therapist.

- Client complexity.

- Client and patient as a person.

- Culture and therapist or therapy.

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Rochelle Pinner
DC Psych programme
Metanoia Institute

16th September 2016

Ref: 1/16-17

Dear Rochelle

Re: An Exploration with Psychological Practitioners in the National Health Service: Reflecting on their work with Clients experiencing Persistent Somatic (Embodied) Distress

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as research ethics representative for the DCPsych programme.

Yours sincerely,

Prof Vanja Orlans
DCPsych Programme Leader & Faculty Head
Faculty of Applied Research and Clinical Practice
On behalf of Metanoia Research Ethics Committee

APPENDIX D – ETHICAL APPROVAL HRA

NHS
Health Research Authority

Mrs Rochelle Pinner
Counselling Psychology Practitioner
Milton Keynes University Hospital
Health Psychology, Pain Psychology
Eaglestone Hospital
Standing way

Email: hra.approval@nhs.net

09 November 2016

Dear Mrs Pinner

Letter of HRA Approval

Study title:	An Exploration with Psychological Practitioners in the NHS: Reflecting on their work with clients experiencing persistent somatic (embodied) distress.
IRAS project ID:	194912
REC reference:	16/HRA/5411
Sponsor	Metanoia Institute

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. Please read *Appendix B* carefully, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

Page 1 of 9

196

APPENDIX E – RESEARCH PARTICIPANT INFORMATION SHEET & CONSENT FORM

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

RESEARCH PARTICIPANT INFORMATION SHEET

Version 1
Date 12/10/16
IRAS project ID 194912

Study title

An Exploration with Psychological Practitioners' in the National Health Service: Reflecting on their work with Clients experiencing Persistent Somatic (Embodied) Distress.

What is the purpose of the study?

The research study forms part of a doctoral training program in Counselling Psychology & Integrative Psychotherapy at the Metanoia Institute, with the aim to be completed within the next twelve months.

The purpose of the research is to develop our understanding of working with clients that present with persistent somatic (embodied) distress and develop a model to support practitioners in their work and subsequently improve therapeutic outcomes for their clients.

<u>Why have you been asked to take part?</u>

You have been asked to take part for your specialist experience/interest working with clients experiencing somatic (embodied) distress and experience within the NHS. Participants have been contacted through online special interest groups/events, through direct contact with specialist teams/departments and via institutional therapist/supervisor lists. Participants need to have had;

Minimum 3 years NHS experience working with clients with persistent somatic (embodied) distress (in their current or previous clinical practice)

Worked therapeutically/psychologically within a clear 'therapeutic contract' with their clients

Be in current clinical supervision and/or have access to psychological/therapeutic support

Be a qualified Counselling Psychologist and/or Psychotherapist

<u>Do I have to take part?</u>

Taking part is entirely voluntary. If you do decide to take part you will be given this information sheet and be asked to sign a consent form of which you will be given a copy. You are still free to withdraw at any time and without giving a reason.

<u>What will the study involve?</u>

I will ring you to check you meet inclusion criteria for participant in the study. Taking part in the research will include one individual interview and one follow up small group discussion, each taking approximately 60-90 minutes each. My priority will include least interruption to you as the participant and so the individual interview will take place at a time and place convenient to you, with all expenses reimbursed.

Individual interview – This will include a semi-structured reflective interview where you will be invited to reflect on your practice. Multiple levels of data will be considered including verbal and observational responses e.g. I may make note of our nonverbal behaviours or embodied experience as the conversation develops.

Interviews will be conducted face to face in person where possible, but Skype/VSee interviews will to be considered. Interviews will need to be audio recorded and will then be transcribed. You will receive a copy of our interview for checking and reflection if you wish, which you are more than welcome to comment on for correction or further comment. The interview data and feedback will be collated and analysed for the purpose of model/theory construction. Direct quotes may be used in the write-up, however quotes will be anonymous and not be identifiable to you.

Nb. If you would like the interview to take place in your own home or private residence, please be advised your contact address and telephone number will need to be shared with my research supervisor for safety reasons. Your details will only be used in cases of emergency and destroyed thereafter.

Small group session – Following the interviews, a small group session will take place with those interviewed invited to consider/reconsider the findings from the interview stage and the proposed model/theory. This will act as part of an interaction and refinement process of the model/theory under construction. The aim here is to consider the potential implications and real life application of the theory/model proposed. Your feedback is welcomed and important to the process. For those participants who cannot attend the group, their feedback will be fed into the group session and together with the group feedback will be brought together in the final grounded theory/model.

This group session will be in a centralised location to all participants as far as possible for convenience, with as much notice given as possible to support attendance.

Due to the reflective nature of the design, participants are welcome and encouraged to make notes and comment throughout the research process. In view of this, I may ask to make contact with you, after the interview or group stage to clarify points that may have arisen.

Nb. Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

<u>What will the impact of participating be?</u>

There is no anticipated long term or detrimental impact of the study. However, some clinical cases or service issues discussed in the individual interviews or raised by other participants in the group session may raise questions or concerns which require further time and reflection for individual participants. If this does happen, please discuss this with the researcher who will be available to offer a follow up session or phone call if this is deemed helpful or needed. If concerns persist and depending on the nature of the concerns, the researcher may suggest a discussion with their clinical supervisor, clinical lead/manager or personal therapist. In the unlikely event that practice concerns in relation to safeguarding are raised, this will be discussed with you before a plan is agreed.

Although there is no intended immediate benefit to the participant at this stage in the research process, the reflective nature of the interviews may offer the practitioner-participant an opportunity to reflect on an area of their clinical practice in some

depth. In addition, they may find benefits from participating in and forming part of an expert group of professionals in an area of their specialist interest.

The outcome for the study will potentially benefit psychological practitioners in their work and ultimately clients' in somatic distress.

<u>Will my participation be confidential?</u>

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it.

All data will be stored, analysed and reported in compliance with the Data Protection legislation and destroyed on research completion.

<u>What will happen to the results of the study?</u>

The results will be presented in a doctoral thesis. The study will be available online via the Metanoia/Middlesex University Website once completed and may be published in a research journal (s).

Please note, you will not be identified in any report/publication.

<u>Research Approval</u>

The following research study has been reviewed and approved by the Metanoia Research Ethics Committee (The Metanoia Institute).

<u>Who should I contact for further information or if there is a problem?</u>

If you require any further information, please contact me or my research supervisor using the contact details below:

Rochelle Pinner (Lead Researcher)   Dr Patricia Moran (Research Supervisor)

Health Psychology Department (Pain Clinic)   Metanoia Institute

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Thank you for your interest and taking part. If you are happy to proceed, please sign and date the consent form and keep a copy for your records.

Rochelle Pinner

Doctorate in Counselling Psychology & Psychotherapy (Year 5 Trainee)

PARTICIPANT CONSENT FORM

Version 1

Date 12/10/16

IRAS project ID 194912

Participant code:

Title of Project:

An Exploration with Psychological Practitioners' in the National Health Service: Reflecting on their work with Clients experiencing Persistent Somatic (Embodied) Distress

Name of Researcher: Rochelle Pinner

Please initial box

1. I confirm that the data I have given is true, I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

  ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time prior to research submission, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided.

  ☐

3. I understand that my interview will be taped and subsequently transcribed and the data used in a doctoral study by the researcher.

  ☐

4. I agree to take part in the above study. ☐

5. I agree that this form that bears my name and signature may be seen by a

   designated auditor. ☐

_____   _____   _____

Name of participant   Date   Signature

Rochelle Pinner_____   _____   _____

    Researcher   Date   Signature

1 copy for participant; 1 copy for researcher

APPENDIX F – INTERVIEW PROMPT SHEET

What can be learnt from Counselling Psychologists' & Psychotherapists' in the NHS, reflecting on their work with clients' experiencing persistent somatic (embodied) distress?

1) How do you work with persistent somatic distress?

- Can you tell me about your experience working with clients experiencing persistent somatic (embodied) physical symptoms?
- Do any particular clients come to mind? Can you tell me more about them?
- Thinking back, what do you feel is happening when a client presents with persistent embodied distress?   Contributing factors?
- What's it like working with embodied/somatic/physical distress in the NHS?
- Generally, how do you approach the assessment/work with these clients?
- What is it like working with clients in persistent distress?
- In what way does this impact the relationship? You?
- What power processes are at play In relation to clients with persistent distress?
- What do you feel is needed? From you? The service?
- What other difficulties or issues arise working with these client cases? How relevant is continuity of care with these clients?
- On reflection, what works well with persistent presentations? What does not work well?
- What aspects of practitioner self-care are crucial with these clients? And why?

2) What does counselling psychology ad psychotherapy offer these clients?

- What aspects of your training prepare you or contribute in the work?

3) In what way does working in the NHS impact on our practice as counselling psychologists or psychotherapist?

- Can you tell me about your work in the NHS?

- What's it like being a Counselling Psychologist/psychotherapist in the NHS? What position/role do we play?

- In what way have you found working in the NHS impacts on: (i) You? (As a person/personally); (ii) Your clinical practice; (iii) Your relationship with the client

- What are the main differences working with clients with this presentation in private practice?

(4)   Is there anything you'd like to add to what we've already discussed?

APPENDIX G – REFINEMENT GROUP PROMPT SHEET

Q - How do Counselling Psychologists & Psychotherapists in the NHS work with clients experiencing persistent somatic (embodied) distress?

    1) What were your initial thoughts/reactions to the findings (model)?

    2) Was the model clear in explaining/showing what the findings from the study were?

    3) Does the model and its conceptual categories fully and accurately represent your experience of the work with these clients? Has anything been left out?

    4) Does the model fully take into account the context of working in the NHS?

    5) Were there elements that were more figural/central in than others?

    6) How can we make these findings useful? (hold explanatory power?)

    7) How might we improve/develop the model further?

    8) Was there anything that surprised you from the findings?

    9) Is there anything you would like to add to the model?

    10) Is there anything you would like to change?

    11) Do you have any other reflections? Or anything else you would like to mention?

    12) Are there any questions you have about the model or process?

Confidentiality Agreement for Transcription Services

I, ▮▮▮▮▮▮▮ transcriber, agree to maintain full confidentiality in regards to any and all audio recordings and documentation received from Rochelle Pinner related to her doctoral study. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents;

2. To not make copies of any audiotapes or computerized files of the transcribed interview texts, unless specifically requested to do so by Rochelle Pinner;

3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession;

4. To return all audiotapes and study-related documents to Rochelle Pinner in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audio recordings and/or files to which I will have access.

Transcriber's name (printed) ▮▮▮▮▮▮▮▮▮▮▮

Transcriber's signature ▮▮▮▮▮▮▮

Date   05.12.16

Participant B

Second Coder cross reference – In Blue

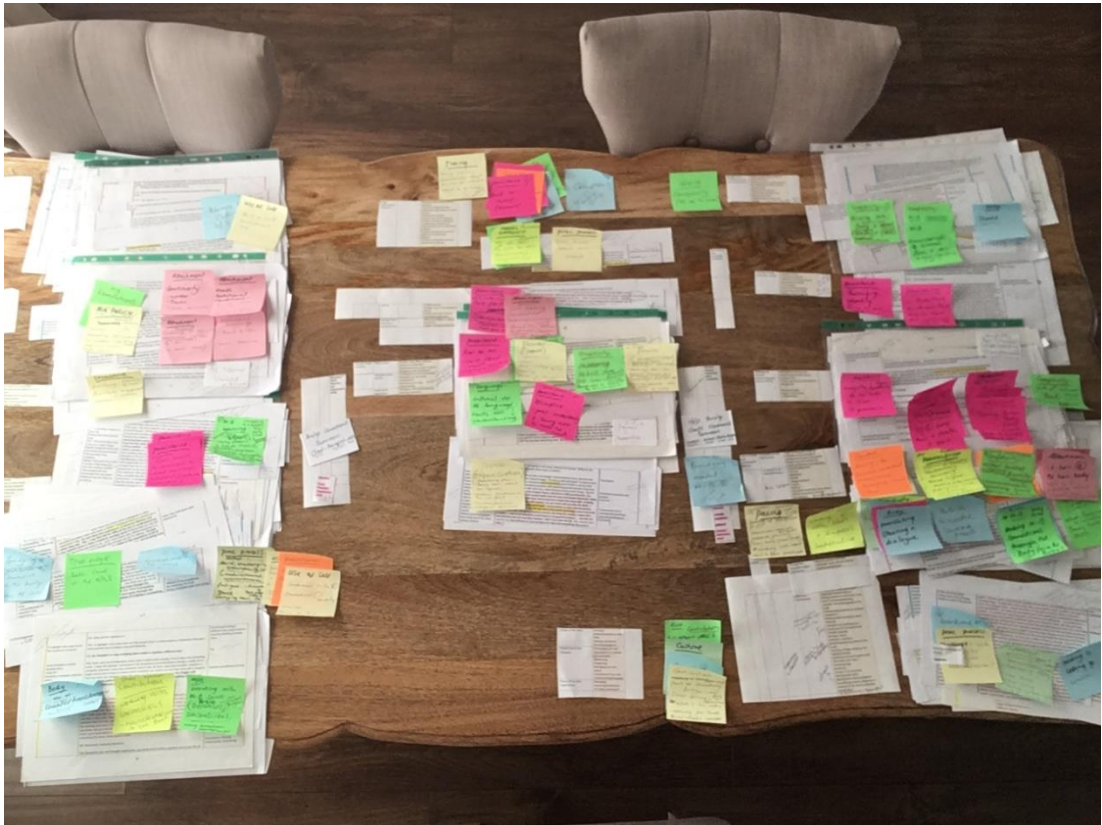| Coding	Narrative	Memos
Q	I.1 Can you start by telling me a little bit about your experience working with clients with persistent or embodied distress?	
-Working in mental health with severe illness -(Making Links) - Clients presenting with psychological & physical distress -Trying to hone in on cognitions, Model not fitting -Realising (discovering) it's a bigger thing/paralysing -Seeing but not knowing what to do with it -Realising, there's all this other stuff -Talking forever -Difficulty grasping embodied experience -thinking something is missing -Lacking knowledge/contacts -working differently -feeling uneasy without addressing the body that was in the room with me	P.1 I think it's probably best to start with when I still worked in mental health, working a lot with people who have schizophrenia or bipolar illness and presenting with a lot of **not just psychological distress but like a very physical distress** and me kind of trying to hone in on their cognitions and doing something about that (laughs), realising that it's just a bigger thing and that they would always be quite unhealthy kind of in a way nearly paralysed…**they would not leave their home and they would be overweight** because of the medication and so all this kind of stuff I would see but I didn't quite know what to do with it and that was for me the first like… Oh my God, **there's all this other stuff and yes we can talk about things forever but the embodied experience, I can't quite grasp.** So that's kind of where it started for me to kind of just think **something is missing and I don't know how to get there** and what that means and I didn't know anybody who worked like that either. So it was not like that I knew that there were lots of health psychology departments out there who may be working in a different way. I just felt increasingly uneasy to just hone in on this intra-psychic kind of material and maybe possibly in the social material or even bio-psychosocial material without actually addressing the body that was in the room with me. So that's how kind of it all started and then I think I went to Hong Kong to work there, which I think I told you as well and there I worked with bankers, very high functioning people but incredibly stressed out physically, kind of really a mess. A lot of them would take amphetamines and just live on coffee and drugs and just manage all the shitloads of money, but again so it was kind of like the other extreme, they were very high functioning compared to someone who was schizophrenic, not leaving the house but again the body was such a big issue and then I was also kind of doing pain management, stress management with those people. So this was really my first experience of being allowed to take the body kind of into the	Complexity/holistic nature of the work – working with psychological/physical distress Health/weight/medication - complexity – Not knowing what to do as a practitioner with the embodied experience Something missing and unsure how to get there in the work Being isolated as a professional Health Psychology Departments Feel uneasy honing on intrapsychic Biopsychosocial assessment Acknowledging the body in the room Relevance of Stress model

1

Participant B

| Coding	Narritive
— recalling — recognising physical expression of distress — making links — discovering extent of overlap / discordance / feeling isolated gaining understanding of holistic importance providing context comparing populations very different but finding similarity in body. integrating body self-learning in process. describing practice	**I.** Can you start by telling me a little bit about your experience working with clients with persistent or embodied distress? **P.** I think it's probably best to start with when I still worked in mental health, working a lot with people who have schizophrenia or bipolar illness and presenting with a lot of not just psychological distress but like a very physical distress and me kind of trying to hone in on their cognitions and doing something about that (laughs), realising that it's just a bigger thing and that they would always be quite unhealthy kind of in a way nearly paralysed...they would not leave their home and they would be overweight because of the medication and so all this kind of stuff I would see but I didn't quite know what to do with it and that was for me the first like... Oh my God, there's all this other stuff and yes we can talk about things forever but the embodied experience, I can't quite grasp. So that's kind of where it started for me to kind of just think something is missing and I don't know how to get there and what that means and I didn't know anybody who worked like that either. So it was not like that I knew that there were lots of health psychology departments out there who may be working in a different way. I just felt increasingly uneasy to just hone in on this intra-psychic kind of material and maybe possibly in the social material or even bio-psychosocial material without actually addressing the body that was in the room with me. So that's how kind of it all started and then I think I went to Hong Kong to work there, which I think I told you as well and there I worked with bankers, very high functioning people but incredibly stressed out physically, kind of really a mess. A lot of them would take amphetamines and just live on coffee and drugs and just manage all the shitloads of money, but again so it was kind of like the other extreme, they were very high functioning compared to someone who was schizophrenic, not leaving the house but again the body was such a big issue and then I was also kind of doing pain management, stress management with those people. So this was really my first experience of being allowed to take the body kind of into the context and I would kind of have...yeah groups of managers and I would be able to kind of educate them a bit about how to recognise mental health problems in their employees and then also for themselves get a bit of teaching on kind of stress. What is stress, there's good stress and bad stress and what do we do...umm, so that was really my first experience of being officially allowed to bring something in the room but that was very kind of rudimentary I would say. ..that was very like me trying to understand a bit better and at the same time it was such a weird environment ...because I remember that in one of those....I would have to have my power point presentation ready and I would have to submit it to the bank, the people who would employ us to deliver the service. First for them to screen it and I think at one stage I had said, it's imperative that you take a lunch break and that you go out you know, out of your environment office and you see the sky in Hong Kong, which is beautiful and you just ...even if its 10 minutes and get a newspaper or piece of

1.1.

P1.

APPENDIX L – IMAGE OF FOCUSED CODING
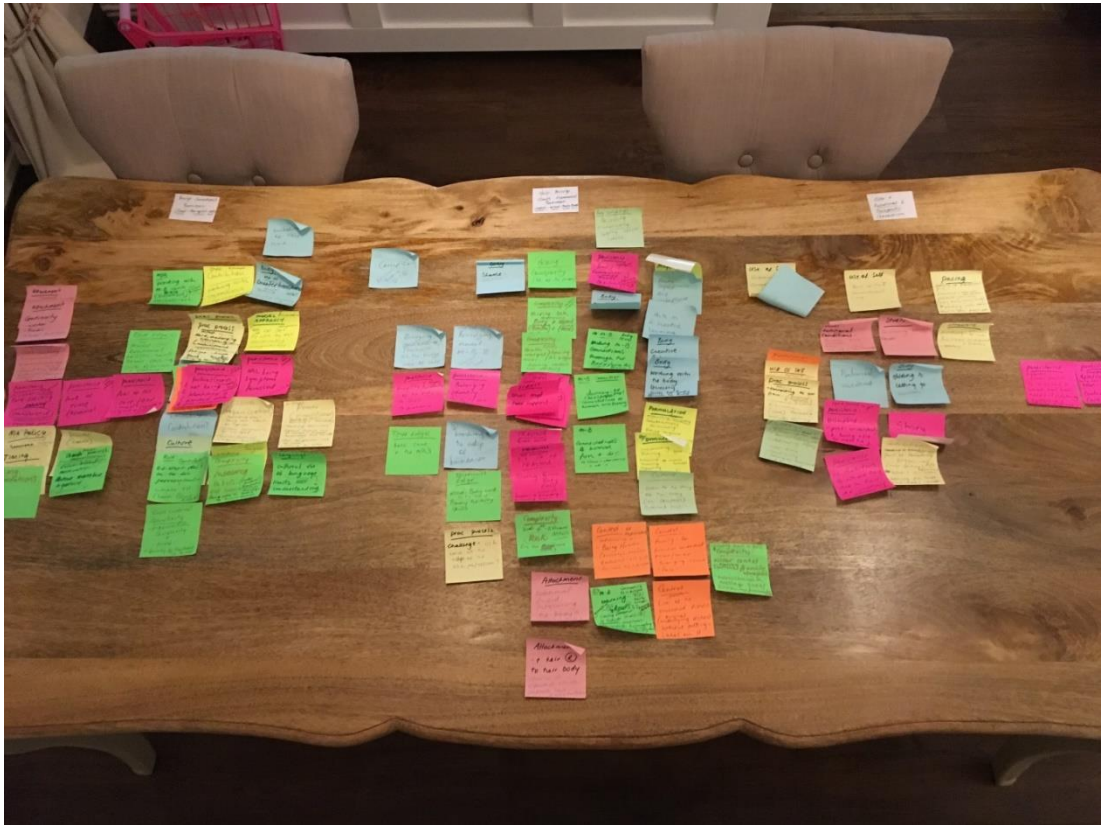
APPENDIX N – CODING TABLE

Table 1. Showing (from right to left) initial codes, grouped initial codes, focussed codes,

theoretical codes, core category

Core Category	4 Sub categories Theoretical codes	3 Focused codes	2 Grouped initial codes (if needed)	1 Initial codes (process/action)
The embodied therapist as a bridge in the NHS - making connections and managing tensions	Providing an embodied therapeutic experience	Providing an attachment relationship	Working with the client as a person	Treating them like a person first Believing them Communicating hope Taking what they say seriously Validating Allowing clients to speak/listening to clients tell their story Being flexible Supportive to individual needs Individualising care Offering individual and group work Offering aftercare or ongoing care Offering booster sessions if needed Helping maintain progress Collaborating Considering cultural stigma
			Providing attachment-informed structure	Allowing time to build a trusting working alliance Considering the client's stage of the therapeutic work in their therapeutic journey Agreeing a focus and a plan and time available Preparing for ending in advance Offering shorter- and longer-term work based on need

			Providing attachment-informed care	Providing holding/soothing/ containment – being with them Mapping the embodied attachment journey and relational patterns Considering pacing Offering continuity of therapist Meeting relational/therapeutic needs Considering expectations Being honest about resources/ role/availability Managing boundaries Considering tension between client needs and the client's difficulty trusting Supporting/encouraging Adapting/attuning theoretical approach to the client Empathically attuning
		Using self in the work	Transmitting the (cultural) values/attitude/ presence of the therapist	Communicating honestly Speaking directly Speaking openly about the body Offering what you think (not as a truth)/inviting them to think with you Being open to be impacted by the client Accepting of the client Being yourself as a therapist Being congruent Respecting the client Being passionate about the work Committing to the client Communicating/transmitting love (practising from your heart)
			The Embodied Therapist	Consider therapist contribution (intersubjective) Embodied presence/attunement Working with gut feeling/instinct Being flexible with boundaries Working creatively with the use of self - e.g. self-disclosure Therapist's connection/closeness to the distress Considering client-therapist fit Considering self-care and secondary trauma
			Working with unconscious processes	Considering transference relationship Working with enactments Managing strong embodied countertransference Offering a bridge between past and

	Connecting Client-Therapist-Organisation (NHS)	Contributing as a professional discipline		present Working with strong resistance/ embodied defences in the work Exploring possible unresolved conflicts Exploring secondary gains Working with expression – implicit-explicit
		Contributing as a professional discipline		Working holistically/integratively Reviewing what helped/worked/or not Individualising psychological care Offering a relational approach and perspective Trying new things Reflexivity in the work Working creatively Taking risks Working at the edge Bridging client needs with NHS resources
		Bridging organisational complexity		Creating a bridge with other professionals/specialities/hospitals involved in care Considering multiple investigations Training other professionals in psychological models Understanding course of a particular condition Consider working with complex comorbid health and mental health diagnosis Consider working with the unknown - e.g. medically unexplained symptoms
		Managing Power processes	Working with the client's power process	Understanding client behaviour – persistent care seeking Explore coping/use/dependency on NHS services with the client Explore the client's fear of loss of care/safety/medication Consider client's previous experience of the NHS Developing client's sense of agency/responsibility/self-management Managing client complaints
			Working with the therapist's power	Challenging our own assumptions about this client group Managing our own power position Limitation of our own understanding

			in relation to our training/language – deciding to work holistically including the body Considering our role in maintaining the distress Challenging the organisation/managers Regular supervision Feeling safer/supported by the NHS Rejecting clients
		Working with organisational power	Managing resources/constraints Refusing treatment Supporting/protecting staff Offering multidisciplinary treatment/services Exercising boundaries of NHS Considering NHS guidelines
Connecting (integrating) context-mind-body-brain complexity	Meeting the client in their complexity	Being open to the whole person at all levels of experience	Listening to what the client brings no matter how foreign to us Understanding roles of illness and illness behaviours over time Considering long term needs Developing client understanding of the relationship between health-mental health Honouring the physical Hearing the emotional story Working with affect Realising cognitive work is not enough Working with the unconscious Working with spirit and the body Working at the symbolic level
		Working with the client's sense of self	In relation to all aspects which inform identity Working with loss Working with distress/pain Working with feelings of shame Connecting to purpose Connecting to humanity/existence Connecting to their body Building a sense of agency/empowerment Connecting to their cultural beliefs Rediscovering who you want to be/values Developing self-compassion
		Working with extreme stress/ trauma and risk	Managing untreated long-term stress/anxiety/unresolved or complex PTSD Trauma informed care/treatment

				Manage/stabilise risk Psychoeducation - creating a bridge between psyche and body using - e.g. the Highland Model Resourcing Normalising Supporting professional understanding
		Formulating and contextualising distress	Considering the client's NHS journey	Helping contextualise often multiple complex diagnosis and treatments Aiding client understanding of professional process and position Respecting and including the client's perspective and experience
			Considering the client's personal journey	Acknowledging systemic role of illness in context; Personal Attachment Familial Intergenerational Cultural relevance/sensitivity in relation to the client's embodied presentation Spiritual Embodied experience Mapping the distress over time
		Integrating body-based and non-body-based approaches	Incorporating non- body-based (generic) interventions	Allowing clients to tell/reclaim their story without labelling Facilitating expression – giving permission Visually mapping journey – including preferred future Taking control of the life-making decisions Writing it down Building a narrative Bending the rules/boundaries (working differently) Problem solving Adapting techniques Containing/tolerating strong affect Client/family/organisational/own anxiety Exploring other aspects of lifestyle to create change Life skills development Developing insight

			219	Mentalizing Journaling offering pre-therapy Psychoeducation
			Incorporating body-based interventions	Allowing clients to tell their embodied story Paying attention to the body – senses, behaviours, movements, posture, gesture Having our own understanding of ongoing embodied distress Translating/decoding possible meaning/language of the body Slowing body movements down – Noticing Considering symptoms as symbolic metaphors - symbolising Using Arts as a learning/expressive tool Using touch if insured/trained Modelling/showing clients in the room Feeling free to work openly/ directly with the body in the room Practising yoga Breathing Working with energy Praying for clients Giving Tai Chi exercises Working with spirit Grounding Embodied visualisation Body-based safe place Practising holding in/letting go

APPENDIX O – PARTICIPANT CONTRIBUTION TABLE

Table 2 shows which participant contributed to the development of each focussed and grouped initial code.

Proving an Embodied Therapeutic Experience

Focussed Code	Grouped initial codes	Participant contribution
Providing an attachment relationship	Working with the client as a person	A, C, D, E, F, G, H
	Providing attachment informed structure	A, B, C, E, F, G, H
	Providing attachment informed care	A B, C, D, E, F, G, H

Focussed Code	Grouped initial codes	Participant contribution
Using Self in the Work	Transmitting the (cultural) values/attitude/presence of the therapist	A, B, C, D, E, F, G
	The Embodied Therapist	A, B, C, D, E, F, G, H
	Working with unconscious process	A, B, C, D, E, F, G, H

Connecting Client-Therapist-Organisation

Focussed Code	Participant contribution
Contributing as a professional discipline	A, B, C, D, E, F, G, H

Focussed Code	Participant contribution
Bridging Organisational complexity	B, C, D, E, F, G, H

Focussed Code	Grouped Initial codes	Participant contribution
Managing Power Processes	Working with the clients power processes	A, B, C, E, F, H
	Working with the therapists power	A, B, C, D, E, F, G, H
	Working with organisational power	A, B, E, F, G, H

Connecting (integrating) context-mind-body-brain complexity

Focussed code	Grouped initial codes	Participant contribution
Meeting the Client in their Complexity	Being open to the whole person at all levels of experience	B, C, D, E, F, G, H

	Working with the client's sense of self	A, B, C, D, F, G, H
	Working with extreme stress/trauma and risk	A, B, C, D, E, F,G, H

Focussed Code	Grouped initial codes	Participant contribution
Formulating and contextualising distress	Considering the client's NHS journey	A, B, C D, E, F, G, H
	Considering the client's personal journey	A, B, C, D, E, F, G, H

Focussed Code	Grouped initial codes	Participant contribution
Integrating body-based and non-body-based approaches	Incorporating non body-based (generic) interventions	A, B, C, D, E,F, G, H
	Incorporating body-based interventions	A, B, C, D, E, G, H

APPENDIX P - EXAMPLE OF IN-VIVO CODES

Table 3 shows an example of in-vivo codes for each initial code for the sub-category 'Connecting Client-Therapist-Organisation'.

	Sub Category (theoretical code)	Focussed Code	Grouped initial codes (if needed)	Initial codes (process/action)	example of in-vivo quotes (Quote, participant and location) par = participant p = participant entry
	Connecting Client-Therapist-Organisation (NHS)	Contributing as a professional discipline		Working holistically/integratively	"I just felt increasingly uneasy to just hone in on this intra-psychic kind of material…or even bio-psychosocial material without actually addressing the body that was in the room with me" (par B, p1)
				Reviewing what helped/worked/or Not	"If it's not necessarily about the relationship and then the patients then get passed on for that reason. So it may not need that may be they need to go on for longer term therapy. It may be that actually what's going on in the six session model that prevents people possibly getting what they might need from it." (par A, p8)
				Individualising psychological care	"it needs to be personalised, it needs to be flexible and it needs to come from people who are urrr I think who have an understanding of distress" (par B, p31)
				Offering a relational approach and perspective	"I'm relational and by that I mean I'm relational in every way. So not just in terms of kind of you know having good kind of counselling skills and listening but also actually relating

223

						physically, literally physically relating to it." (par B, P7)
					Trying new things	"I get a lot of slack, you know I have a lot of other services you know....you can't do this, you can't do that and I'm like... well why not? I mean I set up this therapeutic knitting group" (par B, p32)
					Reflexivity in the work	"Counselling Psychology is fantastic in that you know if I have gone through the process myself and I would be much more aware of it being a counselling psychologist as compared to a clinical psychologist, just because of our kind of background that actually it's a useful tool and I think that brings another dimension into the consulting room" (par C, P6)
					Working creatively	"So we do kind of weird things in the group. Like we dance ... so we all turn outwards so you can't see each other and put the music really loud and dance and we do cat walk-walking all along and everybody claps (laughs) you know just moving the body" (Par C, p19)
					Taking risks	"I've taken risks and I've transformed people's lives by taking risks" (par E, p12)
					Working at the edge	"So in a way they are our guidelines but you know some people follow guidelines and others a bit more wavy you know, I suppose I'm the second category..." (par E, p11)
					Bridging client needs with NHS resources	"I discuss it quite openly with them but then I say...I don't want this to be failure and pain management is a lot about timing and the journey and where you are in this journey, and maybe this is

					not the right thing at the right time" (par B, p30)
		Bridging organisational complexity		Creating a bridge with other professionals/specialities/hospitals involved in care	", I think her parents were starting to feel...nobody's really got it right with our daughter yet, she's still ill. And we've seen all these different people at CAMHs, we've seen paediatricians, we've seen GPs, we've seen surgeons and consultants at the hospital and nobody's made her better" (par B, p6)
				Considering multiple investigations	"She'd gone to all these different doctors she's had, stomach scans and all sorts of x-rays and they've injected dye in her and x-rayed her and all sorts of things and they couldn't find an explanation. She'd been taking aspirin and paracetamols and just about every painkiller going" (par B, p6)
				Training other professionals in psychological models	"So you do get some battles, when you know you go to a professionals meeting and they want to know...well when she is coming back to school. And you know explaining that this is a journey and you know and there's so much going on for this young person" (par B, p33)
				Understanding course of a particular condition	"being aware of the trajectory that people are on" (par F, p33)
				Consider working with complex comorbid health and mental health diagnosis	"I think that there's significant overlap between people who've been through a lot trauma-wise and stress-wise and then the development of physical pain symptoms and mental health symptoms that come along often even pre-dating by a long time before the physical pain problem presents" (par F, p17)

				Consider working with the unknown - e.g. medically unexplained symptoms	"They might have this physical symptom, and they might keep going to the GP, but actually they don't believe anybody can help them. So in a way, the symptom increases that unhealthy attachment because of course nobody can help them. Because nobody can find out what's wrong with them" (par H, p7)
		Managing Power processes	Working with the client's power process	Understanding client behaviour – persistent care seeking	"…'I'm in crisis, I'm in crisis, I am in crisis, you need to do something" (par A, p16)
				Explore coping/use/dependency on NHS services with the client	"I'm clear about what I offer which is support for people to manage, not to treat them, so are you ready to self-manage, are you ready to self-manage your pain?" (par F, p105)
				Explore the client's fear of loss of care/safety/medication	"And they would try and give them other options but they did not want anything else, they didn't want to stay out because they have a bed, they're warm, there's somebody to look after them, somebody to ensure they take their meds" (par A, p16)
				Consider client's previous experience of the NHS	"Validating yep and taking it seriously and validating it and that undid some of the pain that she was physically carrying all those years from where a healthcare professional didn't take her seriously" (par B, p47)
				Developing client's sense of agency/responsibility/self-management	"I'm building much more on the person's own ability to take what they've learnt and to translate it and come back for trouble shooting rather than this" (par C, p16)
				Managing client complaints	"family I remember in that first session their attitude was kind of like …yeah give us your best shot....you could see they were up

			Working with the therapist's power	Challenging our own assumptions about this client group	"just because someone has chronic pain doesn't mean that they're meant to deteriorate like they can improve" (par F, p33)
					for a fight from the very first session...I kind of turned that around by just asking them what they would like and what they would like from this therapeutic relationship and what they thought was going on." (par B, p18)
				Managing our own power position	"I just wanted to stand up and say ....can you please be quiet and ask the patient how they feel please" (par a, p18)
				Limitation of our own understanding in relation to our training/language – deciding to work holistically including the body	"There's all this other stuff and yes we can talk about things forever but the embodied experience, I can't quite grasp. So that's kind of where it started for me to kind of just think something is missing and I don't know how to get there" (par C, p1)
				Considering our role in maintaining the distress	"it spirals down because they keep going back for more, they keep insisting on more tests sand more scans, the GP knows that they're not going to find anything, but they go with it because they really realise there's nothing there, they just go away, but of course they don't go away" (par H, p8)
				Challenging the organisation/managers	"I've always kind of said to my kind of managers, I've said, if you're diabetics you don't just have a programme and then you discharge and you're asked to get on with it...you'll be monitored for the rest of your life" (par C, p14)
				Regular supervision	"And I also have a colleague that we do lots of peer supervision

					with, so if I'm really struggling with something and maybe don't have supervision for a few days I know that maybe that a half an hour debrief phone call to her is invaluable" (par A, p58)
				Feeling safer/supported by the NHS	"the boundaries are automatically clearer, it's safer for us because if somebody hurts themselves we can direct them to places," (par C, p41)
				Rejecting clients	"we're going to close the door on them now because they've complained and have been really rude to us in the session and they've insulted us … you know they want to let them go and even if you think about, you know how powerful you feel" (par B, p27)
			Working with organisational power	Managing resources/constraints	"They were working very hard to keep them out so yeah they're keeping them out and all they want to do is get in" (par A, P16)
				Refusing treatment	"We only have a year to together and you come close to the end of the year and 'please can you extend it, please.' 'No we can't', so you become the bad mother and the institution becomes the bad mother" (par G, p33)
				Supporting/protecting staff or lack of	"I didn't have control over who I would see when and I couldn't necessarily give myself an extra half hour of space here because perhaps I needed time to go and have a coffee and breathe. I might have two really tricky presentations back to back." (par A, p60)
				Offering multidisciplinary treatment/services	"it would be naive of us to think that therapy is going to be enough on its own when actually they just need a little bit of help

228

					in terms of a chemical balance to allow them to engage with therapy and then maybe longer term they come off the medication, which is why sometimes patients are so unwell they can't even engage enough to benefit from therapy." (par A, p47)
				Exercising boundaries of NHS	"You know I have a lot of other services you know....you can't do this, you can't do that" (par B, p32)
				Considering NHS guidelines	"Whereas our thinking is not dependent on the NHS guidelines. Our thinking is dependent on many other things" (par B, p34)

Diagram 1. Initial Codes to Clinical Recommendations