

Exploring “medically unexplained symptoms”
with GPs and counselling psychologists:
a Foucauldian Discourse Analysis.

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Abstract

“Medically unexplained symptoms” or “MUS” has been constructed as a term to describe persistent physical symptoms for which no medical aetiology can be found. “MUS” account for at least 20 per cent of UK medical consultations, yet fit uneasily within a biomedical discourse where illness is legitimised by medical diagnosis. “MUS” supposedly operates as a neutral category, yet critical review of the literature problematises this so-called neutrality: it fails to be neutral whilst avoiding depicting the situation as it is. There is widespread conflict about terminology and aetiology, which results in the subjective creation of legitimacy criteria; disavowal of a psychological dimension; and patients receiving costly and ineffective treatment. This research, motivated by the need within this conflict to better understand the implications of how we talk about “MUS”, explores how practitioners are constructing “MUS”. Four semi-structured interviews with GPs and counselling psychologists were undertaken and analysed using Foucauldian Discourse Analysis. Alongside underlying biomedical discourses, discourses of separation, mindbody dualism, psychology and holism were identified. These contributed to various constructions of “MUS”, including “MUS-as-choice”, “MUS-as-challenge”, “MUS-as-unreal”, “MUS-as-placeless” and “MUS-as-untold-story”. This research problematises the separation of illness into categories, the psychologisation of “MUS” and the lack of availability of an acceptable holistic discourse with which to construct illness. It emphasises the performative nature of our talk about “MUS” and the importance of discourse awareness for deepening our understanding of social and cultural influences on how we see the world and act within it. Exclusive biomedical and psychological constructions of illness displace “MUS” as legitimate illness and limit opportunities for constructive dialogue. As practitioners, we need to resist getting caught up in these frameworks. Suggestions are made for how practical disturbances of current working practices might be achieved.

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1. Introduction

“Medically unexplained symptoms” as a term (hereafter referred to as “MUS”) has been constructed to describe a heterogeneous group of conditions characterised by persistent physical symptoms that cannot be accounted for by any known physical disorder (Brown, 2006; Webb, 2010). Symptom severity ranges from mild to extremely debilitating (Brown, 2007). There has been extensive research on “MUS” and the term is widely recognised, yet there is no clear definition or agreed classification criteria and it is used, received, criticised and rejected in many different ways.

In taking on the challenge of exploring “MUS”, a label that is well recognised whilst its legitimacy is debated, it is easy to become confused. However, it is this ontological paradox that provides justification for further exploration of the topic. This research will attempt to understand some of the controversy around “MUS” by exploring usage of the term and the implications of this. The term itself - “medically unexplained symptoms” - will be used in this study without any attempt to define it further, i.e. to limit it to specific types of symptoms; to do so would be to miss the point that it is this widespread and sometimes vague usage which influences this research. Therefore, only literature which explicitly uses the term is explored in order to maintain this focus. Nevertheless, other terminology will be discussed in the context of “MUS”.

The use of “medically unexplained symptoms” has gained popularity over the last twenty years but has a long history of conflicted terminology (see 2.2). Situating “MUS” within its historical context is useful because it reflects the changing nature of terminology and its relationship to wider societal structures. According to Foucault (1973) the development of medical science within modern western society constructed standards of normality against which people situated themselves. Diagnosis by a medical professional via a physical examination became the way of legitimising illness. Foucault (1973) referred to this as the epistemological privilege awarded to the visible. Diagnosis was constructed through labels that were constructed through diagnosis. An illness needed a name to be legitimate. The changing nature of diagnostic terms, and the urge to name undiagnosable symptoms,

reflects the extent to which diagnosis is now embedded in societies and the difficulty of incorporating “medically unexplained symptoms” into this structure.

1.1 Healthcare and psychological frameworks

The impact of “MUS” on healthcare systems is worrying. “MUS” is the most common single category of complaints in general medical practice (Kirmeyer & Taillefer, 1997). In the UK it accounts for approximately 20% of GP and 50% of secondary care outpatients consultations (Chitnis *et al.*, 2011). Estimated annual healthcare costs range from £3.1 billion (Chitnis *et al.*, 2011) to £8.5 billion (Webb, 2010). “MUS” patients receive symptomatic treatment, repeated investigations and multiple specialist referrals. This suggests needs are not being met and costly resources used ineffectively (McGorm *et al.*, 2010; Webb, 2010). In response, the Department of Health is beginning to prioritise improvements in service provision for “MUS” and Commissioning Support for London (2010) has produced commissioning guidance outlining best practice management which takes a holistic approach to health and wellbeing. There is a commitment towards a drive for mental and physical health being treated together in the NHS Five Year Forward View (Care Quality Commission *et al.*, 2014).

“MUS” is widely referred to in the western psychological literature. Various psychodynamic and cognitive behavioural therapy models of “MUS” exist. What is apparent across both theoretical modalities is a contemporary shift towards integrated mindbody frameworks. Psychoanalytic and psychodynamic therapy has consistently recognised the somatisation of emotional distress from Freud’s early work on hysteria and conversion (Freud, 1923) to early deficit models focusing on object relations (Winnicott, 1958; Mahler, 1967) and attachment theory (Bowlby, 1977), which has more recently been associated with secondary gains (Blaustein & Tuber, 1998). Current understanding of emotional processing based on advances in neurobiology suggests associations between affect regulation phenomena and “MUS”. Within contemporary psychoanalysis disturbed attachment behaviour (Mikulincer, Shaver & Pereg, 2003; Luyten *et al.*, 2012), impaired affect regulation (Taylor, Bagby & Parker, 1997) and disturbances in mentalisation (Fonagy & Target, 2000; Luyten *et al.*, 2012) are viewed as causal mechanisms for “MUS”. Edwards *et al.* (2010) also report on a link between “MUS” and alexithymia, whereas Waller

and Scheidt (2006) see it more specifically as a reduction in emotional awareness and capacity to identify emotions and distinguish them from physical states. According to Griffies (2016), people with “MUS” “do not convey their inner affective worlds through the use of words or other symbols” (p.60). “MUS” are common among people with a trauma history (Gillock *et al.*, 2005) and Scaer (2014) postulates an association between the somatic symptoms in complex PTSD and the dysregulation of the autonomic nervous system resulting from extreme or chronic stress.

Early CBT models focused on symptom perception and assumed the misinterpretation of minor, benign physical symptoms (Barsky, 1992; Mayou, Bass & Sharpe, 1995, Kirmayer & Taillefer, 1997). Rief and Barsky (2005) later produced a psychobiological model of “MUS” in which potential physiological processes were identified. There is growing evidence that “MUS” is associated with biological disturbances, such as central sensitization (Yunus, 2008, 2009) and allostatic load (McEwan & Wingfield, 2003). This acknowledgement means such models may have more face validity with patients. As a result Katsamanis and colleagues (2011) view them as “Trojan horse” techniques to help confrontation of underlying emotional issues (p.219). Contemporary information processing models focus on the role of memory and expectations (Brown, 2004; Rief & Broadbent, 2007); whilst elaborated multifactorial models of “MUS” attempt to integrate earlier models (Brown, 2006; Deary, Chalder & Sharpe, 2007). Risk factors such as familial dysfunction, sexual or physical abuse and major life events or dilemmas have been identified (Edwards *et al.*, 2010; Deary *et al.*, 2007).

Some attention has also been focused on patient engagement and GP:patient relationships. Patient motivation has been identified as a barrier to engagement (Chianello, 2010), and practices such as reattribution (reattributing causes of symptoms) (Edwards *et al.*, 2010) and emotion-focused interviewing (Abbass, 2005) have been developed. Balabanovic (2016) has recently created a model for engaging patients with “MUS”. Focus on engagement models is beyond the scope of this study, but it is relevant to note that challenging relational dynamics are suggested as barriers to engagement in both client:therapist and patient: doctor relationships (Luyten *et al.*, 2012; Maunder & Hunter, 2004).

Both outcomes-based and practice-based research, largely quantitative, have identified moderate benefits from CBT treatment (Kroenke, 2007; White *et al.*, 2013), and there is emerging evidence for the potential of psychodynamic treatment, particularly for specific disorders such as IBS (Guthrie *et al.*, 1991). Models incorporating mind-body approaches and extending the focus beyond exclusively medical psychological interventions are being reviewed. Both the BodyMind approach (Payne, 2016) and body-oriented psychological therapy (Röhrlich & Elanjithara, 2014) found significant reductions in somatic symptom levels within the small-scale service contexts under study, including a reduction in service utilisation in the latter study. There is clear need for further research. Further discussion on the psychotherapeutic models and treatments for “MUS” is also beyond the scope of this review, but it is useful to note that the contribution from applied psychologists has largely come from the clinical discipline. Contributions from counselling psychologists appear entirely absent which is surprising given the discipline’s holistic focus. It might reflect their smaller presence in healthcare settings or perhaps a discrepancy between theoretical position and practice.

For over 100 years “MUS” in various forms has challenged practitioners and been the subject of widespread study and debate. Despite all this its use remains controversial and tension and confusion remain. This research will attempt to explore what it is about “MUS” that maintains this paradox.

1.2 Historical, Cultural and Theoretical Frameworks

The task of locating “MUS” within historical, cultural and theoretical frameworks is complex and involves recourse to some fluid and dynamic terminology. To do it justice would require a much deeper focus than is possible here. Nevertheless, I have tried to briefly outline some specific historical and theoretical shifts and conceptions within western society that are particularly relevant to this discussion (see Appendix G for a more detailed outline).

Modernism

Modernism, marked by “the Enlightenment”, brought an emerging belief in the power of science to understand human bodies. Health became something that occurred in the body independently of the patient’s emotional and spiritual life (Radley, 1994). There was a drive to uncover specific aetiology of disease by

examining bodies. Findings were named and medical labels were constructed. This laid the basis for the biomedical model, which looks to biological factors – physiology, anatomy and biochemistry - for diagnosis and treatment (Radley, 1994). Medicine became established as the dominant healing system in western society and the elevation in status of the practitioners working within it. Modern psychology has also been profoundly influenced by the emphasis on objectivity and observability (Orlans, 2013).

Within modernism the humanist and structuralist movements developed in the mid-twentieth century. Humanist psychology, emphasising free-will and human potential, challenged the determinism of behaviourism, psychoanalysis and the biomedical model. Humanistic counselling was seen as “a reaction against the disease model of mental distress that divided people into those with problems and those without” (Donati and Legg, 2011, p.261). However, like most other psychological therapies, in focusing explicitly on mental distress it maintained body-mind dualism.

In contrast structuralism emphasised that understanding human nature was dependent on recognising its relationship to larger, overarching systems or structures (Strawbridge & Woolfe, 2010). These frameworks were constituted and brought into reality via language (Burr, 2003), which was considered the link between individual psychology and social structures (Strawbridge & Woolfe, 2010). The biopsychosocial model (Engel, 1977) reflects a structuralist framework, recognising the impact of psychological and socio-cultural factors in determining illness and treatment. Nevertheless, although the biopsychosocial model is widely recognised within social sciences and healthcare (Burr, 2003), the biomedical model still appears dominant in current medical practice (Stacey, 1988).

Postmodernism

Postmodernism represents a rejection of modernism’s grand theories or metanarratives espousing ultimate truths and underlying structures, stressing pluralism or the co-existence of a multiplicity and variety of situation dependent ways of life (Burr, 2003). Counselling psychology embodies a postmodernist perspective in its encouragement of the deconstruction of arguments and questioning of notions of universal truths (Orlans, 2013). This suggests it could have a useful role in relation to “MUS”, partly because of its characteristics which reject

generalised theories, such as the biomedical framework, in favour of subjective and intersubjective narratives, attention to language and a reflexive approach.

Against the backdrop of postmodernism, poststructuralism and social constructionism have developed.

Poststructuralism

Poststructuralism views meanings as carried by language and always contestable and temporary (Burr, 2003). Language is seen to operate within smaller systems or “discourses” which Foucault (1972, p.49) described as “practices which form the objects of which they speak”. Burr (2003) suggests a discourse refers to a set of meanings and representations which together construct versions of events. Within a discursive framework “MUS” would be seen as a discursive object influenced by and influential on various discourses.

Foucault saw the Enlightenment as a shift in the structure of knowledge. The science and practice of medicine developed within this wider structure of organising knowledge which in turn rationalised its structure and experience (Foucault, 1973, 1976, 1979). These wider epistemological structures or discourses enabled medical investigation, diagnosis and treatment to become acceptable, respectable and expected under the “medical gaze”. Foucault argues this biomedical way of viewing the body is connected to a system of ordering related to social control (Burr, 2003). Work, domestic and political behaviours are regulated using classifications such as normal/ abnormal, healthy/ sick, sane/insane. For example, without a sick note from a doctor a person may be forced to work. It is arguable that “MUS” has thwarted the existing biomedical structure by eluding the current criteria for investigation, diagnosis and treatment. Therefore post-structuralist thinking and discourse analysis are useful frameworks for exploring “MUS”.

Social constructionism

Poststructuralism, along with critical psychology and discourse analysis, has a social constructionist orientation (Burr, 2003). Social constructionism has no one fixed definition but is applied to approaches that adopt a critical stance toward assumed knowledge, assume constructions of knowledge sustain or exclude patterns of social action and assume knowledge is historically and culturally specific and constructed

through social processes (Gergen, 1985). This fits with counselling psychology's model of not assuming "the automatic superiority of any one way of experiencing, feeling, valuing and knowing" (Orlans, 2013, p.2). Social constructionism is useful for exploring how and why meanings are constructed. From both a social constructionist and counselling psychology stance it is inappropriate to accept "MUS" as a concept just because it is deemed the most suitable term and widely used. Instead it is recognised that "MUS" has been constructed through social processes with a wider social purpose within a historical and cultural context. Most importantly, it is recognised that this has real consequences for social action and power (Burr, 2003).

Social constructionism frames illness as a social matter (Burr, 2003). Disease can be established without the physical experience of illness; "illness" can be granted to a person or the self via individual judgements. These judgements are seen as dependant on cultural prescriptions, norms and values around ability to function. Hardey (1998) argues that it is the reaction to symptoms rather than the experience of them that depicts illness. If illness is socially constructed then "MUS" needs to be explored within its wider social context, including the discourses within which it is located. Therefore this research adopts a social constructionist approach to exploring how practitioners construct "MUS" and the implications of this, particularly in relation to counselling psychologists who theoretically embrace this approach.

The following eight chapters set out the research process. Chapter Two critiques the literature on "MUS". Then in Chapter Three I reflect on the reflexive position I assume before embarking on the data collection and analysis stage. Chapter Four explores the epistemological basis; then the research method is set out in Chapter Five. Chapter Six presents the analysis of the interview transcripts and Chapter Seven discusses these findings in relation to the contribution they make, implications for practice, limitations and recommendations for further research. Further reflexivity is explored in Chapter Eight.

2. Literature Review

This chapter critically reviews literature focusing on using “MUS” terminology and the implications, then hones in on more specific research which is influenced by a social constructionist perspective and focuses on language, structures, systems and the wider socio-cultural environment within which MUS is situated.

2.1 Method

Initial material was obtained from searching the PsycInfo database. Search criteria always included the term “medically unexplained symptoms” or “MUS”; other terms added to narrow the focus were “terminology”, “discourse”, “psychology” and “counselling psychology”. This generated approximately 750 articles. Based on title relevance 250 abstracts were skimmed and about 80 articles identified that exposed the use of and conflict around “MUS”. Further articles were identified from references within these articles. It became apparent that despite a recognised conflict around medical and psychological aetiology, psychological perspectives were missing from the debate. Therefore, I then focused in on three pieces of literature that in different ways implicitly suggest a need for a wider more critical focus.

2.2 Terminology

It is argued that the term “medically unexplained symptoms” (“MUS”) emerged from dissatisfaction with other terms. However, despite widespread usage, there is no consensus on how medically unexplained symptoms should be diagnosed and categorised (McFarlane et al., 2008; Smith & Dwamena, 2007), nor as to whether “MUS” refers to a single syndrome or several different ones (Greco, 2012). Brown (2007) suggests terminology is determined by the medical speciality within which it is encountered rather than the symptoms presented. There is consensus that the term is at best controversial (Greco, 2012) and at worst unsatisfactory and stigmatising (Guthrie, 2008). Therefore, there appears to be as much dissatisfaction with the term created to allay dissatisfaction as there was around previous terminology.

There is a complex history of constructing new labels to describe physical symptoms in the absence of existing diagnostic labels. “MUS” is associated with “hysteria”: Freud (1896) believed that unresolved intrapsychic conflicts were unconsciously converted into somatic symptoms. According to Stone *et al.* (2002), “hysteria” has

become unacceptable and offensive to the vast majority of patients, presumably because of its lay connotations around uncontrollable female emotion.

Outside of psychoanalytic discourse, “hysteria” then became known as “Briquet’s Syndrome” and later “somatoform disorder” in the Diagnostic and Statistical Manual of Mental Disorders (DSM) III and IV respectively (APA, 1980, 1994).

“Somatoform disorder” diagnosis involved excluding “the conscious fabrication of symptoms” which positioned doctors in moral arbitration roles and patients as potential malingerers (Greco, 2012, p.2366). The exclusion of organic factors was also required, suggesting organic and psychological factors are mutually exclusive and knowledge about organic factors is full, final and complete. “Conversion”, “dissociation” and “somatization” are psychiatric terms commonly applied to “MUS”. Brown (2007, p.773) criticised them for implying “unproven psychological mechanisms”, suggesting psychological mechanisms need to be proven to be viable. “Psychosomatic”, despite being linked since the early twentieth century to a prestigious academic field of medicine, is considered offensive by some patients (Stone *et al.*, 2002). DSM-5 (APA, 2013) replaced “somatoform disorder” and other related classifications with “somatic symptom disorder”. Interestingly, diagnosis no longer requires somatic symptoms are medically unexplained. Instead, emphasis is on the degree to which thoughts, feelings and behaviours about symptoms are deemed disproportionate or excessive.

“MUS” origins are also found in less explicitly psychogenic (having a psychological rather than physical cause) terms such as “functional nervous disorder”, first used in the late nineteenth century (Stone *et al.*, 2002). “Functional somatic syndromes” is now an umbrella term constructed to cover a number of distinctly named conditions, such as irritable bowel syndrome, fibromyalgia and myalgic encephalopathy (ME). Fink *et al.* (2007) claim there are sufficient similarities between these conditions to justify the category; Trimble (1982) sees the term as too broad, encompassing all conditions characterised by disturbances in bio functioning, some of which would not normally be regarded as medically unexplained. Brown (2007) argues there is little direct evidence of a physical cause and their existence as distinct conditions is disputed. Therefore, the term appears as controversial as “MUS”.

Stone *et al.* (2002) and Brown (2007) both suggest patients are more comfortable with “functional” terminology because of its medical rather than psychological implications. What is interesting is their implication that a medical basis is preferable to a psychological one, not because it is necessarily aetiologically correct, but because it can be more comfortably related to. Nevertheless, Greco (2012) argues that the term is used as a code word for psychogenic among doctors and that there is significant ambiguity among both doctors and patients as to its meaning. The necessity for a code word implies doctors feel the need to hide psychogenic plausibility from patients, even when they identify it themselves. More recently, the term “persistent physical symptoms” has been introduced, commended and criticised for similar reasons (Morton *et al.*, 2016). Whereas this medical terminology and the debate around it is situated within medical or psychological boundaries, neither explanation necessarily mirrors the limits of patients’ understanding of their symptoms. In a small-scale qualitative study with Danish patients, Risor (2009) found patients drew on personal, social and moral idioms, as well as symptomatic idioms, to explain their illnesses, suggesting that in debating terminology there might be a need for further consideration and deconstruction of psychosocial aspects beyond the current polemical debate about whether aetiology is biological or psychological.

Nevertheless, causal implications fuel criticism of the above terminology. McFarlane *et al* (2008) believe competing systems of classification are the problem: somatoform disorders in psychiatry and functional disorders in medicine. He believes that “insufficient cross-reference [...] creates idiosyncratic and overlapping approaches that lack consensus”(p.369). It is, therefore, unsurprising that “MUS” gets favoured for its neutrality (Stone *et al.*, 2002). According to Creed and Guthrie (2010), “MUS” implies no current organic cause has been identified but leaves open the potential aetiology of the problem. In addition to aetiological neutrality, Greco (2012) adds it implies attributional neutrality: the patient may as yet be right that their symptoms have a physical origin and the doctor implies the symptoms are as yet unexplained. “MUS” both anticipates and diverts a conflict (Greco, 2012). The term “MUS” appears to contain the problem so that recognition of the complexity of treating it does not have to be faced. Yet, if practitioners are using the “MUS” label to avoid alluding to a psychological dimension which they believe to be there then

they would be deceiving patients. They would be potentially colluding in a stigmatising portrayal of psychological problems, closing down psychological treatment opportunities and maintaining costly and ineffective biomedical treatment strategies. There are also complex negative implications of diagnostic uncertainty for patients (Hills, Lees, Freshwater & Cahill (2016), such as stigma, and uncertainty has been argued to have a negative effect on patient outcome (Deary, Chalder & Sharpe, 2007). To this extent “MUS” is not a neutral term and this is not an abstract debate about terminology. The way we use terminology has real implications for patients and their lives.

To address the problem of terminology and disputed aetiology, McFarlane *et al* (2008) call for the development of psychophysiological models; Creed and Guthrie (2010) suggest an approach which focuses solely on symptom description (avoiding aetiological assumptions), whilst Brown (2007) calls for further efforts to find a set of mutually acceptable and meaningful terms. These integrative suggestions seem to make sense in the light of problematic aetiology, and are more in tune with increasing understanding that bodily symptoms reflect the brain’s integration of multiple aetiological factors (Sharpe *et al.*, 2006; Damasio, 1994). However, they fail to recognise that models, approaches and terminology are constructed within wider structures and limited by existing discourses. If one of the fundamental issues is that existing structures and related discourses cannot accommodate a complex biopsychosocial problem then developing new models, approaches and terminology alone will not resolve this. If terminology is being constructed to restrict debate, deceive patients, maintain positions and avoid aetiological conflict, particularly at the very first stage of patient/doctor encounter, then opportunities for effective treatment responses could be severely limited. There is first a need to acknowledge and better understand the relationship between language, medically unexplained symptoms and the social, political and historical environment within which they are situated. Counselling psychology, with its critical relationship to both research and practice and emphasis on social context, is well placed to make a valid contribution to this, but CoPs would need to critically engage with the issues and put themselves forward to work in this area.

2.3 The role of language

The previous section shows that it is not possible to review the use of “MUS” terminology without exposing conflict. This conflict reflects the power of language to construct, position and legitimise phenomena. The way we use language has significant implications for what we can think, say, do and can be done to us. Ultimately “MUS” challenges the existing structures within which it has been constructed. Yet there has been little critical attention to the way that terminology and classification feed into the conflictual dynamic and are in turn informed by it (Greco, 2012).

Legitimacy

Greco (2012) notices discrepancy between professional knowledge and lay experience: “MUS” can be both medically suspect and experientially devastating (Barker, 2008). This paradox is embedded in the wider role of diagnosis and debate about legitimacy. According to Stone *et al.* (2002) a diagnosis signifies to the patient and their significant others that the complaints are viewed as real and the problem is being taken seriously. This relates to what Nettleton *et al.* (2005) describe as the pressure to be “successfully ill” and avoid becoming a “medical orphan”. Although patients might be experiencing profound and debilitating symptoms, *without* a diagnosis they may have no medical language to draw upon to communicate this to others and possibly no system to turn to for support. This illustrates the power of discourse to construct meaning and reality. Without a diagnosis patients can struggle to position themselves in a society which expects legitimate sickness to have a name.

In the context of a qualitative symbolic interaction study among a small sample of Danish GPs, Mik-Meyer and Obling (2012) found that GPs’ criteria for judging legitimacy among patients presenting with “MUS” and unable to work was not always limited by a biomedical framework: they subjectively constructed additional criteria from which to judge the legitimacy of patient sickness. Drawing on a biopsychosocial discourse, decisions seemed influenced by whether or not they identified social problems and “problematic personality traits”.

Further research would be necessary to explore exactly how widely used such criteria are. However, in this sociological study it appears the GPs felt empowered to legitimise sickness based on psychosocial criteria. Yet this criteria needs critical

examination. Patients' personalities are explicitly referred to in terms of traits and types and explicitly constructed as different and separate from social problems. GPs' phrases that are categorised as implying problematic personality include "personal shortcomings", "pre-morbid psyche", "low threshold for adversity", "whiners" and "inept at living". Such language appears unsophisticated, unprofessional and pejorative. It suggests that both the GPs and the authors are constructing "MUS" as a problem of personality by deferring to an over-simplistic personality discourse (which the authors describe as "common-sense psychology" without further explanation) (Mik-Meyer and Obling, 2012, p.1028). "Problematic life circumstances" and "violent family histories" are classed as unrelated social problems.

This is an essentialist way of viewing personality which constructs personality traits as stable, unified and uninfluenced by social factors. Several psychological positions have questioned the idea of a stable personality across situations and over time (Burr, 2003). For example, psychoanalytic theories stress motivational concepts and social learning theory refers to the situation specificity of behaviour. A social constructionist approach construes personal qualities as a function of the specific historical, cultural and relational situation in which we are located (Burr, 2003). Counselling psychology reflects this position with its own emphasis on social contexts and engagement with subjectivity and intersubjectivity (BPS, 2005; Orland, 2013). By drawing on alternative psychological discourses those same GPs' descriptions might be viewed as signs of depression or anxiety rather than problematic personality, and the patients' behaviour explored in terms of distorted cognitions or internal conflicts, possibly resulting from difficult or complex social experiences. This illustrates the powerful influence of discourse and the very real social consequences. For example, if problems are constructed as transient and changeable rather than innate and constant they are more likely to be viewed as treatable.

Mik-Meyer and Obling's (2012) research suggests psychologically uninformed GPs are subjectively extending their legitimacy criteria with potentially ineffective and irresponsible consequences. However, unless the psychological dimension to "MUS" is explicitly recognised it is unlikely that GPs will become better psychologically informed. The question of current medical systems' ability to accommodate "MUS"

needs to be acknowledged. Wider contributions to the debate from outside the medical and sociological disciplines would be valuable. The questioning culture of counselling psychology has the potential to provide critical resistance to some of the underlying and damaging assumptions around “MUS”.

Disavowal of the psychological

As has been highlighted, the “MUS” debate is fuelled by aetiological conflict between the medical and psychological. Patients are often positioned as resisting a psychological classification. Nettleton *et al.* (2005) found that a salient concern of the neurology patients in their study with unexplained, undiagnosed symptoms was that their symptoms might be viewed as psychological. Tucker (2004) argues patients have to position themselves as physically ill to avoid the stigma of a psychological disorder and Horton-Salway (2007) describes a “moral ordering” by patients and GPs that places physical above psychological illness in terms of genuineness. The stigma of mental health problems charges suggestions of a psychological character to “MUS” with “potentially explosive connotations” (Greco, 2012 p.2368). Given these sensitive findings it is understandable that caution is given to psychological dimensions, but Greco (2012) suggests this caution leads to a lack of critical examination. She critically reviews debates around the use of medical terminology from a social theoretical perspective.

Greco (2012) argues that in articulating patients’ experiences of delegitimisation and marginalisation social scientists have made vital contributions to the “MUS” debate, however in so doing they have reinforced the position of patients as such and therefore potentially contributed to the polemical situation. She suggests that the political commitment towards validating lay narratives has involved epistemological neutrality in relation to aetiology. Greco is arguing that social scientists implicitly avoid taking a position on aetiology by treating this as outside the realm of their work; yet they represent the voices of patients who largely disfavour a psychological aspect to their suffering. She implies social scientists perform this caution uncritically and without sufficient understanding of the psychological dimension, whilst their choices implicitly perform the role of maintaining the polemical positions of dismissive doctor and delegitimised patient.

Greco (2012) also argues that medical discourse displays resistance to psychological explanations (despite doctors' talk of patients' resistance to psychological attributions). The introduction to DSM IV (APA, 1994, p.xxx) recognises that "there is much 'physical' in mental disorders, and much 'mental' in physical disorders" but goes on to only discuss this in relation to mental disorders. This persistent disavowal of a psychological dimension to other physical illnesses might be what constructs a psychological dimension to "MUS" as frightening. The supposed neutrality of the "MUS" term fuels the conflict and poses barriers to potential implementation of psychological interventions (Greco, 2012).

Greco (2012) sees this cautious approach to "MUS" within medicine and social scientific research as both performative and paradoxical: "neutrality" is a strategy to reduce clinical conflict but it avoids acknowledging a potentially "difficult truth" creating a deadlock. Greco locates this within wider political fields where epistemological privilege is still awarded to the visible (Foucault, 1973) and recourse to a biomedical discourse constrains the exploration of the psychological within all symptoms, not just "MUS". Greco is not implying a psychological over a physical nature to MUS, but highlighting a collusion which reinforces negative and reductive connotations of the psychological. She calls for "a problematisation" of the psychological dimension (2013, p.2368). This involves acknowledging internal differences, tensions and paradoxes and defining assumptions that may hold across apparent conflict. The aim would be "to assert that the psychological is relevant *everywhere* and to render it *discussable* in its multiple versions and implications" (Greco, 2012, p.2368). Such an approach would involve moving beyond the polemical positions of dismissive doctor and difficult patient which maintain a polemical deadlock.

However, despite calling for a problematisation embracing multiple versions and different values, Greco limits her invitation to social scientists, even suggesting it to be unrealistic and possibly unreasonable to expect "clinical researchers" to get involved. There appear several limitations to this. By excusing the need for "clinical researchers" Greco fails to recognise the importance of the involvement of the medical profession and a focus on both psychological and physical dimensions. Greco does not distinguish between the different kinds of social scientists nor actually define who she means by clinical researchers. Nor does she recognise the

absence of distinctly psychological research. She is critical of social scientists, largely sociological, for colluding in the disavowal of the psychological, but looks to them to open their perspective to a psychological dimension rather than calling on psychologists and psychotherapists to enter the debate. Social scientists' contribution is important, but in order to critically explore the psychological dimension it is necessary to open up the debate to new voices and the opportunities for resistance and facilitation that their versions might bring.

2.4 Structures and systems

In his article on "MUS" in *Therapy Today*, psychiatrist Tim Webb (2010) argues that 20 to 50 per cent of all medical problems relate to "MUS" and that the case for improving approaches to the psychosomatic component of medicine is clinically and financially sound as well as increasingly topical. He also believes that evidence exists to suggest we know enough about psychological therapies and drug treatments to impact on patient recovery, clinician satisfaction and cost reduction. What could be seen as potentially scandalous is that current structures do not allow for it. For example, conventional medical formulations do not allow for understanding a problem in both psychological and physical terms; structures locate physical and mental health specialists' work in different fields resulting in a lack of integration of knowledge; specialities are largely divided by parts of the body with an onus on increasing specific separate knowledge about that area; techno-medically trained doctors are uncomfortable with conditions that cannot be diagnosed using objective tests (Webb, 2010).

Webb (2010) believes that to deal effectively with "MUS" it is necessary to transform healthcare delivery to create a system that involves both medical and psychological practitioners, including psychotherapists, and positively identifies and treats the psychological causes of "MUS". This will involve a major restructuring at several levels involving an unprecedented level of teamwork. Both medical and psychological practitioners will need to acquire new knowledge and skills to enable them to work at the biological/psychological interface. Webb fears the complexity of the challenge may maintain inertia whilst recognising the cost implications of not acting to be a powerful motivator against this.

Webb's article provides disturbing insight into the current situation. He does not refer directly to the power of discourse; yet he situates "MUS" within its political and socioeconomic context and his pragmatic arguments reiterate that current structures and systems are ill-equipped to manage "MUS" because they cannot accommodate symptoms which might involve both psychological and biological dimensions. Therefore, Webb reemphasises that approaches to "MUS" are influenced by the context within which they operate, and vice versa. Therefore it seems that further consideration of discourse would be helpful in the exploration of practice and needs to extend beyond the medical domain. "MUS" exists within social, economic, political and cultural structures and its use can be both restricted by them but also used to uphold them.

2.5 Summary, Conclusion and Research Question

It is clear from the literature reviewed that there is a lot of dissatisfaction with the term "medically unexplained symptoms". "MUS" hides meanings, neutralises conflicts, acts as a code word, hurts feelings, implies legitimacy, insinuates delegitimacy, suggests a psychological dimension, avoids a psychological connotation, humiliates patients, confounds doctors, maintains structures, challenges political assumptions and creates meaning in many other different and conflicting ways. Fundamentally, "MUS" masks paradoxes, inconsistencies and contradictions. Nevertheless, despite this performative dimension, there is limited exploration of "MUS" from a discursive perspective.

The Enlightenment contributed to the construction of an environment where the biomedical model and the status of observation and science flourished. As doctors and diagnosis became the source of legitimacy the space for symptoms which could not be accommodated within the biomedical discourse diminished. This has contributed to a long and problematic history as to how to accommodate unexplained symptoms within this context. It appears "MUS" was constructed as a concept in order to fit patients and their symptoms into existing structures, even when these structures cannot respond adequately to them. Therefore, there is a need to understand further how "MUS" is situated within its discursive environment, and how this generates both constraints and opportunities.

Despite a long history of recognition that psychological distress can result in physical symptoms, and widespread agreement among practitioners that a psychological dimension to at least some “MUS” exists, an inability to officially and explicitly accommodate this is troublesome and has particularly significant consequences at the GP/patient interface. Approaches appear constrained by the dominant biomedical discourse. This is highlighted by Webb (2010) who compellingly argues that fundamental restructuring of patient services needs to occur before “MUS” can be appropriately responded to, including greater involvement of psychological therapists in any new structure. Mik-Meyer and Obling’s (2012) research suggests that the limitations of biomedical discourse can force GPs to subjectively construct their own criteria in order to position patients as legitimate or not. This opens the potential for GPs to unilaterally draw on social and psychological discourses of which they may not have appropriate experience or be sufficiently trained to defer to. This in turn has significant risks for the positioning of patients. Greco’s (2012) review highlights the existence of a polemical deadlock that she believes is fuelled by a disavowal of a psychological dimension. She argues that the danger of the current approach is that it avoids psychological exploration, limiting understanding of “MUS”. This lack of psychological exploration and the need for it provides further rationale for this research.

The literature reviewed approaches “MUS” from different angles; yet it all highlights how difficult it is to accommodate “MUS” within dominant biomedical discourse. It also implies that that significant perspectives are missing from the discussion and significant others need to contribute to the debate in order that resistance to the current situation can be created, change can occur and patients can be better accommodated.

Clinical psychologists have been active in developing models and theories, and psychotherapists and applied psychologists have been involved in providing therapy. However, unless they are prepared to engage with the current debate and the challenges to effective primary care it exposes, many patients will not get to benefit from psychological interventions because they will remain stuck in a primary care structure within an unaccommodating biomedical discourse and never receive any psychological intervention. It is particularly disappointing that CoPs have not contributed to this discussion. As research-practitioners they are encouraged to

appreciate, as well as critically explore, the complexity of problems: to accept the co-creation of meaning and consider the existence of multiple perspectives within a socially constructed world. Alongside others they are therefore, arguably, in a good position to resist uncritical endorsement of “MUS” and contribute creatively and constructively to the situation. Given this position, this research will include CoPs as participants, in order to explore how they are constructing “MUS” and what contributions their voices can add to the discussion. Therefore a significant part of this research will be exploration of the psychological dimension, from a psychological perspective, involving psychologist participants.

This literature review has strongly identified the relevance of discourse to the topic of “MUS” and the usefulness of situating “MUS” within its discursive environment in order to better understand how it is being used and why. Therefore this research explores how GPs and CoPs are constructing “MUS”, what might be the implications and how might CoPs respond to this? Both GPs and CoPs are included in order to encompass voices across the traditional medical/psychological divide, rather than from one particular professional domain.

2.6 Reflexive statement: Part 1

In choosing this topic for my counselling psychology doctoral research my curiosity around “medically unexplained symptoms” was mainly twofold.

Firstly, it stemmed from personal experience of uncomfortable “neurological” symptoms that resulted in secondary care referrals and various tests over several years; they were never “medically explained”, nor was it ever suggested there might be a psychological dimension. In hindsight I believe they were maintained by a misunderstanding that unusual physical symptoms ought to have a medical explanation, resultant health anxiety and interactions with medical staff that neither hinted at the possibility of a psychological dimension nor normalised what I was experiencing. Overall I remember a persistent fear that I was seriously unwell, a lack of reassurance from medical staff that I was not and an embarrassment around having an illegitimate sickness with no name. These are the memories and feelings I remained aware of as I began this study.

Secondly, and partly influenced by my personal experience, I believed that a pervasive mind-body dualism that is detrimental to wellbeing prevails in our society's approach to health. On first reading Foucault (1973) over a decade ago I remember being drawn to what he had to say about the genealogy of medical practice, positioning it as a "disciplinary regime" which had contributed to the objectification of bodies through the "medical gaze". As a result of my personal experience I could particularly relate to the legitimising power of the medical establishment and how illness has become dependent on a doctor's diagnosis rather than subjective experience. Later on when I learned about the existence of the term "medically unexplained symptoms" (something I had never heard of as a term nor a concept before embarking on my counselling psychology training) and the debate around its legitimacy I was quickly drawn to the social constructionist literature to explore the topic. It seemed to offer a useful and relevant way in which to explore the wider subject in the same way that it had provided a context for my own "illness". To this extent I was implicitly choosing a stance that provided a framework within which I could comfortably explore and start to make sense of my own experience and, in FDA, a method of analysis with a history of scepticism towards medicine. My desire to deconstruct "MUS" was perhaps part of an unconscious personal need to critically explore a system that had not served me well personally.

Social constructionism also fitted with the prevailing philosophy of counselling psychology that I was critically adopting as a new trainee. I was disappointed to find a lack of counselling psychological contribution to the topic. In hindsight I think that by undertaking this research as a CoP and involving CoPs in my research I hoped to match CoP values and skills to the gaps and difficulties identified in the literature review. Perhaps I also hoped to encourage CoPs to become more aware of and involved with "MUS", and others to become more aware of what CoPs could offer in this area. To this extent my implicit motives may have been to match my own interests with a role for them in my new profession.

As a result of these personal influences and academic interests I understood that I was vulnerable to certain biases, potentially defensive responses and other presuppositions and preconceived ideas about what I was investigating, such as those discussed above. Initially I therefore attempted to adopt the phenomenological strategy of epoché (or bracketing) (Langdrige, 2007). I tried to maintain doubt

about my own knowledge and examine material from a variety of perspectives. Like the existential phenomenologists I did not believe that you can ever completely bracket off your presuppositions (Langdrige, 2007), but thought I understood the importance of attempting to do so in research as a necessary part of being open to others' perspectives and experiences. Therefore I attempted to conduct my research with an awareness of my personal biases and an open attitude towards all relevant perspectives.

Exploration of this topic turned out to be more personally challenging than expected. It was the first time that I had chosen to study a topic with such personal resonance. I had thought that enough time had passed since my own experience of "MUS" that my relationship with it would fuel my interest without exposing me to emotionally charged responses. I underestimated how challenging I would find reading some of the literature. I was reminded that resolution is not necessarily final and learnt that *epoché* is not easily practiced.

I had been unaware of the link between "MUS" and hysteria and felt affronted (perhaps ignorantly) by its lay connotations. I had been unaware of the way that doctors referred to patients with "MUS" as "heartsink patients" and "frequent flyers" (Greco, 2012). This did not fit with my own experience at the time – I had received kindness and support from medical staff. I recoiled at the thought that I might have been viewed in this way. Mik-Meyer and Obling's (2012) research and interpretations were particularly challenging to digest: GPs' descriptions of patients with "MUS" as "joyless", "inept at living" and "pitiable people" were difficult for me to read as were their findings that GPs discover fundamental human weaknesses on both a social and personal level in these patients.

As a trainee counselling psychologist, I realised the relationship I needed to develop with this topic was not that different from a challenging relationship with a client in therapy. I could notice the way the material was making me feel. Then by treating my feelings as a kind of academic countertransference I could use them in understanding potential positions and explore more deeply what the significance of them was for my research.

Fortunately, there was research that showed a more compassionate approach to a complex phenomenon and as the complexity of "MUS" became increasingly

apparent I felt more intrigued and less challenged by these perspectives. This position felt closer to my starting one. I could never personally relate to the positions of dismissive doctor and misunderstood patient. I had experienced both interest and kindness from doctors and had felt firmly and exclusively positioned as a physical health patient. I had never considered that this had anything to do with mental health. It was the idea that my experience, and possibly that of my doctors, had been constrained by a limited view of illness drawn from a broader biomedical, western cultural discourse that fuelled my interest in the topic.

I began to see the confusion and complexity surrounding “MUS” as further indication that the current situation is problematic, and my own emotional response as further indication that the topic evokes strong reactions and needs further exploration. This strategy helped me to focus my energy on developing an open understanding of the topic. Some evidence of success became apparent as I found myself letting go of some of my more rigid ideas about the pervasiveness of body/mind dualism and the dominance of the biomedical discourse and developed a more sophisticated understanding of the complexity of the polemic and nascent efforts that are being made towards integration and anti-polemical engagement. A passionate belief that this topic needs wider, critical attention remained and accompanied me into the research phase.

Nevertheless, it seems important to note where I was at this stage in my research in relation to two significant processes. Firstly, at this point in my research my understanding of illness had shifted from an understanding that physical symptoms result from biological malfunctioning to one that psychological difficulties can cause physical symptoms. As a result I now see that I was constructing “MUS” as a psychological problem stuck in a medical dimension because of a cultural misunderstanding of illness.

Secondly, at this stage of my research I was unaware of the more implicit and unconscious ways that I was influencing the research, particularly the choices I was making at each stage of the process and how these would influence the direction and shape of the research. To this extent, the reflexive relationship I could have with the research process was constrained by the limits of my own knowledge and

understanding of the process, the discourses that were available to me at that time.

This is discussed further in reflexive statement parts 2, 3 and 4 (chapters 3, 4 and 5).

3. Methodology

3.1 Epistemological position

This research focuses on how “MUS” was constructed during interviews with four practitioners and some of the possible influences on and consequences of these constructions. A qualitative methodology was used because it allows for exploration of meaning and subjective interpretations of phenomena. It also allows for personal and epistemological reflexivity. Burr (2003) argues that qualitative methods are less likely to decontextualize experiences and this is important for this research as the context is a crucial part of the exploration.

“MUS” is mediated historically, culturally and linguistically. Therefore its meaning is created and negotiated through discourse and conversation (Willig, 2001). The term “MUS” does not represent a social reality, but constructs one. That is why a social constructionist epistemology guided the exploration of this topic. A social constructionist stance is concerned with identifying the available ways in which “MUS” is constructed, how these enable and disable opportunities and the implications for human experience and social practice (Willig, 2001). It demonstrates how categories like “MUS” construct realities as well as reflect them. Nevertheless, social constructionism is not a methodology, but a theoretical position. It is guided by criticality and a rejection of universal truths. Its suspicion of taken-for-granted knowledge allows for the exploration of uncritical use and endorsement of “MUS”. Counselling psychology reflects a social constructionist epistemology in the way it holds criticality as a key principle in the context of exploring “truths” (Orlans, 2013). Counselling psychology also places significant value on the phenomenology of our clients’ difficulties (Corrie, 2010); however, a phenomenological stance would be less appropriate for the purposes of this research where the focus is on the influence of social and cultural forces.

3.2 Method of analysis

Discourse analysis (DA) takes a social constructionist approach to research (Coyle, 2007), exploring how language constructs versions of the world and the consequences of this. It encourages us to explore how we use and are used by

language in society and how language positions individuals in relations of power (Davies, 2000). Therefore it offers a way to question and resist powerful images that circulate in society (Willig, 1999). Foucault (1972, p.49) described discourses as “practices which form the objects of which they speak”, whereas Burr (2003) suggests a discourse refers to a set of meanings and representations which together construct versions of events. Discourses are ways of thinking, feeling, talking about or imagining something, but unlike an individual perspective or attitude they draw on a broader sociocultural framework and in turn, through their use, they strengthen and reinforce that framework of meaning within the society in which its use is situated.

Discourse constructs our experience of the world. For example, if we discuss “MUS” in a way that suggests people with “MUS” are not experiencing real symptoms this might encourage an environment in which little time or resources are focused on “MUS” or people with “MUS” are dismissed as illegitimate patients or “malingerers”; if we discuss “MUS” as a genuine biopsychosocial problem affecting many people this might influence the attention given to the issue and encourage a more sympathetic response. Discourses are powerful influences with powerful consequences and deserve significant attention when exploring a matter.

There are several forms of discourse analysis in use. In the UK discursive psychology (DP) and Foucauldian Discourse Analysis (FDA) are most common (Coyle, 2007) and both emphasise the linguistic construction of social reality. DP is interested in the negotiation of meaning within interactions in everyday contexts. It focuses on what people do with language and stresses the performative qualities of discourse (Willig, 2001). It enables better understanding of different ways of talking by deliberately systematising them (Parker, 1992). Foucauldian Discourse Analysis (FDA) emphasises the limitations set by the language that is available to us and how this affects the way we think, speak, what we do and what is done to us (Burr, 2003). FDA also recognises the dynamic political influences on the world we live in. It recognises how discourses construct a structural reality which holds power over how we understand and talk about the world (Burr, 2003). FDA is influenced by the work of Michel Foucault and other post-structuralist writers (Willig, 2001). It is used by those interested in issues of identity, subjectivity, personal and social change and

power relations (Burr, 2002). Unlike DP, FDA explores the implications of discourse for possible ways-of-being, for limiting subject positions and the implications of this for selfhood and subjective experience (Willig, 2001). “MUS” can be located within powerful discourses that have implications for how it can be constructed and affect those involved, such as patients, practitioners and their practices. Therefore, FDA was the qualitative method chosen to explore how practitioners construct “MUS”.

3.3 Participants and Recruitment Strategy

The participants for this study were 2 general practitioners (GPs) and 2 chartered counselling psychologists (CoPs) who had experience of working in a professional capacity with people with “MUS”. Both professions work directly with people with “MUS” and it was thought it would be enriching to involve both in the interview in order to deepen the analysis. Different professions are likely to be influenced by different discourses, both individually and as a group, and therefore it was hoped to encounter a variety of different constructions across the medical/psychological divide which might enhance understanding about the different versions of “MUS” in use and the discourses they draw upon.

Participant eligibility criteria

All participants were professionally registered in the UK and had a self-declared interest in working in “MUS”. To potentially allow for a range of experiences they were all at least two years post-qualifying and had experience of working in their professional capacity with at least two persons with “MUS”. To confer eligibility, participants needed to exhibit a sufficient level of English language proficiency to undertake the interview. These criteria were stated in the “call for participants” advertisement (Appendix B) and the participant information sheet (Appendix C) and reconfirmed by email prior to the interview.

The strategies used to recruit participants were dissemination of the advertisement (Appendix B) at the British Psychological Society’s counselling psychology conference, through the Division of Counselling Psychology’s newsletter, at a university medical school, through a hospital interdisciplinary psychosomatic group and via professional contacts. A participant information sheet with further

information was provided to potential candidates who were interested in taking part (Appendix C). What constitutes “MUS” was left to the participants to decide to allow for their subjective understanding of the term, i.e. if they thought they had encountered “MUS” in their practice then their experience of what “MUS” is and means will be reflected in that encounter and therefore relevant to this study. GPs and CoPs who consented to participate attended a face-to-face interview which lasted approximately one hour. It took 9 months to recruit all the participants and therefore there was a gap of 7 months between the first and last interviews.

The sample size was small to allow for detailed analysis of the data gathered, as is acceptable practice in DA (Coyle, 2007). Four participants were deemed sufficient to provide enough text to consider a variety of discursive forms and practices. Due to time constraints more participants would have limited the opportunity to analyse the interviews to such sufficient depth.

The participants recruited were Helen, Hannah, Tom and Maggie (pseudonyms). Helen and Maggie are both GPs, although Maggie also trained as a psychodynamic psychotherapist. Both are practicing in the NHS, but Maggie now works in a voluntary position as a GP seeing patients for extended (45 minute) appointments. Hannah and Tom are both counselling psychologists with experience of working in the public and private sector.

3.4 Data collection and materials

This research was interested in how the participants constructed “MUS”, how they positioned the role of themselves and their profession in relation to “MUS” and the implications of this. Therefore, data was collected via semi-structured interviews. DA favours naturally-occurring texts and it is sometimes questioned whether interviews can be classed as such because they are researcher-instigated (Phillips & Hardy, 2002). However, these interviews were constructed as actual examples of language in use and therefore deemed an appropriate method for collecting this data.

Although the interviews are referred to as “semi-structured” because they were guided by a framework (see below), some of the discussion that emerged was unstructured as it arose from participants’ responses. The aim was to try to conduct an interview which naturally evolved within the boundaries of the topic. These

boundaries were subjectively imposed by both the researcher and participant according to our understandings of the topic “MUS” and were contained by the available discourses. There was no attempt to disguise the fact that this was an interview. Nevertheless, I attempted to keep the interview informal by allowing it to flow from the participants responses to my initial questions.

I had developed a flexible interview guide to support the interview as needed. Its content reflected the gaps that had emerged from the literature review and the resultant research question: How are GPs and CoPs constructing “MUS”, what might be the implications of this and how might CoPs respond to this? Five areas framed the discussion: “MUS”, language, medical/psychological split, discourses and roles (Appendix F). Several questions relating to each topic were constructed. The guide was not designed to be used in any particular order, and not all topics needed to be covered. All questions were open-ended to encourage participants to construct their own opinions and perspectives and additional probing questions were asked as appropriate to aid clarification and encourage elaboration. The aim was that talk would flow freely and be allowed to take a direction of its own within the topic boundaries. Single or correct answers to questions were not assumed; what was produced was and could only be considered as possible versions (Wood & Kroger, 2000).

It is recognised that, due to reflexivity, interviewers cannot be uninvolved or neutral. Therefore the interview was seen as “active”, involving both interviewer and interviewee co-constructing meaning (Holstein & Gubrium, 1995). I acknowledge that I brought prior expectations and agendas to the interview (Burman, 1994), although I chose to restrict my role to the task of asking questions (as opposed to commenting or sharing my own ideas).

The interviews were digitally recorded with participants’ prior consent. They were transcribed verbatim and anonymised to protect confidentiality. Materials for this study included: advertisement for participants, participant information sheet, consent form, debrief form, interview schedule and digital audio recorder (see Appendices B, C, D, E and F).

3.5 Data synthesis, analysis and interpretation

The analysis of the interview transcripts was guided by a six stage FDA process developed by Willig (2001). Burr (2003) stresses such conventions steer “what is in the end a subjective, interpretative analysis rather than providing recipe-type instructions” (p.160) and to this end Willig’s (2001) “procedural guidelines” were helpful. Other FDA procedures (Parker, 1992; Kendall & Wickham, 1999) identify more steps, but Willig’s were deemed appropriate because they allowed for identification of discursive resources, the subject positions they contain and exploration of the implications for subjectivity and practice (Willig, 2001). Therefore they provided an ample and suitable framework to guide this analysis.

Having identified “MUS” as the discursive object to explore, the first stage involved highlighting references to “MUS” and identifying the different ways in which “MUS” was constructed in the texts. For example, was “MUS” being constructed as a biomedical disease process? Or as the somatic manifestation of psychological traits? Or in other ways? In the second stage I attempted to locate “MUS” within wider discourses. I tried to identify which discourses the interviewees were drawing upon when they talked about “MUS” in the way that they did. In the third stage, relating to “action orientation”, I explored what purpose and function these constructions served. I considered what might be gained from looking at “MUS” in a particular way at a particular point and how this related to other constructions formed in the text. For example, was it to attribute responsibility or emphasise a contribution? The aim was to get a clearer understanding of what various constructions of “MUS” are capable of achieving within the text.

In the fourth stage different subject positions offered by discursive constructions of “MUS” were explored. Discourses construct subjects as well as objects; they make certain positions available to be taken up (Willig, 2001). For example, within the biomedical discourse it could be suggested that “MUS”-as-physical-illness constructs a legitimate patient; “MUS”-as-psychological-problem constructs an illegitimate one. The way the interviewees construct “MUS” has implications for their own subject position as well as that of others. In turn this has implications for how their professional role is constructed and viewed.

In stage five I looked at the practices of the subjects positioned within the discursive constructions of “MUS”. This stage explored the way in which discursive constructions and the subject positions contained within them open up and close down opportunities for action (Willig, 2001). This is where the implications of discourse for practice were investigated and is key to the FDA approach. So, for example, “MUS” has been found to be bound up with a biomedical discourse that constructs illness as requiring an observable physical cause and therefore incompatible with “MUS”. Thus “MUS” needs to suggest neutrality in order that “MUS” can retain a potential position within the biomedical discourse. Otherwise the biomedical discourse would be seen as incompatible with large amounts of illness. Thus discourses limit what can be said and done and practices reproduce the discourses which legitimise them (Willig, 2001).

The final stage explored the relationship between discourse and subjectivity. It investigated the implications of taking up various subjective positions for the interviewee’s subjective experience. It explored what can be felt, thought and experienced from within different discourses and subject positions (Willig, 2001). For example, a patient may feel legitimately sick if their symptoms are positioned within a medical discourse. This stage emphasised the construction of social and psychological realities and contributed significantly to an understanding of power relations and what might be maintaining or challenging the current status quo.

Using these stages enabled me to explore constructions of “MUS” from several different angles to get a fuller picture of the discursive practices that are evident within them and the implications of these according to the GPs’ and CoPs’ constructed versions.

3.6 Ethics

Potential participants were fully informed about the purpose of the study without any obligation to participate (Appendices B, C and D). They had the right to withdraw from the study for up to two months following the interview and were clearly informed of this, both verbally and in writing. This was in order to prevent participants withdrawing once the process of analysis had begun. Consent to participate was gained in writing; permission to audiotape the interviews was

explicitly requested (Appendix D). Participants were asked not to intentionally provide any personally identifying information about themselves or patients. Any personally identifying information that was accidentally provided was deleted from the transcript. All data remained completely confidential and was securely stored in my home. Permission to use anonymised quotations from the transcript and to comment on the transcript was explicitly requested. Audio recordings will be destroyed as soon as my doctoral qualification has been conferred, and anonymised data will be destroyed within five years of research submission (by September 2021), according to London Metropolitan University's (2014) Code of Good Research Practice.

The participants for this study were not considered vulnerable, nor was participation anticipated to cause distress, but participants were nevertheless debriefed and a follow up contact provided (Appendix E). The research project did not involve deceiving participants; it did not require the disclosure of confidential or private information; it did not lead to the disclosure of illegal activity or incriminating information and no potential conflicts of interest were anticipated nor occurred.

This research abided by the British Psychological Society's (BPS) ethical guidelines as set out in the Code of Human Research Ethics (BPS, 2010). This research received ethical approval from the Research Ethics Review Panel (RERP) at London Metropolitan University. It did not need approval by an NHS research ethics committee (REC) as "REC review is not normally required for research involving NHS [...] staff recruited as research participants by virtue of their professional role" unless "the project raises significant issues which cannot be managed routinely in accordance with established guidelines and good practice" (NHS, p.13). This project was not deemed to pose such risks. This clause supersedes the clause in the BPS Code of Human Research Ethics which advised NHS ethical clearance was needed for interviewing NHS staff by virtue of their professional role (BPS, 2010).

3.7 Reflexive Statement: Part 2

DA encourages a reflexive approach to research. Without fixed institutionalised techniques it becomes necessary to take responsibility for the texts and decide how to customise work (Philips & Hardy, 2002). In the spirit of DA it was important in

this research to allow for multiple meanings and interpretations at the same time as recognising that discourse can never be studied in its entirety and that my work is another incomplete version of the situation (Philips & Hardy, 2002).

As has already been reflected on in 2.6, with hindsight it is possible to see how a social constructionist stance was implicitly adopted, in part, because it provided me with a framework to explore my own personal experience and therefore was deemed helpful for broadening this exploration out to the research. Nevertheless, my confidence in choosing the most appropriate methodology and method of analysis did not extend far into the process of actually using them. On reflection I can see how I took decisions at several stages of the research process that offered the safe option and kept me closer to a more structured, guided approach than I would have anticipated given my idealised stance. For example, the initial decision to create an interview schedule was driven by a lack of confidence that I could manage an interview without one. This in turn was probably influenced by a traditional positivist academic discourse, which instilled in me a sense that there was a right way to do this research and a fear of not doing it properly. I would have needed to get outside of this discourse in order to trust a less structured approach and understand that the material, for the purposes of this research, would have been relevant however the interview had progressed.

This mistrust of a less structured process led me to reject more radical approaches to interviewing, such as Parker's (2005) suggestion to invite participants to question or interview the interviewer. Such a process creates a structure more like a discussion than an interview, in which the interviewer voices their opinions too. Instead, the more formal interview structure I chose to impose would have constrained what could be explored in the interview. For example, in a less structured discussion, my participants would have been free to bring up anything they thought was relevant to the topic rather than being limited to answering my questions. More importantly, such an approach would have forced me to make visible my own assumptions about the topic (Parker, 2005) and allowed participants to directly question and respond to these. This would have forced me to consider my own ideas and opinions more thoroughly and could have opened up an engaging, reflexive process. However, at the stage of research design I was less aware of how my own assumptions were

shaping the interview schedule and what could be gained by bringing them more explicitly into the interview.

Similarly, Willig's guidelines offered a structured, comprehensive, coherent way of analysing the data. I flirted with using Parker's (1992) twenty steps in the analysis of discourse dynamics but, at the time of consideration, they seemed to add a level of detail and complexity that felt unnecessary to a study of this size; similarly I knew I did not possess the "advanced conceptual understanding of Foucault's method" that Willig (2001, p.109) suggested was needed to use Kendall and Wickham's (1999) approach. What I failed to understand at the time was that Parker's (1992) complexity existed with good reason - it reflected the complexity of undertaking a macro discourse analysis - and therefore by choosing Willig's approach I was not only restricting my analytic focus to the focus of those guidelines, but I was failing to negotiate territory and engage with a complexity in the initial stages that would nevertheless catch up with me later on.

An example of this is Parker's (1992, p.15) twelfth step which is to reflect "on the term used to describe the discourse, a matter which involves moral/political choices on the part of the analyst". Although not an explicit part of Willig's approach, it was nevertheless a fundamental part of stage two as the identification of the discourses involved a morally and politically subjective decision on how to name them. Similarly, Parker's ninth and tenth steps deal with contrasting and overlapping discourses. This was another challenge I was nevertheless confronted with, despite having chosen not to follow Parker's guidelines. To this extent, my choice to use Willig's approach, influenced by its supposed greater simplicity, left me less prepared for the complexity that I would nevertheless face as part of doing the analysis.

4. Analysis

Foucauldian discourse analysis of the four interview transcripts was steered by Willig's (2001) procedural guidelines, as described in the previous chapter. These helped to frame the process of analytic thinking and led to identification of several salient discourses and constructions of "MUS". Nevertheless, these constructions and the discourses they drew upon were not clearly definable categories, but overlapped, contradicted one other and were associated with others in myriad ways. Attempts to reduce them to single coherent themes appeared futile and to contradict the aim of this study. The challenge of structuring this chapter may indeed reflect the struggle to define what "MUS" is. This is discussed in more detail in 6.9.

As a result the structure reflects an attempt to arrange the material in a readable manner, rather than to distinctly limit text to specific categories. The first three sections (6.1-6.3) relate to dominant macro discourses that are drawn upon in constructions of "MUS": dualism/separation, psychological and holistic discourses. The influence of biomedical discourse is not specifically explored within a single section, but is observable and highlighted throughout the chapter. The remaining sections (6.4-6.8) focus on different constructions of "MUS" that seemed to be repeatedly created within these discourses: "MUS-as-choice", "MUS-as-challenge", "MUS-as-unreal", "MUS-as-placeless" and "MUS-as-untold-story".

4.1 Mind-body dualism and the separation of illness into categories

In analysing the interview transcripts, it is apparent that the notion of mind-body dualism pervades constructions of illness and seems to drive an active process of separation that extends beyond the division of mental and physical health. Reductive categories of illness seem to get constructed in an attempt to classify and oversimplify illness.

Hannah situates this in a historical context when asked about the notion of a medical/psychological split:

It's it's interesting because um, it's always kind of held up to be a kind of Cartesian split, but Descartes never said that, he never said that they're not related, he saw them as separate systems, yes [Marianne: Mm hm], but he didn't

say that there there was a total split but I think that that's what's come to be, and I think that, in the west anyway, that's how we see it. (Hannah, 257-260)

Drawing on a philosophical discourse, Hannah refers to the “Cartesian split” which has influenced western cultural notions of separate mind and body systems, even if this was not Descartes' original meaning. The location of what has become a “total split” within historical and geographical contexts emphasises its social construction as a modern western phenomenon. This dualistic discourse can have implications for how we think about, see and can be with our minds and bodies and consequences for how illness can be understood, i.e. as distinctly a problem of the mind or body, and this appears to be what Hannah is keen to emphasise. It comes across in the way Tom talks about working with people with “MUS”:

[...] the way I talk about it is that we we generate hypotheses, so we say ‘look’, let's say for example erm a client comes with I don't know, numbness in a limb or something [Marianne: Mm hm, mm hm] We could say you know there's two possible hypotheses here. One is that it isn't a medically unexplained symptom. There's just no medical professional who's been able to get to the bottom of what's going on [...] Or that this medically unexplained symptom has something, has a has a psychological base to it (Tom, 36-44)

Drawing on a separation discourse, Tom can reduce symptoms to either “MUS” and therefore having a psychological base or not “MUS” and therefore having an undiscovered organic base. Further drawing on a scientific discourse of reductive explanation, it seems that distinct hypotheses get generated based on this categorisation, closing down opportunities for both Tom and his clients to think about symptoms as anything but exclusively medical or psychological. “MUS” gets constructed as a psychological problem, created by the exclusion (definitive or not) of a medical cause. Diagnosis by exclusion could limit the possibility of “MUS” being construed as a diagnosis in its own right (through what it is rather than what it is not). This could maintain a notion that clients can have either a medical or a psychological problem, but not both. For clients this suggests that to accept one means to reject the other, probably making it harder and perhaps more frightening to consider a psychological element as it suggests they need to give up on any further medical investigation or care.

A discourse of separation can also limit practitioners' subjective experience:

So I think there's some constraints about that because then obviously if the client then wants to engage you in a, a medical-based conversation, um, I feel relevantly impotent (Marianne: Mm) and I'm actually very kind of scared to say anything or you know, you know I would very much then redirect them to their GP
 [Marianne: Mm] um, or I would say look I can go and find some of these answers out. Um, so I think there're some limitations into what type of conversation you can have with clients. (Tom, 184-188)

If "MUS" gets constructed as a medical issue, then Tom appears to want to remove it from his remit and he redirects the client or himself to a doctor. Within distinct professional or separation discourses, Tom can limit his remit by the boundaries of what he sees as his job. By drawing on these discourses, he is perhaps clearly and comfortably stating his remit and area of expertise and excluding himself from others. They appear to create a professional comfort zone; to venture into another domain leaves him feeling "impotent" and "scared".

This separation might restrict talk and the relationship he can have with clients. It creates a belief that there is only a certain "type of conversation" he can have, one that draws exclusively on psychological knowledge. This positions the person with "MUS" as either his client or not, and himself as either the expert or not, depending on how symptoms are constructed. Professional responsibility is taken up by either the doctor or the psychologist, but not jointly held. Again, this is likely to have implications for people with "MUS" who may feel they have to trade in the support of one professional in order to get support from another, and to choose whether they are a medical patient or a psychological client, because practice suggests they cannot be both.

Tom's clients' desire to "engage" the psychologist in a "medical-based conversation" suggests they are also drawing on a popular cultural discourse of separation that mirrors a biomedical, institutional one. Within a western cultural discourse of illness, a physical symptom implies a medical problem, and therefore would likely lead to expectations of a medical-based conversation. Therefore, a discourse of separation is likely to influence the available ways both clients and practitioners can think and talk about symptoms. Tom's clients are not necessarily

free to think about their physical symptoms within a psychological framework as it goes against a cultural understanding of illness that is familiar to them. In this way the biomedical discourse creates a tension between those who culturally adhere to it and those that do not.

Still drawing on a discourse of separation, Hannah demonstrates further implications:

But because of the lack of parity of esteem, if you like, between physical health and mental health, whereby physical health is accorded much much greater um (...) authenticity I suppose, um, people need, I think, or a lot of people need to hang on to the fact that there is a physical cause. And (..) because of the stigma (..) and also if there's a physical cause (..) I, the patient, don't have to change. And I can keep my emotional difficulties at bay, and that's, you know, short-term as usual, that's a short-term fix because it does keep them at bay, I'll just have one test after another. But in the long-term it doesn't help the individual, the person achieve a better quality of life. (Hannah, 73-79)

By drawing on a separation discourse, Hannah can draw attention to the distinction between physical health and mental health problems and suggest implications from this. Hannah constructs physical health problems as being positioned as more authentic, legitimising the physical health patient. This legitimacy might encourage a person with "MUS" to position themselves as such. It would mean they could then adopt a passive role and attribute responsibility for diagnosis and treatment ("one test after another") to doctors. A physical health diagnosis might mean people are less likely to feel responsibility for their problems (*they* "don't have to change").

In contrast "MUS" gets constructed as a mental health issue and a mental health diagnosis can be constructed as something unpleasant that you need to avoid ("keep at bay"). The "need to hang on" to a physical cause suggests a fear of entering the mental health realm where there might be stigma and authenticity might be questioned. It is suggested that being positioned as a mental health patient involves exploring "emotional difficulties", opening oneself up to discrimination and/or feelings of shame and taking responsibility for change. Behaviour could therefore be shaped by inequality within a healthcare system that encourages people to construct their difficulties within a physical health framework. However, Hannah depicts the

consequences of this as limiting opportunities for “a better quality of life”. It might only offer a short-term fix (via repeated diagnostic tests) as any psychological dimension is being ignored.

4.2 Deconstructing the psychological

So far the analysis suggests that a separation discourse leads to a distinction between mental and physical health, and that “MUS” often gets constructed as a mental health problem within that framework. However, whereas much of the debate around “MUS” has focused on dualistic concepts of medical or psychological, body or mind, this analysis disturbs that binary further by exposing the complexity and multiplicity of psychological constructions within it. A variety of psychological constructions of “MUS” have already been identified: “emotional difficulties”, “mental health” issue and having a “psychological base”. This multiplicity and the variety of meanings that are created by it highlight the potential risks of simply constructing “MUS” as a singular psychological phenomenon. This section further analyses psychological constructions of “MUS” and exposes the potentially negative implications of exclusive psychological constructions.

Helen describes how “MUS” used to be constructed within an accident and emergency service, and in so doing introduces the idea of “MUS” as “unconventional mental illness”:

And, you know, I just knew, I knew that a lot of those patients would be mentally ill patients. Either conventionally mentally ill, and under mental health teams, but still presenting in A & E with mental health symptoms, or people who are not conventionally mentally ill [Marianne: No] presenting with chest pain. And, you know, when we started the group I’d be looking at, there’d be some 30 year old guy coming in with chest pains: ECG, ECG, ECG, ECG. And nobody thinking he hasn’t got anything wrong with his heart. For God’s sake. What is a 30 year old man going to have? Exclude the rare stuff. You have. This is anxiety or, in this area, cocaine use (*laughs*). I mean, it’s gonna be. Neither of which is helped by repeated ECGs and or bloods for, to see if he’s had a heart attack. [Marianne: Mm. Mm.] But that’s how he was treated. (Helen, 237-248)

Helen constructs “MUS” as mental illness. However, it was not construed as such within the A & E service, which appeared to be governed by a biomedical discourse that dictated medical intervention for physical symptoms. A discourse of conventionality also seemed to govern the service, perhaps influencing ways of thinking: “And nobody thinking he hasn’t got anything wrong with his heart”. People were treated in accordance with what was generally and historically done, seeming to uphold institutional conventions rather than questioning historical process. For example, the patient described was positioned as a physical health patient (“that’s how he was treated”), which prevented him accessing mental health support. Alternative positions were not opened up to him and so he probably positioned himself as a physical health patient too as his understanding probably reflected that of the A & E department. Repeated diagnostic interventions with inconclusive results might fuel anxiety about symptoms and potentially lead to increased health service usage.

The patient’s behaviour can also be constructed within a cultural discourse that encourages and expects people to respond to physical health symptoms by seeking medical support. His response to chest pain was to repeatedly go to the accident and emergency department where he was repeatedly given an ECG. This suggests that health behaviour is maintained by cultural discourses (within which biomedicine is enmeshed in popular understanding) and psychological understanding of physical symptoms is a scarcely available discourse.

In challenging discourses of conventionality and biomedicine, possibilities for a different understanding of physical symptoms were opened up. Change occurred via questioning and disturbing taken-for-granted procedures. Nevertheless, the construction of “MUS” as unconventional mental illness enabled “MUS” to be reconstructed exclusively as a psychological phenomenon despite not conforming to conventional ways of constructing mental illness. Conventions are challenged but it avoids any need for practitioners and patients to acknowledge both biological and psychological elements and for a mind-body construction of “MUS”. To this extent the disturbance of organisational culture is limited as it continues to conform to a discourse of separation.

Although Helen talks about “MUS” as a “psychological” and “mental health” issue, she also refers to “MUS” as “the emotional”, seemingly to draw attention to how others construct it. In this extract, drawing on a gendered discourse Helen endows “MUS” with potentially sentimental, sensitive, feminine, impassioned and non-rational characteristics. She tells the following story:

... when I was training I did gynaecology and [...] my consultant was a, er, a conventional male gynaecologist. He had no interest whatsoever in the emotional. He was interested in gynaecology. He was interested in taking things out, mainly. He was a very good surgeon. [Marianne: Mmhm] That was his limit. [Marianne: Mm] And he would look down the list, and he would look down at the GP letters, and anyone he vaguely thought, so he was quite capable of knowing from the list which was likely to have a non-organic basis, I would get: XXX [name of participant], you go and see them because they’ll just cry. And I would sit there, with my clinic, women with chronic pelvic pain, with my box of tissues, and they would all cry. And I didn’t learn much gynaecology but I certainly learnt a lot about, erm, (*laughs*) distress. [Marianne: Yes] So, er, er, he made his choice. He wasn’t going to go there. But at least he vaguely thought, well, somebody else better do it. (Helen, 277-292)

An emotional construction of “MUS” could indicate understanding and recognition of the legitimacy of subjective experience; however in this instance it appears reductive, denying the physicality of the symptomatic experience and potentially reinforcing distress. By using it, Helen shows how it can close down opportunities for “MUS” to be considered a serious medical subject and therefore how the conventional male gynaecologist could be dismissive. He had “no interest whatsoever in the emotional”. This suggests “MUS-as-the-emotional” can position people with “MUS” as less worthy of professional attention within a medical discourse that privileges physical health.

In contrast, the gynaecologist is said to have been interested in “gynaecology” and “taking things out”, on which his good surgical reputation was based. It seems a conventional biomedical discourse, with its rational and reductive focus on the biological aspects of illness, allows him to take up the position of medical expert

despite his limits. There seems little expectation to consider psychological aspects of problems, especially when they are constructed as sentimental. He is not obliged to “go there”, a construction which clearly positions emotional aspects as external to gynaecology (see also 6.7). He can justify choosing to *do* “gynaecology” and avoid “the emotional” without guilt or professional negligence.

This extract highlights how a biomedical discourse can fuse with wider cultural discourses around gender. There seems to be a clear mobilisation of a conventional gendered discourse which produces rational men who do the real medical work using physical methods (his tool is the scalpel with which he removes the problem); women do the emotion (the box of tissues is assigned to a female trainee, for use with the female patients who will “just cry”). Women are “lists” and their bodies contain “things” to be taken out (and tears which can be wiped away). The gynaecologist does not engage subjectively with the whole person. This appears unnecessary within cultural norms around identify and conduct. Instead he is permitted power and an emotional detachment.

Even Helen, who takes up the position of emotionally orientated practitioner, positions the gynaecologist as “a good surgeon” and reports that she did not learn much “gynaecology”. This suggests her version of “gynaecology” and surgery remains limited within the same dominant medical discourses, strengthened by a gendered cultural discourse that normalises women as emotional and in turn potentially belittles or neglects their psychological difficulties. It suggests “MUS” is still situated outside of conventional medical practice, and this appears maintained by sentimental, psychological, gendered constructions that do little to address or validate the pain and distress experienced by these women.

Tom talks about how he makes sense of “MUS” as a psychological issue:

Well, I suppose I have to work, you know if I believe that it is a diagnosed MUS and there is, and you know everything has been ruled out, you know I I have to operate on that there is some sort of psychological involvement in there.
(Tom, 142-144)

Two contradictory constructions of “MUS” are apparent here. Resonating with a positivist diagnostic discourse, on the one hand Tom constructs “MUS” as a concrete

entity: “a diagnosed MUS”. Yet drawing on a discourse of reality, this is countered with the use of “if I believe it is”, which seems to open up the diagnosis to doubt and subjectivity. Tom can then overrule this by believing in it. Both constructs empower him to take up the expert position: he can endow himself with it in relation to believing this to be an “MUS” or be endowed by others who have diagnosed this as “MUS”. Taking on an expert position can empower practitioners to “rule out” certain phenomenon, even where doubt exists. “Rule out” draws on discourses of measurement and sovereignty, providing further authority to the practitioner, empowering them to overcome further uncertainty. This might be deemed as important or helpful if practitioners want to maintain authority in a culture that respects expertise and certainty, or avoid engaging with the uncertainty of “MUS”.

Tom’s use of “I have to” and “I suppose” further implies a tension between constructions of “MUS” as either a concrete or abstract phenomenon. The former draws on a positivist, biomedical discourse, but the latter exposes weaknesses in this position. “MUS” as a psychological problem appears again constructed or “diagnosed” by exclusion of a medical aetiology. Underlying these constructions is a separation discourse that constructs “MUS” as psychological because of what it is not rather than what it is. Such a process is likely to maintain, rather than overcome, doubt and uncertainty.

4.3 The holistic discourse

Analysis of the transcripts suggests attempts to construct versions of illness that resist categorisation and attempts to draw on alternative discourses. Naming discourse that constructs the body and mind as one system was particularly challenging and reflects the lack of culturally available and mutually acceptable ways of thinking about the body and the mind together in the singular. Therefore, I draw on the elusive concepts of integration, bodymind, mind-body, biopsychosocial and holism interchangeably here as signposting tools.

Hannah defers to a painting by Egon Schiele to represent the distress embodied in “MUS”:

[One reason that my interest in “MUS”] just goes to the heart of being human is that we are (..) connected, we are we are (...) one system. We’re not discrete

systems. And to pretend that everything is either in the body or in the mind (..) is, is ridiculous. And so the evidence is there [points to painting]. And I know that you can't bring that up but this painting here is a fantastic piece of work that shows the distress of the person through the body. It's a self-portrait by Schiele, and I just love it and erm, and you can just see how kind of contorted and twisted he is. But it's emotional distress. [Marianne: Yes] And it kind of typifies everything I think about erm and we can't call them medically unexplained symptoms. I think that's very stigmatising as well. (Hannah, 39-47)

“MUS” is constructed as emotional distress embodying both physical and psychological aspects. Hannah represents this integrated construction of distress visually, possibly because she cannot find words to make her point. This implies art can depict “MUS” in a way that words cannot. Even the term “MUS” is “stigmatising”. Yet Hannah also draws on a scientific discourse to present the painting as confirmation of the mind-body relationship, perhaps attempting to add value to her point by recourse to “evidence”. This construction of “MUS” resists separation and opens up opportunities for a more embodied way of viewing emotional distress. However, a lack of language within which to do this is a significant limitation. How can “MUS” be addressed if there is no acceptable language or discourse with which to discuss it?

Hannah constructs the notion of a separate body and mind as ridiculous and positions people who do this as practising pretence. “To pretend” suggests actively denying the existence of an integrated mind-body system despite knowing it to be so. However, continuing to construct the mind and body as separate systems avoids challenging the dominant biomedical discourse and all the systems, structures, knowledges, models and professional roles that are maintained by it. It avoids disturbing the current status quo and the power balances within it. It also positions patients as victims of deceit.

Hannah's response to a question about which professional roles are important in working with “MUS” (lines 215-216) draws on a holistic discourse:

Ok, so for me, so it has to be anybody who has the time to listen [Marianne: Mm hm, mm hm]. I'm not sure about, er, physicians because I think that people who are, who espouse the medical model are are going to struggle [...] Um, I would

say psychologists wouldn't I? I don't think it, er, it's (...) Care coordinator? Anybody who is respectful, has time, can be very boundaried, is very boundaried (...) and is interested. [Marianne: Mm mm] And I suppose it doesn't really matter what profession you are, but I think it, I'm going to say psychologist because I think it's the, that's the profession that's interested in the, um, how how people make sense of their lives, and I think because I work in the service I do, which is the integration of physical and mental health, um, somebody who works in in in those areas, in both those areas, because that's how I'm trained to look at problems. (Hannah, 224-249)

In this extract, Hannah constructs "MUS" as both an integrated physical and mental health issue, and as something to do with "how people make sense of their lives". These constructions open up possibilities for working psychologically with people with "MUS", although Hannah hesitates to position "MUS" as the limited domain for psychologists. Although I have inadvertently framed my question in relation to distinct professional roles, Hannah partially resists deferring to discourses of professionalism or expertise and instead opens up the position to the available, interested, curious practitioner. It becomes about a way of being ("respectful", "has time", "boundaried") rather than about profession. These values are nevertheless drawn from a therapeutic relational discourse familiar to counselling psychologists. By constructing these values as important practice in working with "MUS", Hannah can implicitly justify and advocate for the role of psychological practitioners and challenge the role of some medical practitioners. In turn, such practice could contribute towards the construction of "MUS" as something to do with "how people make sense of their lives" strengthening such a construction within a wider holistic discourse.

Two subject positions are offered as helpful: the curious practitioner who is "interested in [...] how people make sense of their lives" and the expert practitioner who is trained to work in this area. The latter position draws on a knowledge discourse and is constrained by the specific discourse within which the position is taken up. Practitioners who "espouse the medical model" are "going to struggle"; those who have an important role to play are those who "look at problems" from the perspective of "the integration of physical and mental health". Therefore practitioners who rigidly restrict their practice to a single domain are positioned as

less able to work with “MUS”. Being “interested and curious” in people’s lives is made possible within a holistic discourse and is more likely to encourage the person with “MUS” to be interested in themselves, their bodies and their minds.

The following extract illustrates how the construction of physical symptoms has changed within the A & E service following the formation of a multidisciplinary group which considers “MUS”:

Fantastic. Brilliant. Um. It runs. We meet every couple of months. It’s multidisciplinary [...]so there’s an A & E consultant, there’s the guy who runs it (..) there’s the first response team so that’s an admission avoidance team (...) There’s everyone. There’s community matrons. There’s XXX [name of location] ambulance. There’s mental health. There’s myself. There’s somebody from the XXX [name of mental health service]. Er, there’s the alcohol nurses. It’s a big, big group and it has changed over a couple of years. When we first started there was very little talk of mental health. Very interesting. Or MUS. And now it’s really changed. And people are (..) assuming that somebody might have an emotional need as well. [...] So you really change things, it’s dramatic. I think. It’s absolutely wonderful. And the A & E consultant, who before was a very A & E consultant, you know, he’s really changed too. He sees the value of considering mental health. [Marianne: Mm] And not just now because it gets people out of his A & E and into the community mental health team. He’s actually very much more in tune with the sorts of symptoms people present with and why. (Helen, 250-265)

Drawing on an integrative discourse, staff are now assuming people might have emotional as well as physical needs. “MUS” is being reconstructed as a regular occurrence that needs multidisciplinary consideration. This opens up the opportunity for a variety of practitioners (“everyone”) to engage with “MUS”, especially now that the service recognises “MUS” as part of their remit. The option to opt-out or focus on only physical needs has been closed down. An economic discourse constructs this engagement as a value driven consideration – the numbers in A & E are reduced. However, Helen also believes a shift in ways of seeing and being with “MUS” has occurred. Positive change figures predominantly in this construction (“fantastic”, “brilliant”, “absolutely wonderful”), emphasising a “dramatic” difference between before and after. It seems a difference in understanding has

occurred as a result of the availability of a holistic discourse. Helen is excited about this change, suggesting a broader discourse can lead to changes in attitude as well as working practice. This difference in understanding and mood among practitioners is likely to have positive effects on their engagement with patients.

When asked about constraints to working with both medical and psychological aspects of “MUS”, Hannah responds:

Um, okay, so the most obvious one for me is knowledge [Marianne: Mm hm]
 You know, I’m not medically trained, I kind of learn on the job. Um, but I’m
 lucky, I can always ask, because I work in a hospital, yeah. [Marianne: Mm Mm]
 Um, I can do joint work if I feel that will help. (Hannah, 297-302)

In contrast to Tom, Hannah seems to want to defer to a biopsychosocial discourse. She sees it as a constraint that she cannot draw on medical knowledge or training, suggesting these would be helpful in working with “MUS”. This mirrors the barriers highlighted by Helen and Maggie, who position doctors as constrained by a lack of psychological training (see 6.7). Practitioners appear to be challenged because of the discrete focus of their professional training. Knowledge that separates mental and physical health is likely to produce professionals who view people and their difficulties in the same way. The participants seem to be resisting these constraints: Hannah through “joint work”, Helen by calling for a broadening of medical training. Neither want to take up the position of limited expert who cannot work with “MUS” because it is outside their field of expertise. This suggests both see it as possible to broaden their understanding, further challenging the hegemony of the discrete expert.

4.4 Interest, choice and engagement: “MUS-as-choice”/“MUS-as-interesting”

Being interested in “MUS” is a feature of the transcripts, as is “MUS-as-choice”.

This section analyses this relationship between interest, choice and engagement. The gynaecologist referred to by Helen had “no interest in the emotional” and “made his choice” not to engage with “MUS”. Hannah argued that practitioners need to be interested in making sense of people’s lives in order to work effectively in this area. Helen seems to identify choice, interest and its impact on engagement on both sides of the patient/doctor relationship:

I mean, I think some people are more (...) gravitate towards the emotional wellbeing, the mental health side of things and I think it's very interesting as a GP how patients choose you. [...] I mean it's quite interesting looking at people's lists and seeing who's with different doctors and why. They obviously get something from the relationship. But I think that some doctors are much more, um, interested in that side of it. Erm. I think all GPs, of course, recognise the importance of the psychological, the emotional. But, as I said, I mean we have time constraints, perhaps lack of interest, perhaps you don't want to go there. (Helen, 269-276)

By constructing "MUS" as an issue of "mental health" and "emotional wellbeing" it is distinguished from physical health and made a distinct psychological problem that permits a distinct way of working. This might open up the possibility for engagement to be considered as optional. Helen's use of this discursive construction might be partly in defence of doctors who choose not to engage. She is drawing on a separation discourse which seems to privilege physical health and might allow doctors such choices because it places "MUS-as-emotional-distress" outside of their primary professional remit.

Despite doctors recognising "the importance of the psychological", they seem to be allowed to choose to adopt or reject the position of available practitioner when encountering a person with "MUS". They can choose not to work in this area simply because of "lack of interest" or not wanting to, resulting in unequal treatment of patients. Would such choice be available if a patient had cancer or diabetes? It seems a psychological construction of "MUS" can diminish doctors' responsibility, perhaps without any guilt or liability. Doctors can make their choice. Only those who are interested need engage. However, perhaps in order to counteract any impression of neglect on the GPs' behalf, Helen positions doctors as sometimes being drawn to that side, perhaps as if it is a different skill set or a natural calling.

How doctors practice then influences whether people with "MUS" choose to see them or not. Patients are positioned as having choice over which doctors they visit, however only some doctors offer the "interest", "time" or inclination to engage with "MUS". By referring to "time" alongside "interest" and "want" Helen might be emphasising the institutional constraints of time alongside individual choice or

interest to remind us that engagement can be socially influenced. Therefore, there are limited options available to the person with “MUS”, particularly if positioned as a “mental health patient”. This is likely to contribute to so-called resistance.

However, Helen also implies that interest is something that can be captured when teaching GPs, and that lack of skills might affect interest, choice and engagement:

But when we were teaching GPs, you have to, you have to do it in a way that captures the GP interest. So we did a MUS audit a couple of years ago which was, basically we got practices to look at their frequent attenders and then to look at, of that list, who they thought, possibly, had medically unexplained symptoms. And then decide, whether they could talk to the patient about that. And we gave them little scripts, just like we were talking about earlier. What to say. What not to say and what to say. [Marianne: Mmhm] What they could be offered. So, if it turned out that they thought this was an anxiety er disorder and the patient was amenable they could refer them to IAPT. If the patient was amenable for more psychotherapeutic input they could be referred to XXX [name of psychotherapy service]. Or the patient could just say no. That’s fine. (Helen, 301-310)

Drawing on a discourse of diagnosis, in this extract “MUS” is constructed as identifiable. This suggests it can be recognised, listed, audited and characterised, in this instance as generally something difficult to talk about. The GP is positioned as having authority to pronounce it an “MUS”, and once given that label it becomes legitimised as difficult to talk about and people with “MUS” get positioned as difficult to talk to. By constructing “MUS” in this way, Helen might be avoiding any conflictual discussion about what an “MUS” is or is not. She appears to be conferring GPs this power, in keeping with a cultural positioning of GPs’ role as diagnostician.

Once “MUS” has been constructed as challenging in this way, the strategy to capture GPs’ interest is to develop communication skills and enable them to better engage with people with “MUS”. This focus of Helen’s draws on a relational discourse and seems to shift the problem from lack of interest to lack of communication and engagement skills. It suggests the current discursive resources available to GPs are not sufficient to enable them to discuss “MUS” with patients and there is a need for new ways of talking that could reduce resistance to engagement for both patients and

practitioners. In order to influence engagement GPs were given “little scripts” of “what to say” and “what not to say”, as if being prescribed conversation, a specific language for use with “MUS” patients. With new resources to draw upon which open up rather than close down engagement and therefore widen GPs’ remit, there may be less need or desire to opt out of working with “MUS”.

Patients who are open to being referred for psychological support are positioned as amenable - compliant and manageable. It is implied they have a choice, but if they do not choose psychological support this suggests they might be implicitly being positioned as unwilling. Perhaps this is how it feels to doctors, particularly if their work with “MUS” is institutionally limited by time and skills. It seems that patients are being asked to consider their “MUS” as an emotional or psychological problem, yet the system within which they are being treated is itself constructing engagement with “MUS” as optional and sometimes denying its existence as a real problem. GPs are being given scripts in part because the discourse is new and unfamiliar. It is likely to be the same for patients. So it seems that patients are being asked to accept a psychological dimension that only some doctors choose to engage with and only some services choose to recognise. Both doctors and patients are positioned as resistant and needing support to open up to new perspectives. The parallels in their separate processes are likely to reflect the constraints imposed by biomedical discourses as well as suggesting a need to create and nurture alternative discourses.

Predominantly, “MUS” appears to be constructed as a distinct emotional, psychological or mental health problem which can empower or disempower patients and doctors with choice. However, it is not just individuals or individual groups, but the services and structures within which they are players, that might impact on and be impacted on in relation to opportunities for choice. Helen draws explicit attention to the issue of services engaging or not with “MUS”:

I think there’s a lot of doctors, when we went to er the XXX [name of hospital] I, I, to say that we were interested in putting a psychologist into our patient teams, um, the people, very interesting about who (..) so, so, which outpatient consultants leapt at that and which said, what? So, erm, gastroenterology leapt at it. Leapt at it. Oh my god, please come in. Please help us. Dermatology. Very interesting. Gynaecology? No. We don’t we don’t have any patients with

medically unexplained symptoms. Well, probably a third of your outpatients if research shows right. So, you know, it's, it's, it's doing that work [I: Mm] to slowly, slowly move things and you you know you can push and open doors first. (294-301)

Helen defers to a research discourse to construct “MUS” as widespread (“a third of your outpatients”) and a biopsychosocial discourse to acknowledge the need for psychological input. In doing this, she adds weight to her argument for the latter. She seems to be challenging the medical hegemony, by exposing a gap in service delivery that disturbs the professional power balance and can either be acknowledged or denied by the services. To admit a psychologist is needed is to acknowledge psychological aspects to patients’ presentations and limitations within the medical profession to address these. Gynaecology, in contrast to research evidence, denied the existence of “MUS” within their department. This suggests that within a biomedical discourse services can be limited to biomedical treatment and opportunities for psychological support denied to people with “MUS”. It also suggests a biomedical discourse can protect doctors from having to relinquish the position of omnipotent practitioner and acknowledge the limitations of their knowledge/practice. They do not need to share their professional power base. By highlighting these discrepancies Helen seems to be assigning responsibility to services (perhaps away from individual doctors) to engage with “MUS” and exposing the challenges on a wider structural, rather than an individual, level.

On the other hand, these constructions seem to open up opportunities for services to recognise limitations. Gastroenterology enthusiastically “leapt at it”, as if in answer to their prayers (“Oh my god. Please come in”), creating space for joined up working practices and opportunities to support people with “MUS”. The different choices for engagement that are made reflect the tension between the biopsychosocial and biomedical discourses. Opportunities for patients and practitioners are either opened up (like the doors “you can push and open”) or closed down by the discourses that get drawn upon.

Tom positions his role as “about giving people choice” and suggests some people might benefit from an alternative way of thinking about their “MUS”:

I think it's about (...) providing a narrative that everything sort of happens for a reason, and that there's (..) uh, I think it's just about giving people choice, to be honest [Marianne: Mm hm], choice that they can, that there's other ways of thinking about their problem, that there's actually other ways, that that western medicine doesn't necessarily, isn't a panacea for everything that might might go untoward in our bodies and our minds. (Tom, 237-241)

Drawing on a philosophical (Aristotelian) discourse, "MUS" is constructed as happening for a reason. This opens up different ways of thinking about and understanding "MUS" and potentially provides an opportunity for reflection and insight. A biomedical discourse creates an expectation that "western medicine" should provide "a panacea" for all difficulties, yet cannot offer alternative choices when it does not work. This creates frustration for people with "MUS" as it conflicts with their subjective experience. An alternative therapeutic discourse provides different knowledges and opens up other options for people to construct "a reason", "a narrative" and "other ways of thinking". It empowers people to think and act in a different way and to make different choices. Within this discourse Tom can take up the position of empowering practitioner by "providing a narrative" and "giving people choice". However, although recourse to a discourse of alternative medicine opens up alternative frameworks to "western medicine", it does not directly challenge national health services about the positions they take or the limitations of the support they provide. Unless this happens, choice becomes limited to those who can afford to access alternative services.

4.5 Challenging "MUS": "MUS-as-challenge"

This section explores the different ways in which "MUS" gets constructed as a challenge and how the meaning of the challenge can be dependent upon the discourses within which it is constructed. Hannah constructs "MUS" as a challenge for doctors because they defer to a "pure" positivist biomedical discourse in which all symptomatic problems should be resolvable via biomedical solutions:

My understanding of the research is that this is the patient group that causes the most dissatisfaction among GPs because you cannot apply this, what they call the house model, this idea, House as in the Hugh Laurie character, of find it and fix it. There's a symptom we will find er a solution. So, really, it really tests people who

um espouse those kind of pure science approach, who try and problematize everything according to anatomy. (Hannah, 29-33)

Drawing on a biomedical discourse, Hannah suggests doctors want to be presented with symptoms they can diagnose and successfully treat so they can take up the expert position. Yet “MUS” challenges this (“really tests people”) because “MUS” cannot be approached successfully in this way. Therefore “MUS” and people with “MUS” become challenging as doctors become unsuccessful. “MUS” becomes synonymous with failure and this leads to feelings of dissatisfaction. Hannah draws on a media discourse (“House”) to show how the “find it and fix it” biomedical discourse is adopted by and reinforced through the media: Dr. House always finds a cause and solution in the end. Such reinforcement maintains a cultural faith in the biomedical discourse and is likely to influence patient hopes and expectations as people further buy into this discourse through the media.

Hannah contrasts this portrayal of the medical model by drawing on what might be seen as a psychological discourse of acceptance. She positions psychologists as sometimes taking on a spectator role and accepting impotence:

And I guess that the challenge with psychology or psych psychologists, sometimes we have to witness the tragedy, when actually we just wanna jump in and sort it. But that that goes with the, ooh I’m going to use a nice word for you, I’m going to say goes with the territory (*laughs*). (Hannah, 332-334)

[...] you’ve gone all that way and nothing’s shifting [Marianne: Mm mm] because everybody, well I only speak for myself, I want to think I can help somebody. So there’s that, that’s the grandiosity (Hannah, 321-323)

Yet this position is also construed as challenging as Hannah recognises a desire, drawing on an expert discourse, to “jump in and sort it”. In this way there is similarity with the doctors: accepting not being able to help is difficult. However, psychological discourse (“the territory”) can allow for such a position, whereas a biomedical discourse does not. Therefore doctors struggle to accept helplessness within the comfort of their zone of expertise. Nevertheless, discourses of expertise can both drive expectations to be able to help and sanction the power to resist helping (similar to the gynaecologist’s choice not to engage with “MUS”). In this

way, these discourses empower practitioners with decisions over who gets treatment as well as what that treatment is and this can engender grandiosity.

The participant's use of a discourse of tragedy reflects the patients' suffering, but, drawing on its theatrical origins, also implies it results from a combination of social and psychological circumstances. Hannah constructs "MUS" as a psychosocial issue which also reflects a more counselling psychology position, her "territory". Doctors, psychologists and patients are all positioned as struggling with helplessness, equating the challenge of "MUS" with the challenge of helplessness. Hannah is including herself in this, but distinguishing herself from doctors by drawing on a psychological discourse within which such a position is more permissible.

Maggie also refers to helplessness:

there are people who, whose need is quite specific (Marianne: Mm hm) and difficult, um and somehow as a team we've got to treat them with with respect and find a way to help, even though we feel helpless. And of course, professionals hate feeling helpless. [Marianne: Mm hm, mm hm] Uh, as a GP I hate feeling helpless, I hate having to say well I don't know what it is and I don't know what to do. But I don't often get thrown into that, because because I I have got, always got a psychodynamic. (Maggie, 423-430)

The "MUS- as-challenging" construction offers the subject position of "difficult" with specific needs to people with "MUS". Such a construction engenders impotence, suggesting GPs not only feel helpless, but hate having to acknowledge this (unacceptable within a biomedical discourse). However, as a trained GP and psychodynamic therapist Maggie can draw on a psychotherapeutic discourse and distance herself from this position because she can access a different knowledge/power bases. She can avoid having to take up a helpless position, as she is not restricted by a purely biomedical approach. Most GPs do not have this option available to them and are left with "hate". Maggie's repetition of "hate" perhaps suggests that this is what is being experienced and avoided, and might reflect the fear, anxiety and helplessness caused by discursive limitations.

“MUS-as-challenge” is influenced by the institutional environment within which it exists and is manifested through logistical constraints, such as time, resources and protocols:

Um, so there’s a whole lot of stuff going on when someone is talking and I think GPs are very used to management and so medically unexplained symptoms is more difficult because the management pathways push you into a medical model. (Helen, 35-38)

Helen’s construction of “MUS” as challenging (“difficult”) draws on an institutional discourse. The challenge is how to manage “MUS” within management constraints. Perhaps by using this construction Helen is emphasising the limited options available to doctors and to herself. Positioning “MUS” or people with “MUS” as objects to be managed restricts what practitioners can do to the options available within a management pathway dominated by a medical model. This is despite recognition, drawing on a social, or perhaps holistic, discourse, that “there’s a whole lot of stuff going on when someone is talking”. Perhaps by drawing on these discourses Helen is showing that she knows there is more going on than the biomedical discourse can accommodate. Helen continues:

So, you come and see me with headaches. Well, do I send you for an MRI? You say to me you want an MRI because you think you have a brain tumour. I think you have no symptoms of brain tumour. Do I just give in and do it anyway? Er, or do I say let’s look at what other things could be causing your headaches?
[Marianne: Mm Mm] And, you know, so (...) we’re trained in a biopsychosocial model, um, as GPs and that’s very good, but what you tend to fall into, in a 10 minute consultation, is a bit of a bio (*laughs*) [Marianne: Yes] because that’s comfortable and quick and it also it has to be done because you don’t want to miss the brain tumour. So actually that takes predominance. (Helen, 38-47)

An institutional discourse allows Helen to take up the position of dutiful protocol-driven practitioner. An MRI “has to be done” in order not to miss a brain tumour. However, Helen thinks there are “no symptoms” and positions her actions as surrendering (“Do I just give in”), implying she is not a free agent but controlled by the systems. There is a contradiction between what she thinks and what she does, between her subjective opinion (based on a biopsychosocial discourse) and the

institutional knowledge/power and the latter is dominant. Drawing on a satisfaction discourse, she is also influenced by patient desire. The patient is positioned as empowered and asserting their needs. Again, Helen is assigning power away from herself. Yet this position of empowered patient, made available by the discourse of satisfaction, seems restricted by a biomedical discourse which guides what doctors can do and patients expect. Is anybody really able to “look at what other things could be causing” the symptoms?

And the psychosocial bit is, the GPs are very well aware of it, it's just, I think there's a bit of learned helplessness. You kind of think, well, what's the point because, you know, I don't know, who is going to help these people? Um, who can, you know, if this lady discloses domestic violence now what am I going to do? Who is going to see her quickly to help? Who is going to help with her housing or her refugee status? (Helen, 49-53)

Helen suggests GPs take up a deliberate position of “helplessness”, learned from a system that cannot accommodate psychosocial problems as factors in illness. Biomedical discourse does not allow for psychosocial influences. From within this discourse Helen can position herself as challenged or helpless, perhaps emphasising the institutional power of biomedicine to justify this position. The medical institutions make GPs responsible for treating physical symptoms; yet knowledge and practice is restricted within discourse that frames illness as the result of a biological aetiology. If physical symptoms are associated with social problems, and GPs are responsible for physical symptoms but not trained in or supported by systems that address social problems, there is no mechanism for these types of symptoms to be addressed. Therefore, it seems that GPs learn helplessness because they cannot address the causes of patients' symptoms and patients remain unsupported.

For Helen, the ten-minute appointment is a barrier; for Hannah it is a limited number of longer sessions. There is never enough time for the person with “MUS”.

Um, the biggest constraint has to be (.) time. You can't meet somebody in their twenties, thirties, forties, or more, and expect to get a sense of who they are in a, you know, two one hour sessions, [Marianne: Mm] you just can't. And I think

because everything is reduced to, you know, targets and limits and, uh, I think the biggest constraint is resources and and and time. (Hannah, 302-306)

Within an organisational discourse, people with “MUS” are reduced to objects of targets, limits, time and resources and Hannah, drawing on a psychological discourse, seems to contrast this with her need to get “a sense of who they are”. Developing a broader understanding is probably more difficult within the organisational constraints imposed by a system which does not recognise the need for this. To this extent a biomedical knowledge system will be limited to working effectively with illness which fits into a biomedical framework, and inept at dealing with illness that does not. Therefore Hannah’s work as a psychologist is limited by the institutional culture she works within which draws on biomedical discourse. This suggests that biomedical institutional power transcends beyond the medical profession and exerts itself on other practitioners working within the health system, such as CoPs like Hannah, who seems to feel restricted by it.

Maggie also talks about how organisational culture constrains GP practice:

Um, they’re very constrained for time. I think they feel they have lots of people looking over their shoulder. Not only their partners, but the commissioning group, er, which which says you cannot refer somebody, um, because you suspect a bowel cancer. Certain criteria must be met before you can refer them. (.....) They just work harder. They work harder and they have to work faster. And this leisurely thing that I became accustomed to of, I think, I think yes, there’s a, there’s a difference. Um, I would have been much more likely to say uh, here’s this medication, come back and see me next Tuesday, or come back and see me in ten days and tell me how it went. [Marianne: Mm hm, mm hm] I think that luxury, it would be ha, much harder nowadays. (Maggie, 334-342)

Maggie draws on an institutional discourse to construct the challenge of “MUS” as one of an environment in which GPs have to work harder and faster. She positions GPs as enslaved to the demands of commissioning groups, as well as monitored and judged by them. This positions GPs as controlled by the institutional power, rather than as free agents, and therefore not responsible for the situation. Their own individual professional expertise – “you suspect a bowel cancer” – appears to have been substituted for unitary institutional knowledge and practice governed by

criteria. Within this organisational culture, it seems that having time to talk to and follow up with a patient is seen as “leisurely” and a “luxury” and is not valued within this neoliberal culture. This will disadvantage patients who need more time and is likely to position them as challenging or demanding, something patients are likely to notice.

Maggie tries to address how you establish an atmosphere of being “kind and patient” (lines 404-405) within such an environment:

So how does the doctor establish that atmosphere in their practice, when everybody’s rushed and overworked, I don’t know. By example, and maybe by, I’d sometimes say they have little discussion groups with the receptionists about how to deal with difficult people (Marianne: Mm). You know that, that would be useful. Everybody that a patient comes into contact with has the potential to be plus or minus. (Maggie, 410-414)

It seems that part of the challenge is how to accommodate unexplainable problems within a system that only allows ten minutes for a consultation. Drawing on this institutional discourse, Maggie can position doctors as rushed, overworked and over-monitored, perhaps in order to defend the profession from individual criticism and assign responsibility to the institutional culture influenced by a neoliberal discourse. Yet in so doing it seems that people with “MUS” can get positioned as the problem rather than the issue of doctors being under pressure. If the problem is “difficult people” then the way to deal with the problem can be to have “little discussion groups” about how to be kind and patient with them. Responsibility shifts to the receptionists to be a “plus”. The wider systemic problems can be disavowed and biomedical dominance maintained. So, the meaning of “MUS-as-challenge” gets reconstructed depending on which version of the problem is privileged. Within a demanding organisational environment, driven by neoliberal and biomedical discourses, it seems that “MUS-as-challenge” can lead to a culture of blame and ultimately defensiveness on all sides.

4.6 Believing in “MUS”: “MUS-as-unreal”

Maggie and Hannah both stress the importance of constructing “MUS” as real, implying this is necessary in order to legitimise it:

I would be more likely to say something like, I'm sure this pain is real [Marianne: Mm hm], we haven't found the cause of it yet. Some pains have physical causes and some have other causes. (Maggie, 14-15)

The third group [of GPs] are those that try [...] to help the patient understand that the symptoms are real, the distress is real, the cause is real, it's just not a medical cause. (Hannah, 69-71)

Drawing on a biopsychosocial discourse, "MUS-as-real" opens up the notion that physical symptoms can have causes that are not biological and provides people with an alternative framework within which to understand and validate their symptoms. It is possible Hannah and Maggie use this construction in order to counter a predominant western cultural view of illness influenced by biomedical discourse and to legitimise the symptoms for both patients and practitioners. Drawing on a holistic discourse they are promoting a biopsychosocial construction of illness. Patients are positioned as needing help to understand that the notion of a non-medical cause is possible, highlighting the dominance of biomedical discourse in providing cultural meaning to physical symptoms. This suggests that within a biomedical discourse "MUS" cannot be constructed as real because real illness means biological causes for physical symptoms. Therefore, it seems that the reality of "MUS" can be questioned within a positivist framework that ignores social and cultural factors and allows pain to be constructed as real or not as opposed to just painful. Whether patients can satisfactorily accept the so-called reality of their symptoms when not constructed within a biomedical discourse might depend on the extent to which the power of biomedical discourse and all its implications can be resisted.

When asked what got Maggie interested in "MUS" she says:

Well just being a GP. I mean you can't avoid it. I I If you said to yourself I don't believe in this and I will not do this, you'd be in trouble (Marianne: Mm hm) because a lot of the volume of work is (Marianne: Mm hm) a question of being patient, sitting it out with the patient who's got this distressing symptom and saying, uhhh I haven't figured out what it is yet but let's wait and see, come back and tell me about it (Maggie, 149-153)

In contrast to constructions of “MUS” as a misplaced GP problem, Maggie firmly situates “MUS” as both “distressing” and part of GP work. This could close down opportunities to not “believe in this”. Such a construction seems to shift the focus away from resisting “MUS” on to the approach needed to practice in this area: “being patient”, “sitting it out”, “wait and see” and being honest about the unknown (“I haven’t figured it out yet”). It opens up the position of curious practitioner, able to accept a level of uncertainty within the remit of “just being a GP”. It broadens the professional discourse enough to encompass uncertainty. It also opens up the interpersonal space between doctor and patient to experience the problem intersubjectively by “sitting it out” together. Maggie suggests they are sharing the position of uncertainty: the doctor is closer to experiencing “being patient”.

However, Maggie’s psychological construction of some “MUS” exposes a contradictory relationship between psychological and believability discourses:

I’m just trying to think for instance think about working with people with (...) uh (...) chronic fatigue, say. [Marianne: Mm, mm.] Now I’ve got a prejudice about that, um, and I think there’s a whole industry been built up about it, and I don’t, I think it’s all secondary gain. [Marianne: Mm hm, mm hm.] Um, I I believe there’s such a thing as post-viral fatigue, you know, that’s something I can get my hands on and believe and understand, but people who spend years being waited on hand and foot by their families (Marianne: Mm hm), I believe that it is psychological rather than physical. [Marianne: Mm hm, mm hm] Uh, so with those people I, that that’s really the most extreme case I think, that’s the most extreme case of medically unexplained symptoms that I can come up with, and I’m angry about that because the associations, you know the patient groups for that, I think encourage people to be ill, (Marianne: Mm hm, mm hm) and encourage them to be belligerent. And I don’t think it’s any help to the patient at all. [Marianne: Mm hm.] I would say I’m a complete failure there, probably because I don’t believe in it. (Maggie, 60-71)

Maggie draws on several discourses here in her construction of “MUS” as a psychological issue. A believability discourse allows her to question the existence of symptoms as an entity she can get her “hands on and believe and understand”. This suggests it is this lack of physical existence that leads her to exclaim “I don’t believe

in it”, as if only more concrete phenomena, such as “post-viral fatigue”, can be real. To this end Maggie also appears to be drawing on a biomedical discourse to construct her version of believable. She can believe in fatigue that is caused by a virus because it is biological and therefore ‘real’. Presumably she can then position and treat people with “post-viral fatigue” as legitimate patients with an explainable condition. She can be helpful to them.

In contrast, chronic fatigue syndrome (CFS) is constructed as “psychological rather than physical” and therefore unbelievable (“I don’t believe in it”). If “MUS” as psychological equates with unbelievability, this potentially leaves little space for suffering and distress to be acknowledged or validated. Drawing on a psychological discourse of secondary gain, patients are positioned as benefitting from “MUS” by getting everything done for them by their families. The bodily language (“waited on hand and foot”) suggests it is their bodies and not their minds which are receiving attention. Such constructions open up space for a deeper understanding of “MUS”, but could risk positioning people with “MUS” as illegitimate patients or malingerers, which, in turn, facilitates Maggie’s “prejudice”.

However, this version contrasts with that of the patient associations who construct CFS as a purely physical entity. They have developed “a whole industry” which has actively resisted a psychological construction and promoted a biological one, thus closing down opportunities for symptoms to be construed as unbelievable and patients to be positioned as illegitimate (but also to access psychological support). Drawing on a political discourse, “MUS” becomes a cause that empowers patients and makes it acceptable for them to be ill and belligerent towards doctors who refute their construction. By positioning patient associations as encouraging illness and belligerence, Maggie can justify her own position and her anger.

What these conflicting discourses seem to have in common is that they appear to all drive rigid, exclusive constructions that promote an either/or way of thinking about “MUS”. They seem to suggest physical/biological/medical equates with believable and therefore real. Maggie is disempowered by these exclusive discourses. She constructs CFS as psychological, but when confronted with patient resistance she feels unable to use this in practice, yet seems to find medical discourse unhelpful because she cannot believe in the framework it offers her (that this is physical

illness). This implies there is no acceptable language or discourse available to her which constructs illness in terms of an interaction of biopsychosocial factors. Maggie therefore takes on a position of impotence, feeling helpless and “a complete failure”. This is not likely to be helpful to her patients nor her practice, but it might protect her from conflict with the patient associations.

This section highlights the lack of available discourse within which to helpfully construct “MUS”. The following two sections also highlight issues of ‘lack’ as they explore constructions of “MUS” which struggle to situate it within an appropriate location or service and frame it as the lack of opportunity or ability to talk about difficulties.

4.7 No place for “MUS”: “MUS-as-placeless”

Within the transcripts is the notion of place (“this” and “that”) and debate about the appropriate location of and for symptoms, practitioners and patients. It appears hard to situate “MUS”.

Helen stresses the importance of “acknowledging the distress of the patient” (line 97); yet she admits that this can be subjectively irritating and an intrusion into the consultation:

[...]on a personal level, if you, if that’s intruding into your consultation it might be really irritating. And it often is. (Helen, 100-101)

“Intrusion” implies imposition or infringement and that the distress does not have a valid place in the consultation. So Helen is both stressing the importance of acknowledging distress and implying it is an imposition. This highlights how “MUS” struggles for legitimacy in a GP consultation, even when the distress of the patient is being validated. Contradictory discourses are at play here: a biopsychosocial discourse opens up space for distress, but conflicts with a biomedical discourse which positions distress as an intrusion and having no place in the consultation. The latter is likely to affect validity and legitimacy and how patients construct their symptoms, including the meanings they are likely to consider or accept. Perhaps Helen herself is caught between these two discourses, unable to find an acceptable place within them from which to practice. The contradictory messages are also likely to leave patients confused about what their “MUS” is and

how it is being received. It suggests that responsibility among doctors towards these patients can remain ambiguous.

Mimicking some doctors' reactions, Hannah positions them as dismissive, suggesting there is no place for "MUS" within their practices:

Nothing I can do. She needs or he needs to go and sort himself out. (Hannah, 136)

The use of "go" rejects the rightful place of people with "MUS" in a medical location, whilst "sort himself out" implies there is no role for a doctor in their care. Hannah is positioning some doctors as dismissive and not taking responsibility for dealing with "MUS". The place for that is elsewhere, or perhaps nowhere with the emphasis on the patient taking responsibility. Hannah's version suggests the current situation is not working for people with "MUS". Similarly, Hannah suggests "MUS" can lead to anger among some physicians if the patient is not accepting of test results. Again, mimicking a doctor she says:

Or there might be anger. I've told this person. I've done this test. Erm. He's just got to accept the results. (Hannah, 138-139)

Hannah is critical of a biomedical discourse within which negative test results signify the end of the doctor's involvement. They appear to equate with truth or fact and therefore the patient is expected to accept them, whether or not they address the problem: an illness is only as real as its test results. Within this framework, patients with "MUS" can become dismissible. Through her critical portrayal of the biomedical model, Hannah seems to be implying the need for an alternative approach.

Helen and Maggie further highlight how "MUS-as-a-misplaced-problem" creates potential barriers to working with people with "MUS".

A lot of doctors would say this isn't what I went into medicine for. And I used to say that. I used to say that a lot. I would say why do patients come and see me about their housing [...] Um, so there is that sort of irritation. I've done this training and what I'm good at is this and why aren't people coming in with this? You know, they're coming in with that. So, there's, there's that as a constraint

and so interest, I think, training, because if you have the training you feel more equipped. Not so scared at dealing with it. (Helen, 455-461)

And I guess there's a fear of ineptitude in the psychological. You know, it's not much taught explicitly in your medical training. [Marianne: Mm hm.] And people do what they know they're good at. (Maggie, 548-549)

“MUS” is constructed as a psychosocial problem. By drawing on a separation discourse, Maggie and Helen are suggesting it can therefore get situated outside the scope of medicine or the doctors' remit. By situating “MUS” as a misplaced problem, Helen might be trying to legitimise the “irritation”. Patients are “not coming in with” what doctors are “good at” (“this”), positioning doctors as *not* “good at” working with “MUS” (“that”). However by constructing “MUS” as an inappropriate problem, it could avoid doctors having to position themselves as challenged or question their own competencies. It might mean they do not have to relinquish the position of expert or question the usefulness of their biomedical model. They can blame the patient for coming in with the wrong type of problem and justify feeling irritated. Use of “this” and “that” distinguishes “MUS” from other physical health problems doctors are there to treat. A biomedical discourse empowers them to proclaim who and what they should treat.

Helen and Maggie reconstruct the challenge of “MUS” as one of lack of knowledge and training rather than a misplaced problem. The medical discipline and its institutions regulate and normalise medical training. Doctors are drawing on a training/knowledge discourse to authorise their position. They want to apply their training, yet their training has not incorporated “MUS”. “MUS” sits outside of the traditional medical knowledge base and therefore practice is limited by the knowledges GPs can draw upon. This produces doctors who are ill-equipped for the challenge of “MUS”, creating fear and irritation and potentially resulting in them not engaging with “MUS”. Patients then get positioned as non-patients with illegitimate illnesses. However, Hannah (see 6.3) also talked about lack of medical knowledge as an obvious constraint to her work with “MUS”, suggesting that a separation discourse and the position of the discrete expert is a broader multidisciplinary limitation to working with “MUS”.

Helen positions herself as having changed. She “used to” talk and feel as she describes. By referring to this change, it suggests Helen is challenging the barriers and constraints to working with “MUS”. She also constructs training as both a limitation and an opportunity. In so doing she opens up space for the possibility of wider resistance and transformation.

4.8 Unspeakable “MUS”: “MUS-as-untold-story

There seem to be lots of constructions of “MUS” as manifestations of something untold, unsaid or unspeakable. Maggie and Hannah appear to draw on a somatisation discourse to construct “MUS” as experiencing or communicating psychological distress in the form of somatic symptoms. In Maggie’s construction of “MUS” the symptoms “express” and “speak” of the distress:

Um, but for some people, it’s a, well it’s used, it’s used to express other griefs, other damage, other anger. (..) It’s, it’s like speaking another language really.
[Marianne: Mm hm, mm hm] It’s using the body to speak a language. (Maggie, 212-214)

By constructing “MUS” in this way, Maggie can enable it to be considered as a symptom of an underlying difficulty that is not physical in aetiology. This could open up space for a non-biomedical perspective and the exploration of unspoken distress. “Using the body” might imply the person with “MUS” is actively trying to communicate, consciously or unconsciously, but cannot use verbal language to express their distress (“It’s like speaking another language”). Acknowledgement that such a process occurs might help practitioners to explore underlying distress and to support people to become able to talk about their distress. This seems to be the version that Maggie is trying to promote through this construction.

Whereas Maggie refers to “using the body” for expression, Hannah constructs “MUS” as inability to communicate because of the distress:

[...] there’s also huge sadness, huge sadness on on my part, that somebody’s life, because I’m seeing them when they really really are very unwell. Somebody’s life can be so (..) impacted by what’s gone before, that they can’t even find the words to articulate it. That’s a huge sadness. [Marianne: Mm] If they had been able to

find the words to articulate it, they wouldn't have a body-based disorder.

[Marianne: Mm] It's because they can't. (.) That's a tragedy. (Hannah, 323-330)

Drawing on a psychoanalytic discourse, Hannah constructs "MUS" as a consequence of or a defence against the impact of past suffering that has been so great that the person cannot speak of it. As a result, their distress somatically manifests as "a body-based disorder". Psychological constructions of trauma and tragedy might open up space for a compassionate response towards people with "MUS" ("they really, really are very unwell" and "huge sadness"), which Hannah emphasises through reference to her own "huge sadness". It suggests a need for therapeutic environments which enable opportunities for people to tell and explore their stories and encourage practitioners to take up a position of curiosity, interested in untold stories from the past and present.

Constructing physical symptoms as influenced by untold stories could have significant implications for practice, such as the need to be able to hear these stories and to be open to hearing about emotional trauma. Hannah refers to her own sadness, highlighting how different constructions affect practitioners' subjectivity. Openness to emotional distress might require openness to emotional countertransference, which might be what some practitioners feel unable to deal with or want to avoid.

If people with "MUS" are unable "to find the words", then a lack of acceptable language or discourse to frame or normalise somatic symptoms or illness as commonly occurring from distress is likely to exacerbate this situation. Exclusive discourses might even foster somatisation if they do not provide for cultural understanding or acceptable explanations for somatic symptoms. If a biomedical understanding of illness is dominant in a society, then people with "MUS" or the wider society they live in are more likely to understand it in this way. However, in order to construct illness less exclusively, the structures that maintain it as a purely biomedical phenomenon would need to be dismantled.

Maggie remembers a woman who came to see her with "complete lassitude, depression. She sat all day, unable to do anything, no energy, low" (line 610). In this example "MUS" is constructed as an untold story:

You just have to ask, it's part of the history, and I said um did you ever you know think of having another child, something like that, and she said well there was the, there was the abortion. And. And I don't think she'd talked about this ever. Nobody had ever asked it in a way they were able to say it. [...] So there was another child, there was a lost child that she told me the story, that was all, very matter of fact, didn't do any interpretations. (Maggie, 598-608)

Drawing on psychological discourse "MUS" is constructed as the somatic manifestation of emotional distress and as past trauma impacting on the present. These constructions appeared to enable Maggie to consider historical influences and facilitated a conversation about them ("You just have to ask, it's part of the history"). In so doing the opportunity for the patient to talk was opened up too.

The untold story is an unspoken secret ("I don't think she'd talked about this ever"), again constructing "MUS" as resulting from something that is difficult to talk about. Maggie's use of this discursive construction could be seen as influencing her way of being with the patient which was to:

... present myself as trustworthy enough to hear that story, not to be judgemental, not to spread it any further. Um. So what did I do but be a listener and somehow ask the question in a way that enabled her to answer it. (Maggie, 615-618)

Legitimised by a biopsychosocial discourse to be a GP interested in the patient's broader story, Maggie was able to take up the position of curious practitioner and experience the patient as more than her symptoms. This seemed to enable the patient to feel that somebody was interested in and able to hear the story and therefore to feel comfortable enough to tell it. Her story became legitimate. Until then "nobody had ever asked in a way they were able to say it", suggesting cultural discourses might have limited the exploration of somatisation.

Maggie drew on a psychological discourse as a GP within a medical setting. This integrated, holistic approach appeared to bypass many of the obstacles to drawing exclusively on a psychological discourse. It did not involve dismissal, shame or referral elsewhere. It was not even named, but occurred as part of a consultation. However, Maggie's sees her approach as made available because she took up an honorary position outside of the standard healthcare system:

No, it's not general practice, [M: *(laughs)*] it's not psychotherapy, it's not counselling. It's, it's in a kind of tiny little overlapping zone where all those venn diagrams do overlap. And it's only possible because I'm not paid (Maggie, 495-497)

From within a holistic discourse, Maggie can combine (“overlap”) different approaches. She also positions herself as unique because of this, separating herself from others. Such a position appears unavailable to most practitioners within an NHS entrenched in a biomedical discourse which seems to limit how practitioners can interact with their patients and how patients can be related to. This situation seems to be exacerbated by a neoliberal discourse that encourages fiscal austerity and reductions in government spending. If these discourses close down opportunities to support people with “MUS”, but a holistic discourse is supposedly not affordable within the NHS (unless you are lucky enough to have a psychodynamically trained GP volunteering in your practice) then there is little incentive to broaden the available discourses. Within a neoliberal discourse, Maggie can imply the needs of people with “MUS” are financially unviable. This would significantly limit opportunities to support people with “MUS” and render them powerless, but this perhaps appears acceptable within a neoliberal western culture that values fiscal efficiency above all else.

However, Helen emphasises the need for GPs to remain curious and interested, not in the symptoms but in the people, their stories and their distress:

So I think those are, those are important things. So, I think that the remaining curious about people. The remaining interested about people's stories and the acknowledgement that the symptoms are distressing, but that you will look at other avenues. (Helen, 148-150)

A biopsychosocial discourse is more likely to allow for a biopsychosocial focus, including recourse to a healthcare discourse of continuation of care, which not only facilitates “remaining” curious and encourages commitment to the process, it also acknowledges there is no quick, short-term solution for both the GP and the patient. This is the version that Helen appears to want to promote. This is further emphasised by her use of undertaking to “look at other avenues” suggesting there is both breadth and future commitment to supporting the patient. “Other avenues” implies

alternatives or additions to biomedical support will be explored. Nevertheless, this is only likely to happen if a biomedical discourse does not limit opportunities for practitioners to become curious in the first place.

4.9 Reflexive statement: Part 3

The act of doing the analysis and the challenge of structuring this chapter were unavoidably part of the same process because the complexity of the findings mirrored the complexity of structuring the chapter. If I could not make sense of the findings how could I present them? If I could not identify some coherent themes, how could my chapter have any coherent components? Therefore, the writing of the analysis chapter involved many versions and changed significantly as part of the developing process of doing the analysis. This process also mirrored the development of my own thinking about “MUS”.

In addition, the choice to use Willig’s (2001) guidelines probably influenced the focus and structure of the ensuing analysis in other ways. With hindsight it is possible to see that perhaps by following Willig’s stages I became over focused on constructions of “MUS” as this was stage one, and all further analysis built on these constructions. Had I chosen to follow Parker’s (1992) guidelines I would not have started by asking how “MUS” is being constructed, but instead by accepting the whole text as the object of study and using free association to explore connotations, ideally with someone else. In addition, Parker, unlike Willig, advises researchers not to follow his steps sequentially. This is another way in which the procedural guidelines I chose influenced the analysis and both the findings and challenges that followed.

I had expected the first two stages of the analysis - the process of identifying how I thought “MUS” was being constructed and locating these constructions within wider discourses (Willig, 2012) – to provide me with components on which to both deepen my analysis and structure the chapter. As I began to identify recurrent discursive constructions, I started to draft a first version around “MUS-as-suffering-and-distress”, “MUS-as-choice” and “MUS-as-test/challenge”. However, as I explored the constructions more deeply, I realised that they could merge with, overlap or be identified differently and that I could locate them within different macro discourses.

This highlighted the subjectivity of my analysis and the need for thoroughness and reflexivity.

For example, “MUS-as-suffering-and-distress” appeared located in talk about whether or not the pain or distress was real and whether symptoms could be “believed in” or not (see 6.6) and this led to the identification of the discursive construction “MUS-as-unreal”. “MUS-as-suffering-and-distress” also formed part of the talk about conflict to do with the rightful place to support people with “MUS” and the identification of “MUS-as-placeless”; “MUS-as-emotional-distress” became associated with “MUS-as-challenge” as the former could be constructed as a reason for the latter. Locating these discursive constructions within wider discourses suggested the influence of two potential discursive frameworks: a psychological discourse that enables us to consider suffering and distress and a discourse of separation that enables some sorts of pain and distress to be considered differently to others.

With so much overlap and so many entangled concepts, a large part of the challenge was to work with the complexity, and decide on a structure that would best reflect the texts and enable me to present the analysis in a readable format without losing their richness and complexity. In trying to deconstruct the texts my own thinking and understanding about “MUS” was developing. For example, it was in noticing that my participants were largely constructing “MUS” as a psychological problem, that I realised I was doing the same (see 2.6). However, in considering how this opened up and closed down opportunities and the consequences for positioning, practice and subjectivity, I started to challenge my own position. I realised the limitations of viewing “MUS” as a distinctly psychological problem, how this exclusivity could potentially encourage further resistance to a psychological dimension to physical symptoms. This also mirrored the change in focus in the “MUS” literature, which was increasingly highlighting biological components of “MUS” (e.g. Luyten *et al.*, 2012; Scaer, 2014; Yunus, 2008, 2009; McEwan & Wingfield, 2003). So as a result of the analysis my own thinking about “MUS” was changing; it was shifting from a psychological understanding of “MUS” towards a more holistic understanding of “MUS”. This shift probably impacted on my analysis, as I became more aware of the wider discourses that the participants were drawing on and the exclusivity of some of the ensuing constructions, and also on my therapeutic practice as I became more

interested in and focused on some of the biological elements of “MUS” theory and was able to consider these with my clients.

As the process of analysis developed, I had to find ways of sharing my findings on the page. In doing so, I had to make subjective decisions about what I thought was most salient. At first, I had thought I would present my findings under the different discursive constructions of “MUS”, as I had seen other analysis presented. However, on its own this felt reductive as it missed an opportunity to focus on the macro discourses that seemed to be influencing participants’ talk. Yet, structuring the chapter around these macro discourses, as I had also seen other analyses presented, again seemed reductive as the discursive constructions formed within them seemed vast and varied and worthy of more specific focus. (I was also aware that this split between macro discourses and discursive constructions was adopted from Willig (2012) and was in itself full of overlap and contradictions and somewhat fabricated.) I therefore began to understand that I could not simply take on somebody else’s structure and would have to make my own. This provided a shift for me as I acknowledged I would have to move away from pre-given structure. This led to a structure that incorporated sections on macro discourses and on discursive constructions, and where the overlap was sometimes explicitly incorporated, e.g. into section 6.4 on interest, choice and engagement. The number of decisions that had to be made further emphasised the subjective nature of the work and how other versions could exist.

5. Discussion

This chapter summarises the findings from this analysis, the unique contributions of this study, makes recommendations for practice and discusses the limitations of this research and the implications for further research.

5.1 Comparison with previous research and the unique contribution of this study

In several ways this research supports findings from previous studies. Like previous research (Stacey, 1988; Radley, 1994; Burr, 2003; Orlans, 2013) it suggests that conventional, biomedical discourses continue to dominate approaches to health systems, health problems, services, diagnosis, treatment and practitioner-patient relationships. Biomedical discourse seemed to influence how all the practitioners constructed “MUS” at times and they all referred to ways in which health systems, other practitioners and patients constructed “MUS” within biomedical discourses. Within this rational and reductionist discourse thoughts, beliefs and emotions do not seem to be considered part of the diagnostic and treatment process. The literature review explicitly highlighted how a biomedical discourse appears still so significantly dominant and rigid that efforts to accommodate “MUS” within it can be extremely difficult. This analysis identifies similar influences and implications. Although there are many attempts to practice outside of the biomedical framework, its overriding influence can conflict with alternative discourse and limit alternative practice, for example through the 10 minute GP consultation.

What is also interesting about the biomedical discourse is how it appears to have an influence beyond that of institutional practice. It appears to have infiltrated much of western culture so that attitudes and behaviours towards health and wellbeing seem driven by it. The analysis suggested how discourse around gender and biomedicine appear interconnected, as women’s emotional distress became dismissible within a biomedical framework which favours a rational, coherent, unitary approach. Health behaviours, such as visiting the GP for physical symptoms, and health expectations, such as expecting diagnostic investigations, seem to be accepted as a normal part of western culture so that our thoughts and behaviours make sense within this framework and cannot be separated from it. Its dominance appears widely encompassing.

Dualistic mind-body conceptions of illness were also notably present, with particular significance for psychological constructions of “MUS”. The negative and reductive connotations of the psychological, as highlighted by Greco (2012), were implied in the prioritisation of physical health diagnoses, the fear of the psychological and the choices made by practitioners and patients, including how they were positioned or positioned themselves. Brown’s (2007) implication that a medical basis is preferable to a psychological one because it is more comfortably related to (rather than aetiologically correct) is apparent, as is Greco’s (2012) suggestion of the need to hide psychogenic plausibility on the part of both doctors and patients.

The holistic and humanistic influence of counselling psychology was sometimes apparent in the language of the CoPs and their attempts to focus on the whole person. Subjective experience appeared valued by all participants, yet often in contradiction with the expert position that all participants seemed to adopt at times. It is suggested that recourse to an exclusive, distinct medical or psychological discourse contradicts a holistic perspective and influences the maintenance of a dualistic approach, for example Tom positioning his role as dealing with the psychological and not the medical aspects of “MUS”.

The literature review suggested that if existing structures and related discourses cannot accommodate a complex biopsychosocial problem then developing new models, approaches and terminology alone will not resolve this conflict. This analysis suggests that existing discourses and related structures can limit, restrain, restrict and confuse constructions of “MUS”, and indicates how opportunities for effective treatment responses might be severely limited by the dominant medical discourses within which “MUS” exists.

In addition there are also several ways in which this research has exposed further tensions, contradictions and complexity and made original contributions to existing research. These include restructuring the challenges of “MUS” within a discursive framework, deconstructing and problematising the psychological construction of “MUS” and identifying a lack of an available, culturally acceptable discourse within which to construct illness that results from biopsychosocial phenomena.

Restructuring of the challenges within a discursive framework

Significantly, this research suggests how discourses and discursive constructions can shape how practitioners practice and experience people with “MUS” (and vice versa). This illustrates how important it can be to locate “MUS” within a socio-cultural context. There is a wide variety of literature about terminology relating to “MUS”, but very little focus on the performative nature of this terminology (with the exception of Greco, 2012) and apparently none that situates practitioners’ talk about “MUS” within its discursive environment. This is a unique contribution of this research. Exploring the discourses which practitioners draw upon to construct “MUS” can open up a wider and deeper understanding of some of the issues and challenges.

A good example of this is the identification of a discourse of separation. Whereas mindbody dualism and its influences are widely acknowledged, the reconstruction of this more passive discourse as separation seems to better encapsulate the active splitting of mind and body that occurs within the health service. It is as if the mind has been actively separated from the body by the creation of separate services, trusts, ministers, manifestos, policies, practitioners, training institutions, textbooks, buildings and patients. Most importantly, this discourse creates and maintains an understanding of mental health as an entirely separate system from physical health. It enables the discursive constructions of mental health and “MUS-as-mental-health-problem” to exist. Therefore, the process of categorising illness is more active and complex than a dualistic construction allows for and appears to reflect a western cultural necessity for separation and classification.

There appears to be a huge tension between exclusive medical and psychological discourses and how they construct “MUS”. A distinct psychological construction can exclude a person from being able to make sense of the physical nature of their symptoms and can open them up to mental health stigma. A distinct medical construction can limit them to a biomedical understanding of illness which might not explain their symptoms. Such exclusive constructions can be reductive, ignore social factors and limit access to medical or psychological support respectively. Neither, alone, seems helpful to the person with “MUS”.

A discourse of separation also encapsulates the process of categorisation that can occur within distinct physical and mental health environments. It enables a gynaecology service to deny the existence of “MUS”, whilst a gastroenterology service embraces it (see 6.5). It is so pervading that, if necessary, it can encompass symptoms that do not fit usual criteria, for example Helen’s classification of “MUS” as “unconventional mental illness”, an attempt to squeeze it into a category within which it struggled to belong. Paradoxically, it can create rigid criteria which results in people being denied access to services and support. It can enable a process of privileging, prioritisation, disavowal and stigmatisation of certain kinds of illness to occur.

Not only did this analysis show how discourses of separation can permit some practitioners to construct “MUS” as choice, but it showed how this construction can relate to interest and engagement. Treated as individual processes such choices might simply evoke outrage – doctors should not be allowed to choose not to work with a patient; viewed with a social constructionist lens it becomes apparent how such practices get influenced by broader social processes. Interest, choice and engagement are constructed, negotiated, opened up and closed down within the socio-political environment in which they operate. Lack of skills, training, knowledge and systems to work with “MUS” can discourage interest, leading to aversive choices and lack of engagement, especially when, in turn, “MUS” gets reconstructed as avoidable. Further, given the relationship between knowledge and power, practitioners who proactively engage with the uncertainty of “MUS” may have to relinquish the position of expert and work outside their comfort zone. Therefore, without a change in discursive conditions, choice, interest and engagement with “MUS” remain unattractive. At the same time, resistance to exclusive biomedical or psychological discourses could open up opportunities for broadening working knowledge and practices, with potential positive influences on interest, choice and engagement. Helen, Maggie and Hannah all expressed enthusiasm for working with “MUS” when the work was situated in environments not restricted to biomedical treatment.

Similarly, constructions of “MUS-as-challenging” hide the complexity of the problem. Simplistic constructions of the difficult patient and the dismissive doctor can mask broader discursive conditions, such as lack of psychosocial training and time restrictions, which might make it too easy for these positions to become

available. However, exploring discursive constructions exposes different versions of the challenge. For example, the analysis suggests that engaging with “MUS” involves engaging with uncertainty and helplessness. Within a biomedical discourse that values success and expertise, the idea of uncertainty and helplessness can be alien, frightening and equate with failure.

Yet “MUS” defies the biomedical model so practitioners might not be able to be successful if they draw exclusively upon such a framework. “MUS” often does not respond to biomedical treatment (which is often how it becomes labelled as “MUS”) and therefore challenges the “truth” about medicine, bodies and illness, in turn challenging medical expertise and positions. “MUS” is complex because lives are complex and this research suggests that drawing on broader, more holistic, culturally new and unfamiliar discourses might change expectations of success and allow more space for accepting uncertainty and helplessness. Practicing within them could disturb the fear of failure and enable more curiosity and less frustration.

According to Foucault (1972), discourse not only defines what can and cannot be said about a topic, it also defines the ‘truth’ about a topic and its ‘subjects’ by implication. Discourses socially construct realities. The reality debate around “MUS” is given space by a biomedical discourse that creates expectation about how symptoms should respond to treatment. Within this scientific framework illness can be categorised as real or not. Psychosocial and cultural meanings can be irrelevant. This can have significant implications not only for malingering, stigma and legitimacy, but also for practitioner-patient relationships (see below).

It appears hard to locate “MUS” in terms of what type of problem it is and hard to situate people with “MUS” within existing service settings. This research suggests that a separation discourse, which suggests there should be appropriate groupings for everything, influences this. The analysis reveals how “MUS” can get constructed as an intrusion into the medical consultation and positioned on the outside of mainstream medicine. Whereas a biopsychosocial discourse opens up space for distress within an appointment, a biomedical discourse might position distress as an imposition facilitating opportunities for tension and contradictions. Such tension is likely to disturb the patient-practitioner relationship. Constructing “MUS” as a misplaced problem creates a barrier to working with people with “MUS” because it

positions their care outside the scope of medicine or the doctors' remit, creating a struggle for legitimacy.

There are alternative practices that are accommodating to "MUS", but as long as they lie outside of the NHS, which is free at the point of delivery, access will be limited to those who can pay. Therefore, it seems important that a legitimate space can be constructed for "MUS" within primary care and beyond. This might involve opening up the NHS to a wider range of therapeutic services.

Deconstruction and problematisation of the psychological

Another unique contribution of this research is the deconstruction and problematisation of the psychologisation of "MUS". From the beginning I wanted to interview people who worked at the interface between physical and mental health. I wanted to avoid reproducing the polemic debate – doctors vs patients, mind vs body, etc. What became increasingly apparent within this research was that the practitioners I interviewed seemed to mainly construct "MUS" as a distinct psychological problem.

Drawing on psychological discourse "MUS" can manifest as somatisation or the conversion of emotional distress into physical symptoms and as the impact of past trauma on the present. This research suggests that such constructions open up the need to allow time and space for people with "MUS" to talk. This in turn means practitioners might need to position themselves as curious and interested in listening to peoples' stories. If they position themselves as such, they are more likely to be positioned as such by the people they are talking with, encouraging a space for people to open up about their distress. A biomedical discourse can limit the length and breadth of conversation, whereas psychotherapeutic discourse tends to emphasise and value the creation of a trusting environment in which a therapeutic relationship can develop. The latter opens up opportunities for deeper exploration of subtle, but complex issues.

This information complements the psychological research that suggests people with "MUS" are more likely to show signs of alexithymia (Edwards *et al.*, 2010) or lack of symbolisation (Sloate, 2016). This research extends the problem of difficulty in emotional expression beyond the patients' internal psychological world and highlights the external social forces that might also contribute to this difficulty. It

suggests a lack of curiosity, interest, time, space, communication skills, training and availability of a biopsychosocial discourse also restrict emotional expression for both patients and professionals. These ideas add a social dimension to the problem of emotional expression and contribute to a broader understanding of the issue. For example, a person's emotional expression may be limited by attachment trauma and may manifest as somatic symptoms. However, if the cultural environment for emotional expression is also restrictive, this may further contribute to a lack of emotional expression and further manifestation of "MUS".

Considering that it seems unhelpful to approach "MUS" as a biomedical problem and that psychological discourse can lead to more useful and helpful insight, it is not surprising that practitioners have tried to reformulate "MUS" as a psychological problem. However, in so doing two key issues have been overlooked: the complexity of the psychological, and the biosocial elements of "MUS".

Firstly, a psychological problem is not a single coherent phenomenon. This analysis suggests a variety of psychological constructions of "MUS" were used from sentimental talk about the emotional, to health care service talk about mental health. The different ways of talking about the psychological in "MUS" appeared performative. They seemed to open up and close down options for practitioners and patients. For example, constructing "MUS" as "the emotional" drew on a cultural, gendered sentimental discourse, which enabled practitioners to dismiss "MUS" as unimportant, leaving people with "MUS", particularly women, unsupported and untreated.

Secondly, through the process of separation, mental health is not only being distinguished from physical health, but it can also become disadvantaged. It gets deprioritised, marginalised, restricted, dismissed and delegitimised. Psychological constructions of "MUS" can equate with "unreal", malingering, secondary gain, stigma and "all in your head". Whereas the stigma around mental health is not limited to "MUS", situating it within this context helps us to understand why there is resistance and a disavowal of the psychological (Greco, 2012). Therefore, it is hazardous to call for acknowledgement of psychological aspects of "MUS" without acknowledging what it means to label "MUS" as a psychological problem. To do so

casually is to invite resistance and uphold the dominance of biomedical representations of illness.

Thirdly, the psychologisation of “MUS” might perform the substitution of one purist approach for another. Whereas it is important not to disavow the psychological (Greco, 2012) it is equally important not to disavow the biological and social in acknowledging the psychological. As well as highlighting the need for more careful constructions of psychological aspects of “MUS”, this research suggests the need for new discourse that allows for understanding illness within broader, inclusive frameworks.

Holism

Another unique contribution of this research is the identification of a lack of an available, culturally acceptable discourse within which to construct illness as resulting from biopsychosocial phenomena. Even in trying to write about this, it is difficult to know how to describe it, which reflects this lack of culturally established discourse. In using “holism” I am aware of its associations with so-called alternative therapies, which can be dismissed within so-called mainstream healthcare practices, yet in its usage I am partially trying to reclaim its relevance.

It is nearly forty years since Engel (1977) formulated the biopsychosocial model as an alternative to the reductionist biomedical model that can neglect psychological and socio-cultural factors in determining illness and treatment. The biopsychosocial model was created to address the fact that patients’ problems are more complex than the biomedical model allows. However, this analysis suggests that practitioners are still drawing on biomedical discourse, and systems and practices are still being developed within it. It is also apparent that the participants are trying to approach “MUS” within broader multidisciplinary frameworks. However, it appears that there is no widely acceptable language to describe illness that combines biopsychosocial influences. There is no strong discourse to guide such an approach. We can talk specifically about the biopsychosocial model, multidisciplinary working, bodymind approaches and holistic perspectives in relation to specific services, models and approaches, but we seem a long way off a person experiencing a symptom and reflecting broadly on all these aspects of their life to understand what might have contributed to it. Western culture appears to have subsumed the biomedical

discourse. We identify difficulties with doctors talking to patients about psychosocial aspects of their illness, and patients understanding psychosocial aspects of their illness, but we do not tend to consider this as a wider problem of cultural discourse. Therefore, it is unsurprising there is much confusion, resistance and distress around “MUS” for both practitioners and patients, when the available cultural frameworks would suggest such illness cannot exist. For example, if practitioners largely construct “MUS” as psychological, but patients largely construct it as biological there is plenty of space for conflict. A culturally acceptable holistic discourse within which to construct illness could reduce this polarisation and conflict surrounding “MUS”.

5.2 Implications/recommendations for practice

From a social constructionist stance the main implication of this research is to critically highlight limitations of and tensions within current constructions of “MUS”, and to encourage critical questioning and exploration of the discourses we draw upon when working with people with “MUS”. Parker (1992) argues that it is in the identification of misused or oppressive practices and the objects of such practices that critical discourse analysis can contribute to practical intervention.

Four areas of implications of this research are discussed below.

How we talk about “MUS” matters

This research highlights the extent to which how we talk about “MUS” matters. As practitioners the language we use is full of meaning, implications and consequences. Every time we refer to or do not refer to “MUS” we are suggesting and implying many things to the people we are talking to and we need to be considerate of this.

This research suggests it would be helpful for practitioners to pay special attention to how we construct psychological aspects of “MUS”. In order to challenge psychological constructions of “MUS” as unreal, illegitimate, less important than or distinct from physical health, it may be helpful to acknowledge the biological and social aspects to symptoms at the same time. This could include acknowledging everyday examples of mindbody connection, such as how we blush when we are embarrassed, feel hunger when thinking about our favourite food or how our blood pressure goes up when we are stressed and our heart rate increases when we are

frightened. We can recognise how psychological factors affect the speed in which a cut heals and the likelihood of catching a cold. Talking about health and illness in this way not only opens up alternative ways of thinking and talking to people about “MUS”, but could demonstrate that this is how we, as practitioners, construct illness too. In doing so, less dominant discourses might become stronger and a biopsychosocial understanding of illness could potentially become more familiar and acceptable. This is important to address the deficit in culturally acceptable language. Significantly, we can ask people how they understand their symptoms and what the meaning they make of them is.

In order to acknowledge wider influences on health and illness, this research suggests we need to ask about wider aspects of peoples’ lives, including symptom experience, emotional states, social situations, histories, trauma, etc. Not only could this reveal important information, but, by asking questions that are not exclusive to a single discipline, we would be drawing on wider discourses and constructing “MUS” as more than just a medical or psychological issue. This means some practitioners might need to practice outside of their professional comfort zone and be prepared to ask and learn about broader issues. Psychologists might need to ask and hear about their clients’ physical symptoms and doctors might need to ask and learn about their patients’ traumatic history, and both might have to consider and engage with people’s wider social situation. Perhaps we need to consider more process as well as content, and focus on how we ask about people’s stories. This might include paying attention to being curious, interested and listening to people, as was discussed in the analysis. By drawing on psychotherapeutic discourse, all practitioners can access knowledge and skills about therapeutic engagement such as listening, reflecting, mirroring and collaboration. However, a significant part of psychotherapeutic discourse is also the importance of supervision and reflexive space, and this could be incorporated more widely into general practice so that more practitioners have space to explore their own process.

Talking does not have to occur in isolation. Considering the various restrictions on talk associated with “MUS”, talk can be one component within broader therapeutic approaches, such as body psychotherapy or dance movement therapy, both of which are used therapeutically with people with “MUS” (Rohricht & Elanjithara, 2014; Payne, 2015). Body psychotherapy already displaces the exclusivity of many

psychological and medical approaches as it takes a bodymind approach to distress. However, it is mainly accessed via private practice.

None of this can happen, of course, if we avoid talking about “MUS”. Avoiding talking about the psychological aspects can maintain the illusion that psychological influences on illness are unusual or shameful; avoiding talking about the biological aspects can maintain the illusion that the symptoms are all in the mind (when the client knows they are in their body!). This research suggests it is also important to acknowledge the ambiguities, tensions and paradoxes; to be more honest and acknowledge the uncertainties and difficulties. Considering “MUS” is constructed as a difficult subject to talk about, patients are positioned as difficult to talk to and doctors’ positioned as lacking sufficient communication skills it would be helpful to train practitioners in ways to talk about “MUS”, as was being done for GPs by Helen’s service. For this to be significantly effective, it might need to be integrated early on into pre-service training, so that practitioners feel more equipped to engage with “MUS” from the start. It could be done on a multidisciplinary level so that different practitioners can all benefit from each other’s experiences.

Nevertheless, what appears crucially important and is suggested by this research is that language and talk do not occur in a vacuum. What participants have to say “constitutes much more than simply an account of their personal opinions or beliefs” (Burr, 2003). Burr (2003) reminds us how social and material power structures can provide our talk with effectiveness which in turn reproduces these discourses. Given this constructionist and performative nature of language, communication strategies are likely to have much more impact when they are considered within the wider discourses in which they operate. For example, constructing “MUS” as a biopsychosocial phenomenon will be difficult as long as the concept of biopsychosocial illness remains culturally alien and unacceptable; yet if done it can contribute towards destabilising the biomedical hegemony.

Awareness of discourses is important

Foucault (1979) uses the term ‘power/knowledge’ to indicate that it is forms of ‘truth’, knowledge and scientific understanding that establish power. If the power of the dominant discourses is to shift in order to allow space for alternative discourses,

which better acknowledge and support people with “MUS”, then better awareness of this power and how we draw on, engage with and reproduce discourses is crucial.

In order to understand better our own engagement with discourse, as practitioners we might reflect on how we construct “MUS” and illness in general. Do we think about illness in a dualistic way? Are we quick to draw on a separation discourse and classify illness as either a physical or mental health problem? Considering that this sort of categorisation can limit or close down ways of understanding, being with and talking about symptoms for both patients and practitioners, we might need to consider the discourses we draw on and be wary of falling into the exclusion trap.

Following on from this, greater awareness of how taken-for-granted biomedical discourses operate as business-as-usual, appear to have been subsumed into western culture and how this severely restricts the ways in which “MUS” can be viewed and treated would be important. Both GPs and CoPs are aware of and educated in the biopsychosocial model, but how many consistently draw on, engage with and reproduce a biopsychosocial discourse, even when they theoretically embrace it? The analysis exposed examples of GPs and CoPs’ understanding appearing influenced by purely biomedical or psychological frameworks. Considering these limitations in terms of discourse could help practitioners to reflect on their practice and critically question which discourses are influencing them and their environment. Ultimately, this might lead to greater congruence between values and practice, and the exposure of hidden agendas.

Awareness of discursive influences seems helpful in identifying the broader issues. For example, Maggie positions herself as “helpless” when confronted with patients with CFS. FDA suggested the available discourses contributed to feelings of helplessness. A biomedical construction of CFS was unacceptable to Maggie, but a psychological construction was unacceptable to the patients and the patient associations that supported them. Drawing on a holistic construction of illness might have been more acceptable to both parties. The interesting question becomes how come constructions of “MUS” were seen as limited to these two discursive positions. Where is the holistic discourse that enables both aspects of illness to be recognised and accepted? Recognition that illness does not fit neatly into either physical or mental health categories would be likely to disrupt the political structures upon

which the national health service (NHS) is founded, from the training institutions to service delivery, from professional roles to budget allocations, from healthcare trusts to professional knowledge. And it would be likely to disrupt the power base of these social, political and economic structures. To remove the dominance of biomedical structure within healthcare would be to disturb those who control and have power within this structure. Is this why it is so difficult to shift our understanding of illness?

This example highlights how a lack of consideration of discourse can limit understanding of an issue or problem and lead to a misplaced focus or practice recommendation. So, recommendations to change the way we talk about “MUS”, such as those above, are severely weakened within discursive environments that cannot support such practice. It is not sufficient to recommend GPs explore patients’ psychosocial narratives, if we ignore the values and systems that only allow them to spend ten minutes with a patient. It is not sufficient to recommend that psychologists explore medical issues with their clients, if there are few joined-up working practices in which professionals can work together and support each other. By considering discourse new dilemmas and tensions underlying a practice might be discovered and the understanding of a problem can change completely.

Resistance (ask questions & challenge assumptions)

Following a day of excellent presentations on small scale service provision and therapeutic approaches at the British Psychological Society’s Division of Neuropsychology’s (2015) conference on managing functional neurological symptoms (2015), I asked the panel of presenters the question: “How do we challenge the divisions in our healthcare institutions which separate patients, services and care into mental and physical categories?” The only response I received was “That is an excellent question”. Throughout the day these divisions had been highlighted as challenges and barriers to supporting people with “MUS”, yet nobody was actually thinking or talking about what could be done about them.

Webb (2010) feared the complexity of the challenge of restructuring healthcare delivery to work at the biological/psychological interface would maintain inertia. Foucault (1976) believed that the possibilities for action and resistance lie in our capacities to recognise and question socialised norms and restraints. Therefore, resistance is about detaching the power of truth from social, economic and cultural

forms of hegemony. The biomedical discourse continues to thrive because its weaknesses are hidden and ignored, whilst its power is maintained by those who benefit from it through their own positions of exclusive power and expertise. Yet surely there is also scope to evade, subvert and contest the biomedical discourse, if those who question it use their voices and influence. This seems important for change to occur.

CoPs are trained to work from a biopsychosocial viewpoint with a focus on subjective experience. In so doing, we are already theoretically challenging the biomedical discourse. However, such rhetoric needs to be reflected in practice, and the absence of counselling psychology voices in critical debate about “MUS” questions the extent to which we are promoting these values and transforming them into practice. Yet, CoPs are subject to the same discursive restraints and lack of available discourse as everybody else. If CoPs can stay faithful to their social constructionist values we might be able to influence resistance and shifts in culture by taking a critical approach to how we construct “MUS”.

Nevertheless, this research suggests that tribalistic professional identities can be unhelpful in forming integrative working models and practices. It also suggests that counselling psychology values, such as a critical relationship to research and practice, attention to language, rejection of generalised theories, engagement with subjectivity and intersubjectivity and the questioning of notions of universal truths (Orlans, 2013; BPS, 2005), are useful for engaging critically with “MUS”, but that it might be about this stance, rather than any specific professional identity behind it, which can be beneficial. For example, the analysis revealed the potential for GPs to construct “MUS” holistically, and CoPs to limit their understanding to exclusive, reductive constructions, e.g. Tom’s either/or approach to “MUS”. Therefore, all practitioners have the potential to engage discursively with “MUS” and to deconstruct the notions of psychologisation, holism, choice, interest, emotional engagement, challenge, reality, displacement, language and somatisation that are suggested as relevant to “MUS” in this research. This research suggests it might be practice rather than profession that appears more important and this is the relevance to CoPs of this research.

There are a number of ways in which CoPs, GPs and other practitioners, service providers and healthcare managers might explicitly challenge restrictive constructions of “MUS” and open up discursive spaces which could allow for alternative experiences for people with “MUS”. We could encourage and participate in debate about “MUS”, both written and verbal, small and large scale. We could question existing approaches, acknowledging the weaknesses, constraints and limitations as well as opportunities and strengths. We could challenge the discourses powering services and resist practicing in incongruent ways, just because it has become the norm or because it seems too difficult to practice outside the box. We could demand training that encompasses the broader skills required to meet the needs of people with “MUS”. We could model and reflect on alternative practices and share the results. We could stand together to resist simplification and reductionism and engage with the tension and complexity around “MUS”. We could question outdated and ineffectual hierarchies and hegemonies and work together as healthcare practitioners to resist separation. We could resist knowledge/power that is being reproduced to protect convention. We could set up interdisciplinary working groups to discuss, debate and promote these issues. Active resistance could lead to change.

Practical disturbances of current working practices

This research has demonstrated how alternative holistic discourses, and the positions and practices they can offer such as joined-up working, extended GP consultations and multidisciplinary input, are challenging the dominant biomedical discourses and opening up opportunities for thinking about “MUS” in new ways. By highlighting these new ways of seeing and being with “MUS”, this research is making these opportunities available for consideration by others. Below are some possible considerations for ways of challenging restrictive discourses and restructuring services. Some of these practices already happen in isolation, but it is their existence on a larger scale, driven by shifts in discourse, that could lead to wider discursive change.

GP practices are often the first point of call for people with “MUS”, yet discursive limitations to the support they can provide have been suggested, such as reductionist biomedical support, poor communication skills and lack of time, knowledge, interest and engagement. GP services could offer longer appointments to patients not responding to first-line treatments. To complement GP knowledge and skills, other

practitioners, such as psychologists, psychotherapists and social workers, could be invited to join consultations. This was part of the project of the Primary Care Psychotherapy Consultation Service (PCPCS) within the Tavistock and Portman NHS Foundation Trust, which resulted in improvements in mental health, wellbeing and functioning and a decrease in costs of NHS service use (Parsonage, Hard & Rock, 2014). Psychologists and other psychosocial practitioners could be based within GP services, extending first-stop primary care services beyond the biomedical. People could phone up and book an appointment with a psychologist, social worker or physiotherapist, normalising a biopsychosocial approach within an everyday service.

Medical training could encompass sufficient psychosocial elements to equip doctors to engage with and respond to the psychosocial needs of their patients. Applied psychological training could incorporate greater emphasis on biological processes. Practitioners could receive joint training. Greater awareness could lead to further implications for practice, which might include increased understanding of mindbody systems, joined-up or multidisciplinary working, and/or the use of holistic approaches. It could include the involvement of a wider variety of therapeutic practitioners who are currently excluded from a lot of NHS services, such as psychotherapists, body psychotherapists, dance therapists, yoga therapists, etc.

This is not to naïvely imply that all medical, psychological and social practitioners would need to become fully skilled in working across the whole biopsychosocial spectrum. All practitioners will have their limits, whether they fall within conventional boundaries or not. It is about moving away from exclusivity in healthcare provision so that one way of working or one type of support does not exclude all others. For example, a dualistic approach might mean that “a problem” gets handed over or handed back between professionals, whereas a holistic approach might include the continuing involvement of both practitioners. What seems important is openness and flexibility in the ways of seeing, thinking about and working with “MUS”, and this includes the recognition of limitations and an openness to working with others. To this extent tribalistic professional boundaries might need disturbing, particularly where conventional hierarchies are rigidly applied.

5.3 Limitations of current research and implications for future research

By its very own social constructionist nature, this research has many limitations, or it could be said there might be many other versions of it. This is just one. It is a small study, intended to make a small contribution to the voice of resistance; to be a critical, questioning voice. Nevertheless there are certain limitations – both specific and broader – that are worth discussing. Some of these limitations highlight opportunities for further research.

Firstly, the use of semi-structured interviews to collect participants' data might have limited naturally occurring talk. An "interview" in itself creates a formal environment, further emphasised by the use of information sheets, audio-recording, consent forms and debrief sheets. The process draws upon an academic discourse that instils seriousness to the process. This could influence participants' performance, limiting or moulding what they feel able or appropriate to say. Similarly, my own position as a trainee CoP might have positioned me at odds or alongside the participants, depending on such things as which profession they aligned to or what they thought a CoP might want to hear. Also, informing them I was undertaking an FDA might have influenced how they talked about "MUS". In addition, I made the choice to interview GPs and CoPs, rather than any practitioner working with "MUS". In this way, I was exclusively drawing on specific professional domains, even though this is something I go on to question. In so doing I also excluded other practitioners, such as psychotherapists or consultants, and limited the interdisciplinary and multidisciplinary voices I go on to promote. An alternative approach would have been to work with an interdisciplinary focus group or to collect data from discussions held by an existing multidisciplinary team. This would make interesting future research as it might allow for more naturally-occurring talk, reduce the researcher role in the process and allow for interdisciplinary discussion.

Producing such a piece of research as this, which challenges the way in which a society constructs illness, healthcare and "MUS", could be construed as naïve. Willig (1998) refers to this as "inherent idealism" because of its recommendations' reliance on the modification of discourses. For example, Parker (1992) reminds us that discourses are grounded in social and material structures, such as institutions, and

that access to alternative discourses depends upon changes in real conditions outside the text (Parker, 1992). One material constraint highlighted by Parker (1992) is the material organisation of space. Current institutional organisation of space within the NHS does not facilitate joined up working or training. It generally supports a construction of illness as either psychological or medical, to be treated by either mental or physical health practitioners, who are trained in and by separate institutions, in different modalities, to provide care in different services that are located separately. Thinking and practicing differently might necessitate a colossal reorganisation of space that could involve far-reaching social, legal and economic negotiation and coordination.

Parker (1992) also sees the habitual, physical orientation of the individual to particular forms of discourse as a further social constraint. Therefore, for change to occur there is a need to break from past practices. “Discursive change does not precede behavioural and experiential change, but is bound up with it” (Willig, 1998, p390). This is why it is so important in discourse analysis to consider the implications of using different discourses and constructions in terms of opportunities, identity and practice, and to recognise the interrelated dynamic between them. The power of convention and habit should not be underestimated, which is why discourses can become so rigid, all-encompassing and dominant.

Willig (1998) believes such idealism can be countered by actively addressing material and social structures as part of any interventions that follow. For example, small-scale interventions are being developed that provide organisational space for joined-up, multidisciplinary working practices and allow for alternative ways of thinking and talking about illness. These working practices need to be shared and discussed as they challenge the hegemony of the dominant discourses and their reproduction can slowly begin to break down institutional dogma and structures. Further research into small-scale initiatives within their discursive environment will contribute to this. Another interesting FDA study would be to explore the material organisation of space within healthcare services and the implications of this.

A further limitation of FDA is to do with subjectivity. In FDA participants’ words – attitudes, opinions, beliefs and experiences - get “treated as nothing more than manifestations of discourses” (Burr, 2003, 174). Whereas it seems plausible to argue

the influence of discourse on a sense of personal identity, it is more questionable whether it is all that is required for it to be formed (Willig, 2001). FDA focuses on the constitutive force of discourses on subjectivity, but further research could broaden the methodology to explore individual differences and contradictory motivations. Hollway (1989) designed a qualitative research method that explores discourses and subjectivity combining a macro discourse analysis approach with Lacanian psychodynamic interpretations. Key to her analysis is the relationship between the two. Whilst a purely FDA approach limits the role of desires, wants, hopes and fantasies to a “side-effect” of discourse, Hollway’s approach explores these processes more deeply (Burr, 2003). Such an approach could be useful in further exploring these research transcripts. This could be a helpful way of further linking discourse to practice. For example, Luyten *et al.* (2012) explores “MUS” in relation to attachment theory and proximity seeking behaviours. Dismissive constructions of “MUS” are likely to feed into this framework and it would be interesting to explore further the relationship between external discourse and internal psychological processes. Likewise the issue of emotional expression discussed earlier. Further research, using fresh or current transcript material, could be done using this method.

The transcripts were rich in discursive material and it was not possible to explore thoroughly all the discourses within the constraints of this research. One discourse that deserves further exploration is a discourse of lack. Both patients and professionals have to deal with lack: lack of diagnosis, lack of location, lack of profession dedicated to the mind-body, lack of interest, lack of certainty and so on. Research focusing more specifically on this area would be an interesting topic for further study.

Considering this research recommends a more holistic approach to working therapeutically with illness, it would be important to investigate the implications of doing this. For example, a worthwhile further study could be to focus on holism as the discursive object and explore how it is being constructed within healthcare and the implications of this. As Willig (1998) points out it is important to counteract the reification of alternative discourses (e.g. holism) with the recognition that this kind of work is “an on-going, never-to-be-completed project” (p.391).

5.4 Reflexive Statement: Part 4

I began this research very sure that I wanted to take a social constructionist stance and use Foucauldian discourse analysis to explore the topic. It seemed so appropriate for deconstructing a term that was in wide use but seemed to have such fluid, yet influential meaning. What I was less aware of was the challenge of taking a personally and epistemologically reflexive approach to the task. I had begun the research with the idea of adopting *epoché* (Langdrige, 2007), but soon realised that to do justice to my epistemological stance I would need to explore more intimately and reflexively my own role, position and personal bias. I had to recognise that my subjectivity was a resource to be mined rather than a problematic bias (Hore, 2014; Parker, 1992). This meant acknowledging, respecting and endorsing my own voice, and remaining constantly critical of its role in the production of the discourse I was analysing.

Although one appeal of social constructionism was the notion that there is no one “correct” way to do anything, I became very caught up in the right way to do the research. I realise I remained implicitly influenced by a positivist research discourse, despite my explicit rejection of it. My own anxiety about doing it right limited my creativity and spontaneity. For example, on meeting Maggie I learnt that she was a psychotherapist as well as a GP. Instead of embracing this within the interview as an opportunity to learn from this interesting combination, I kept the focus very much on Maggie-the-GP (in my research proposal and ethics review I had said I was interviewing two GPs!) and ignored Maggie-the-psychotherapist. I did not want Maggie-the-psychotherapist to taint the experience of interviewing a GP, as if GPs are homogenous creatures with no other external influences. It was ironic that I was using a discourse analysis approach because it appealed to me as open, curious, pluralistic and challenging of universal truths, and yet I was being highly influenced by an “academic upbringing” in scientific psychological research that wanted to separate and categorise my participants and attempt to control variables. It was only as I analysed Maggie’s transcript that I realised the richness her experience could bring. As I developed my ideas about the disadvantages of the discrete expert, I viewed my neglect as a missed opportunity.

Another potential missed opportunity was my decision not to use a focus group to collect material (see 7.3). I did consider it at the time of designing the research, but it appeared more logistically challenging in terms of getting participants together in one place at the same time and perhaps (in hindsight) more challenging for me, as the interviewer, to control. However, what is most significant is that, at that time, I could not see the added value of a focus group in the way that I could towards the end of the research.

My own thinking about “MUS” had not developed to the extent that I could see particular value in exploring multidisciplinary perspectives. As discussed in 2.6, my own thinking at the research design stage was that “MUS” was a psychological problem being unhelpfully treated in a medical world. My thinking about “MUS” was focused around the issue of dualism and the limitations and restrictions of the biomedical discourse. My ideas about the problem of the discrete expert, the discourse of separation, the problematisation of the psychological and the need for a more holistic approach did not exist and only started to develop as I undertook the analysis. Therefore, I did not recognise the value of stepping back and allowing participants from different practitioner backgrounds to interact with each other, put forward and respond to ideas and suggestions and challenge them within a group of interested practitioners. However, as my ideas developed, the value of a focus group became both apparent and a missed opportunity.

Analysing the transcripts was at times an agonising process. Having thought of myself as a social constructionist, I realised this was not how I routinely viewed the world (nor my transcripts) and I had to be mindful of my approach at every step. I had to learn to look at things differently (to look for the social construction). This should have been inevitable. Critical, social constructionist, discourse analytic approaches developed out of recognition of the power of dominant discourses and their implicit influence on everyday life. Nevertheless, I was taken by surprise at how difficult it was at times to use a social constructionist lens.

For instance, I found myself striving for coherence and consistency in the narratives produced by my participants, in the same way as Hollway (1989) frames research participants themselves as doing in their talk. Hollway sees this as “one effect on subjectivity of the dominant Western assumption of the unitary rational subject; we

attempt to construct our experience within its terms” (p.43). Hollway sees the vast majority of discourses being underpinned by the principle of unitariness, including much psychology training. Multiplicity and contradiction get suppressed. My desire for coherence and consistency in the face of multiplicity and contradiction became a significant battle in the choice of material to use, the discourses to highlight (privilege) and the structuring of my analysis chapter. However, as I allowed myself to recognise the multiplicity and contradiction within the topic, I realised that my struggle mirrored that of others experiencing “MUS” and it enabled me to engage with the topic in what I believe is a more useful manner. In a similar way, at first I attempted to implement Willig’s guidelines dutifully, following each step in a linear fashion. As the analysis progressed I was able to adopt a more fluid approach, which meant I remained guided by Willig’s method, but did not always write about each stage. For example, sometimes I focused more on action orientation and positioning, at other times practice or subjectivity. I worried less about identifying every stage every time and was able to embrace a less rigid, linear approach which better reflected how my participants talked.

Sometimes I struggled with naming the discourses. Burr (2003) points out how the identification of discourses can become a labelling exercise in which everyday categories of events are turned into discourses. I found myself struggling to move outside of both psychological and medical discourse. I was pulled in by counselling psychology discourse which guided my critical thinking, but also by medical discourse which provided me with the language of illness, e.g. “patient”, “treatment”, within which to talk about the issue. This reflects the significance of “there is no meaning outside discourse” (Foucault, 1972). I could not move outside of discourse. Therefore it was necessary to ask at every stage, not only what discourses are the research participants using, but what discourses am I drawing upon in order to identify these.

Part of the research process was therefore to reflect on how this research is a product of myself, the participants and our relationship (Finlay, 2002). As a trainee CoP I was drawn in by the discourses of social constructionism, critical social psychology, social justice, pluralism and holism. I therefore acknowledge that the analysis occurred through these lenses. This by no means detracts from its contribution; part of its worth is in acknowledging the personal and counselling psychologist stance

that critically guided it. This research makes no claims to “truth”, but is one version - one social construction - of this research process and its usefulness lies within that.

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Appendix A: University ethics approval



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

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

Title: **Discourses, their uses and implications: exploring “medically unexplained symptoms” with GPs and counselling psychologists. A Foucauldian Discourse Analysis.**

Student: Marianne Seabrook

Supervisor: Dr. Marta Sant

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

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

Signed:

A handwritten signature in blue ink, appearing to read "Chris Chandler".

Date: 13/02/2014

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

Appendix B: Call for research participants

Research title: Discourses, their uses and implications: exploring medically unexplained symptoms with GPs and counselling psychologists.

Call for research participants: GPs and Counselling Psychologists working with people with “medically unexplained symptoms”

I am a trainee counselling psychologist currently studying for a Professional Doctorate in Counselling Psychology at London Metropolitan University. I am exploring experiences of GPs and Counselling Psychologists working with people with “medically unexplained symptoms” (“MUS”) as part of my doctoral research. This research will consider in depth what guides and influences practice and what might be some of the implications of this.

I am interviewing GPs and Counselling Psychologists who:

- Have an interest in “medically unexplained symptoms” (“MUS”)
- Have experience of working in a professional capacity with people with “MUS”
- Are registered either with the General Medical Council (GMC) or the Health and Care Professions Council (HCPC)
- Have at least 2 years post-qualifying experience of working in the UK.

Participation would involve attending a face-to-face interview which would last approximately 1.5 hours at a time and location convenient to you. You would be expected to discuss, in-depth, your experience, views and perspectives about working with people with “MUS”. The interview transcripts will be audio-recorded and analysed using discourse analysis. The personal identify of participants will be kept anonymous.

This study has been approved by London Metropolitan University’s Research Ethics Review Panel and adheres to the British Psychological Society’s ethical guidelines

as set out in the Code of Human Research Ethics (BPS, 2010). The research is supervised by Dr. Russel Ayling (r.ayling@londonmet.ac.uk).

If you meet the above criteria I would really appreciate your participation. If you are interested in taking part and would like an information sheet with further details please contact me via email at the address below. I look forward to hearing from you.

Marianne Seabrook

Contact email: mas2145@my.londonmet.ac.uk

Appendix C: Participant Information Sheet

Participant Information Sheet

Research Title

Discourses, their uses and implications: exploring “medically unexplained symptoms” with GPs and counselling psychologists. A Foucauldian Discourse Analysis

Brief description of the research

This research is exploring GPs’ and counselling psychologists’ experiences of working with people with “medically unexplained symptoms” (“MUS”) and how they make sense of this experience. It will investigate in depth what guides and influences the practice of four practitioners and what might be the implications of this. The interview transcripts will be analysed using discourse analysis.

This research will contribute towards the researcher’s Professional Doctorate in Counselling Psychology at London Metropolitan University.

For this research I am interviewing GPs and counselling psychologists who:

- Have an interest in “medically unexplained symptoms” (“MUS”)
- Have experience of working in a professional capacity with people with “MUS”
- Are registered either with the General Medical Council (GMC) or the Health and Care Professions Council (HCPC)
- Have at least 2 years post-qualifying experience of working in the UK.

What would participation involve?

Participation is voluntary. It would involve attending a face-to-face interview, at a time of your convenience, which would last approximately 1.5 hours (including a brief introduction before the interview and a debriefing afterwards including an opportunity to ask questions), at a private location convenient to you. You would be expected to discuss, in-depth, your experience, views and perspectives about working with people with “MUS”. You would have the right to request breaks, refuse to answer questions or terminate the interview at any point during the interview process without having to give a reason.

I would like to hear from you if you feel comfortable talking about your experience(s) of working with people with MUS. It is not anticipated that the interview questions will arouse difficult feelings or emotional distress; however, if you believe that talking about your experiences might be distressing or upsetting in any way and for whatever reason, then you might want to consider whether your participation is appropriate.

If you do decide to participate you will be asked to sign a consent form. You can withdraw consent at any time up to two months following the interview. As data analysis will begin after this it will not be possible to withdraw after this date. The interviews will be audiotaped and transcribed, and the transcripts will be commented on and quoted from in the study. Any identifying information, including your name, place of work, client/patient details will be removed or altered from the data and will not appear in the study. All data will be stored in password protected files and transcripts will be stored in a secure location. Consent forms will be stored separately. It is possible that the research will be published. This would mean the anonymous transcribed material would be publicly available.

Following the interview participants will be debriefed and provided with follow up contacts should they feel any distress or require further information. This will include the research supervisor's contact details.

This study has been approved by London Metropolitan University's Research Ethic's Review Panel and adheres to the British Psychological Society's ethical guidelines as set out in the Code of Human Research Ethics (BPS, 2010).

If you are interested in taking part in the study please contact me via email. Either myself or my research supervisor will be happy to respond to any further queries.

Name of researcher: Marianne Seabrook

Contact email: mas2145@my.londonmet.ac.uk

Name of research supervisor: Dr. Russel Ayling

Contact email: r.ayling@londonmet.ac.uk

Appendix D: Consent Form

Title of research: Discourses, their uses and implications: exploring “medically unexplained symptoms” with GPs and counselling psychologists. A Foucauldian Discourse Analysis

Researcher: Marianne Seabrook

Email: mas2145@my.londonmet.ac.uk

Brief description of the research

This research is exploring GPs’ and counselling psychologists’ experiences of working with people with “medically unexplained symptoms” and how they make sense of this experience. It will investigate in depth what guides and influences the practice of four practitioners. The interview transcripts will be analysed using discourse analysis.

This research will contribute towards the researcher’s Professional Doctorate in Counselling Psychology at London Metropolitan University.

Consent statement

- I confirm that I have read and understand the information set out in the participant information sheet and have had the opportunity to ask questions. I have been given enough time to consider my participation.
- I am aware that I can withdraw my consent to participate at any point up to two months following the actual interview. I understand that as data analysis will begin shortly after this it will not be possible to withdraw from the project following this date.
- I understand that data will be held securely and presented in written form anonymously.
- I give consent to the audio recording of the interview.

Appendix E: Debrief Form

Debrief Form

Title of research: Discourses, their uses and implications: exploring “medically unexplained symptoms” with GPs and counselling psychologists. A Foucauldian Discourse Analysis

Thank you for your participation in this study. The aim of the research is to better understand the social, historical and political context in which “medically unexplained symptoms” (“MUS”) are situated and what are the implications of this for those involved, e.g. doctors, psychologists and patients, in different ways and at different levels. With a better understanding of the way we use the term “MUS” it might be possible to influence support and services for people with “MUS”. It is possible that counselling psychologists could play a wider role in this area.

If you have any issues or complaints that you would like to raise about this study, please contact my supervisor on the details provided below. I would like to remind you that you have the right to withdraw from this study for up to two months following the interview.

Should you experience any distress as a result of your participation, the following organisations are useful sources of help and support:

Mind

www.mind.org.uk (Tel:0300 123 3393)

British Association for Counselling and Psychotherapy (BACP)

www.bacp.co.uk (Tel: 01455 883300)

The British Psychological Society (BPS)

www.bps.org.uk (Tel: 0116 2549568)

Samaritans (24 hours a day)

www.samaritans.org (Tel: 08457 909090)

Contact details

Researcher:

Marianne Seabrook

Trainee Counselling Psychologist

Email: mas2145@my.londonmet.ac.uk

Research supervisor:

Dr. Russel Ayling

Research Supervisor

Professional Doctorate in Counselling
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London Metropolitan University

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Tel: 020 7133 2140

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Appendix F: Interview Schedule

The interview discussion will be flexibly supported by four open-ended questions. Additional probing questions have been developed as prompts for the discussion. The questions have been developed to provide a flexible framework for discussion, but will only be used as and when deemed helpful by the researcher. The conversation will be allowed to flow freely and take on its own direction.

Research Question	Potential interview questions
<p>How do GPs and counselling psychologists construct “medically unexplained symptoms”?</p>	<p>What is your experience of working with people with “medically unexplained symptoms” or “MUS”?</p> <ul style="list-style-type: none"> • What does “MUS” mean to you? • How would you define “MUS”? • How would you describe your role? • Are there challenges to working with people with “MUS”? • What motivates you to work with people with “MUS”? <p>What language do you use to talk about “MUS”?</p> <ul style="list-style-type: none"> • How would you talk to your patients/clients about their symptoms? • How would you talk to other professionals about “MUS”? • There is this notion of a medical/psychological split. What does this mean to you? • How do you relate to the medical dimension? • How do you relate to the psychological dimension? • Is it possible to work with both the medical and psychological aspects? • What opportunities do you see for working at the medical/psychological interface?

<p>What might be the implications of this?</p>	<p>What influences how you work with people with “MUS”?</p> <ul style="list-style-type: none"> • What do you turn to or draw on to guide your practice? • Are you influenced by particular models, frameworks or protocols? • What is it like working within existing structures? • What opportunities do you see within existing structures for working with people with “MUS”? • What constraints do you see within existing structures for working with people with “MUS”? • Are you limited in how you work with people with “MUS”?
<p>How might counselling psychologists respond to this?</p>	<p>Which professional roles do you see as important in working with people with “MUS”?</p> <ul style="list-style-type: none"> • How do you see the role of your own and profession? • How do you see the role of other professions? • Who do you believe has overall responsibility for working with people with “MUS”? • Do you see this area as multidisciplinary? • Do you see opportunities for multidisciplinary working? • Do you think contributions from any professions are missing? • Do you see a potential role for counselling psychologists?

Appendix G: Historical, Cultural and Theoretical Frameworks

Historical, Cultural and Theoretical Frameworks

The task of locating “MUS” within historical, cultural and theoretical frameworks is complex and involves recourse to some fluid and dynamic terminology. To do it justice would require a much deeper focus than is possible within this review. Nevertheless, I have tried to outline some specific historical and theoretical shifts and conceptions within western society that are particularly relevant to this discussion.

Modernism

The beginning of the modernist period is marked by “the Enlightenment”, a cultural movement in the 17th and 18th centuries. Reason and rationality displaced Christianity as the basis of knowledge and the means to understanding truth and morality. Knowledge was separated from religion through an emphasis on objectively verifiable “facts” influenced by the philosophies of empiricism and positivism (Strawbridge & Woolfe, 2010; Burr, 2003).

The emerging belief in the power of science extended to the scientific understanding of human bodies and had a significant influence on modern medicine and modern psychology. Whereas previously health had been conceived as directly relating to the patient’s emotional and spiritual life, it became something that occurred in the body independently of this (Radley, 1994). There was a drive to uncover the specific aetiology of a disease by examining the human body. Findings were named and medical labels were constructed. This laid the basis for the biomedical model which is still dominant in medicine today (Stacey, 1988). The biomedical model looks to biological factors – physiology, anatomy and biochemistry - for diagnosis and treatment (Radley, 1994). Medicine’s recourse to science led to its establishment as the dominant healing system and the elevation in status of the practitioners working within it. Yet “MUS” poses a direct challenge to the biomedical model as the physical symptoms and the suffering occur without medical explanation.

Modern psychology has been profoundly influenced by this emphasis on objectivity and observability, arguably at the expense of a more reflective or philosophical focus (Orlans, 2013). This is apparent in the behavioural focus which aimed to apply

scientific methods to the study of human beings and is still perceptible in experimental psychology and the cognitive behavioural therapeutic approach (Strawbridge & Woolfe, 2010).

Within modernism two significant movements developed which extended the modern focus on the study of human beings.

Humanism

The development of humanist psychology in the mid-twentieth century challenged the appropriateness of using the same methods to study the natural and human world (Strawbridge & Woolfe, 2010). Its emphasis on free-will and human potential was a challenge to the determinism of behaviourism, psychoanalysis and the biomedical model. By the 1960s this emphasis was viewed as a serious challenge to the predominant positivist empiricist philosophy. In the emerging human science model, human beings were viewed as self-conscious and reflective with the capacity for choice and personal responsibility.

Donati and Legg (2011, p.261) see the parallel development in counselling as “a reaction against the disease model of mental distress that divided people into those with problems and those without, in the same way that physical medicine divides the population into the sick and the healthy.” What this suggests is that humanistic counselling was developing in reaction to the polarising organisational structure of biomedicine, and positioning itself as different. However, like most other psychological therapies, in focusing on mental distress it maintained a body-mind dualistic conception of therapy, separating itself from medicine which dealt with the body to deal with the psychological problems of the mind. The development of counselling psychology was influenced by the humanistic focus on the whole person, rather than just their symptoms or illness (Orlans, 2013).

Structuralism

Structuralism, originating in the early 1900s and revived mid-century, saw the humanistic perspective as neglecting the impact of social and historical processes on the human psyche. It emphasised that understanding human nature was dependent on recognising its relationship to larger, overarching systems or structures (Strawbridge & Woolfe, 2010). For example, both Freud and Piaget proposed the existence of

underlying psychic structures to explain psychological phenomena. These frameworks were constituted and brought into reality via language (Burr, 2003). Language was considered the link between individual psychology and social structures (Strawbridge & Woolfe, 2010).

The biopsychosocial model reflects a structuralist framework. Engel (1977) believed the biomedical model limited because it neglected psychological and socio-cultural factors in determining illness and treatment. The biopsychosocial model recognises the impact of these factors on a person's health. Nevertheless, although the biopsychosocial model is widely recognised within the social sciences and healthcare fields (Burr, 2003), the biomedical model is still dominant in medical practice.

Although humanism and structuralism represented shifts within modernism, they still encompassed the idea of grand theories or metanarratives espousing ultimate truths and underlying structures.

Postmodernism

Postmodernism is a cultural and intellectual movement which represents a challenge to, as well as a rejection of, the fundamental assumptions of modernism (Burr, 2003). Postmodernism stresses pluralism or the co-existence of a multiplicity and variety of situation dependent ways of life (Burr, 2003). Polkinghorne (1992) stresses the relevance of postmodern thinking for psychological practice. He argues that academic psychology provided limited usefulness for practitioners in responding to clients; therefore they turned to a fragmented and discordant body of knowledge that was informed by actual therapeutic interactions. Polkinghorne sees this type of generation of knowledge as epistemologically postmodern. Counselling psychology embodies a postmodernist perspective in the context of approaches to "truth", encouraging the deconstruction of arguments and the questioning of notions of universal truths (Orlans, 2003). This suggests counselling psychology may have a useful role in relation to "MUS", partly because of its arguably postmodernist characteristics which reject generalised theories, such as the biomedical framework, in favour of subjective and intersubjective narratives.

Several theoretical orientations have developed against the backdrop of postmodernism, sharing its fundamental rejection of the idea of universal truths.

Poststructuralism

Poststructuralism viewed structuralism's notion of rules and structures underlying the real world as deterministic (Burr, 2003). The idea of meta-narratives and overarching conceptions of reason and truth were dismissed. Instead poststructuralists argued that all thinking and evaluation are limited by perspectives (Strawbridge & Woolfe, 2010). Although language remains central in poststructuralism, the meanings carried by it are always open to question, always contestable and always temporary (Burr, 2003). Language is seen to operate within smaller systems or "discourses". Foucault (1972, p.49) described discourses as "practices which form the objects of which they speak" which emphasises the relationship between language, practices and things. Burr (2003) suggests a discourse refers to a set of meanings and representations which together construct versions of events. Within a discursive framework "MUS" would be seen as a discursive object influenced by and influential on various discourses.

Foucault saw the Enlightenment as a shift (rather than a development) in the structure of knowledge. The science and practice of medicine developed within this wider structure of organising knowledge which in turn rationalised its structure and experience (Foucault, 1973, 1976, 1979). These wider epistemological structures or discourses enabled medical investigation, diagnosis and treatment to become acceptable, respectable and expected under the "medical gaze". Foucault argues that this biomedical way of viewing the body is connected to a system of ordering related to social control (Burr, 2003). Work, domestic and political behaviours are regulated using classifications such as normal, abnormal, healthy, sick, sane or insane. For example, without a sick note from a doctor a person may be forced to work. It is arguable that "MUS" has thwarted the existing biomedical structure by eluding the current criteria for investigation, diagnosis and treatment. Therefore post-structuralist thinking and discourse analysis are useful frameworks for exploring "MUS".

Social constructionism

Poststructuralism, along with critical psychology, discourse analysis and other approaches in the social sciences and humanities, has a social constructionist orientation (Burr, 2003). Social constructionism has no one fixed definition but is applied to approaches which share the following assumptions: a critical stance

toward assumed knowledge; that knowledge is historically and culturally specific; that knowledge is constructed through social processes and that constructions of knowledge sustain or exclude patterns of social action (Gergen, 1985). This fits with counselling psychology's model of not assuming "the automatic superiority of any one way of experiencing, feeling, valuing and knowing" (Orlans, 2013, p.2). Social constructionism is a useful approach for exploring how and why meanings are constructed and what are the implications. From both a social constructionist and counselling psychology stance it is inappropriate to accept "MUS" as a concept just because it is deemed the most suitable term and widely used. Instead it is recognised that "MUS" has been constructed through social processes with a wider social purpose within a historical and cultural context. Most importantly, it is recognised that this has real consequences for social action and power (Burr, 2003).

Social constructionism argues that illness is a social, not a physiological, matter (Burr, 2003). What is deemed illness is only partly dependent on physical experience. Disease can be established without the physical experience of illness; "illness" can be granted to a person or to the self via individual judgements. A judgement of illness is seen as dependant on cultural prescriptions, norms and values around our ability to function as usual. Therefore, Hardey (1998) argues that it is the reaction to symptoms rather than the experience of them that depicts illness. If illness is socially created then "MUS" needs to be explored within its wider social context. To explore "MUS" it is necessary to explore the social, historical and relational discourses within which it is located. Therefore this research will adopt a social constructionist approach to exploring how practitioners construct "MUS" and the implications of this, particularly in relation to counselling psychologists.

Appendix H: Transcription rules and transcript excerpt

The interviews were transcribed verbatim using the following conventions:

- Dots enclosed in brackets indicate a pause in talk. The number of dots indicates the length of the time gap in seconds equal to the number of dots, e.g. (...) indicates a pause of three seconds.
- Significant or potentially relevant non-verbal activity is written in italics and recorded in brackets, e.g. (*laughs*).
- Square brackets between adjacent lines of concurrent speech indicate overlapping talk, e.g. [Marianne: Mm hm]
- Speech that is difficult to make out is replaced with (inaudible).
- Words in capitals indicated speech which is noticeably louder in volume than the speech surrounding it.
- Square brackets around three dots, i.e. [...], are used in the analysis chapter to indicate that part of the verbatim speech has been removed for purposes of relevance to the point being made in that instance.

A sample extract from one interview transcript is included below for illustrative purposes:

1

2 I: So the first thing I'd like to ask you is what does "medically unexplained symptoms" mean to you?

3 P: OK. So, medically unexplained symptoms, in my understanding, means that a patient or client
4 presents with symptoms to which there is no known organic explanation. So (...) the medical
5 establishment to date are not able to provide for themselves or for the client an explanation of why the
6 client/patient should be suffering with symptoms.

7 I: So, can you tell me a bit about your experience of working in this area?

8 P: Ok. So, as a psychologist in what's, erm, what's come out of, or emerged from the old er liaison
9 model I work in the acute general hospital. And so I would see people, um, typically at the most acute
10 end of the medically unexplained spectrum. So, typically these would be people um in wheelchairs.
11 Typically, but not always. Or people with unexplained pain, in the sense that they may well have, er, a
12 physical condition, but the level of pain they report or the frequency or the intensity is not explained
13 by medical doctors, by their diagnosis, their their condition. So they would be in the hospital. So they
14 would have gone to accident and emergency complaining er generally of pain. It could be respiratory
15 disorders. It could be gastric disorders. Those are the ones we get. And gynaecological ones, actually.

16 They're the ones that we tend to see most frequently as inpatients. And then they would be seen by us
17 as the liaison, as the psychological service, psychiatric service, in the hospital. And they would come
18 to, erm, me as outpatients if they wanted to follow up. [I: Ok] So my experience is working with
19 people who've agreed to a follow-up.

20 I: Mm hm mm hm. And what makes you interested in in this area?

21 P: I think what makes me er interested, and it's more than an interest, it's absolutely fascinated, it's
22 because it's an area of medicine that causes huge anxiety among treating clinicians

23 I: Mm

24 P: And I'm talking about medical er clinicians. So, there's no consensus as yet, there doesn't seem to
25 be any successful model of treating these patients. And what the research suggests is that anything,
26 and it's very unclear, between 30 and 70 per cent of patients er who attend GP surgeries are, have
27 medically unexplained symptoms. Which is huge.

28 I: Mm

29 P: My understanding of the research is that this is the patient group that causes the most
30 dissatisfaction among GPs because you cannot apply this, what they call the house model, this idea
31 House as in the Hugh Laurie character, of find it and fix it. There's a symptom we will find er a
32 solution. So, really, it really tests people who um espouse those kind of pure science approach, who
33 try and problematize everything according to anatomy

34 [I: Mm]

35 P: (..)physiology. And become hugely frustrated when their knowledge doesn't explain the, the
36 patient's presentation. And when they're then unable to comfort the patient in a way that the patient
37 needs without colluding with them. And there's all these words, I'm sure that in your analysis words
38 like collusion are going to be huge. Um. And I think that so that's one part one reason why it
39 fascinates me. And the other reason I think just goes to the heart of being human which is that we are
40 (..) connected, we are we are (...) one system. We're not discreet systems. And to pretend that
41 everything is either in the body or in the mind (..) is, is ridiculous. And so the evidence is there (*points*
42 *to painting*). And I know that you can't bring that up but this painting here is a fantastic piece of work
43 that shows the distress of the person through the body. It's a self-portrait by Schiele, and I just love it
44 and erm, and you can just see how kind of contorted and twisted he is. But it's emotional distress. [I:
45 Yes.]

46 P: And it kind of typifies everything I think about erm and we can't call them medically unexplained
47 symptoms. I think that's very stigmatising as well.

48 I: Mm

49 P: So, even in the title, what's my interest, it's just this is such a um a conflicted area both for patients
50 and for those treating them.

51 I: Ok. Can you say a bit more about that?

52 P: I thought I'd just exhausted all I could say. [I:(*laughs*)] Well it comes down to the fact that, it's not
53 just GPs, it's erm it's GPs who then might (..) refer on. And I suppose what I've learnt very recently
54 and started thinking about, very recently, last couple of weeks, is that the role of the GP is pivotal,
55 and if you ask G, GPs, when you have difficulties like this, what he or she wants to do it's, "I have to
56 maintain the therapeutic relationship, with my patient". And in a way that really constrains what
57 they're able to do. And I've seen it so many times. So, some GPs, who get frustrated with their own
58 inability, but they kind of project it onto the patient, will just say "There's nothing wrong with you.
59 You've had this test." And be very dismissive.

60 I: Mm hm

61 P: Which is just a very alienating erm (...) comment to make. It's not great for the therapeutic
62 relationship. Others will collude with the patient. And they'll send them for test after test in the full
63 knowledge that (..) the earlier tests have ruled out possibilities of disease, of physical disease, yeah.

64 I: Um hm. Um hm.

65 P: And that means that the higher order tests, if you like, are not going to find anything, but they'll
66 keep doing it because what they're trying to do is protect the relationship. But actually protect the
67 relationship at the expense of the patient's well-being.

68 I: Mm hm. Mm hm.

69 P: And (..) the third group are those that try what I think is called empathic confrontation. Which is to
70 help the patient understand that the symptoms are real, the distress is real, the cause is real, it's just
71 not a medical cause.

72 I: Mm hm. Mm hm.

Appendix I: Sample analysis workings

The excerpts below are examples of an annotated transcript and more detailed workings illustrating the process of identifying constructions of MUS, discourses, action orientation, positionings, practice and subjectivity according to Willig's (2001) procedural guidelines.

The following colour code was used:

Medically unexplained symptoms (MUS)

Constructions of "MUS"

Discourses

Action orientation

Positionings

Practice

Subjectivity

31	P: I think, er, what tends to happen is that we, we, I mean I can only really speak for general practice.	Comment [MS1]: Discourse of conventionality
32	What we do in general practice is, you know, somebody comes in, we, we assess symptoms, we sort	
33	them, we assimilate them into some kind of erm, er, schema of things we need to do so, you know,	Comment [MS2]: Can be assessed, sorted, assimilated (Take in and understand fully, absorb and digest)
34	there would be the red flag – really serious, or I need to investigate or this is not very serious or I	
35	know exactly what this is immediately and I can treat it. Fine. Um, so there's a whole lot of stuff	Comment [MS3]: GPs as experts
36	going on when someone is talking and I think GPs are very used to management and so medically	Comment [MS4]: Social discourse
37	unexplained symptoms is more difficult because the management pathways push you into a medical	Comment [MS5]: MUS as difficult/challenging
38	model. So, you come and see me with headaches. Well, do I send you for an MRI? You say to me you	
39	want an MRI because you think you have a brain tumour. I think you have no symptoms of brain	Comment [MS6]: Want – what satisfies the patient. Discourse of satisfaction. The place of the surgery. Place of giving in and losing. Surrendering. Enjoyment. Theorising. Explaining. Thinking
40	tumour. Do I just give in and do it anyway? Er, or do I say lets look at what other things could be	
41	causing your headaches?	
42	I: Mm Mm.	
43	P: And, you know, so (...) we're trained in a biopsychosocial model, um, as GPs and that's very good,	Comment [MS7]: Medical model pushes patients to see physical symptoms as organic disease
44	but what you tend to fall into, in a 10 minute consultation, is a bit of a bid (laughs)	Comment [MS8]: GP as expert
45	I: Yes	Comment [MS9]: Surrender ?fail
46	P: because that's comfortable and quick and it also it has to be done because you don't want to miss	Comment [MS10]: Are we allowed that positioning?
47	the brain tumour. So actually that takes predominance.	Comment [MS11]: Disclaiming responsibility; inevitability within discourse
48	I: Right	Comment [MS12]: Discourse of responsibility/morality
49	P: and the psychosocial bit is, the GPs are very well aware of it, it's just, I think there's a bit of	
50	learned helplessness, You kind of think, well, what's the point because, you know, I don't know, who	
51	is going to help these people? Um, who can, you know, if this lady discloses domestic violence now	Comment [MS13]: Impotence/helplessness

- 52 what am I going to do? Who is going to see her quickly to help? Who is going to help with her
 53 housing or her refugee status? [I: Mm Mm] So, I think that's, I think those skills are needed, I think
 54 the other skills is about, I mean there's lots of, there's lots of work done about reframing and all
 55 that kind of stuff (..) uh, in my experience I think it's being, erm, honest, direct and empathetic to the
 56 patient and not doing a, a us you and them thing where the patient feels you are saying there is
 57 nothing wrong with you, pull yourself together, stop faking it.
- 58 I: Mm hm. Mm hm.
- 59 P: But what the patient hears and because that's what you're saying is we all have these things. [I:
 60 Yeah] We all have it. You know. I get headaches. I get neck tension when I've been anxious all day.
 61 Now I haven't got a brain tumour. I'm working too hard. Or, you know, er, diarrhoea when you have
 62 exams. Ok. You know. Does that mean you have bowel cancer? Well no, it means you get anxious.
 63 And a mechanism of that, the gut mechanism, is you get diarrhoea. [I: Mm] And the treatment of
 64 that is to manage your anxiety, not colonoscopy.
- 65 I: Right.
- 66 P: So it's, it's, it's explaining it in an empathetic way and, and not making the patient feel silly or
 67 small because they are having those somatic symptoms. That's the easy group. The complex group
 68 (..) are very hard (laughs) to manage (laughs again) and that kind of easy stuff doesn't work (laughs
 69 heartily). So, there's gradations. I mean we, we teach here, er, well I try and teach a sort of rag
 70 rating, so, um, traffic lights. Green are the minor stuff: tension headaches, a bit of bowel upset, IBS,
 71 the sort of things that GPs should see as their bread and butter. That's explanation of what's going
 72 on. And those are medically unexplained symptoms. But they're not, cos it's explainable. They are
 73 readily explainable. They are somatic symptoms of an underlying psychological or emotional upset.
 74 Doesn't have to be anything very serious. Often, doesn't need to see a psychologist, or, you know.
- 75 I: Yeah. Yeah.
- 76 P: And then there's the sort of, so we talk about that, we talk about amber which is the big hole
 77 which is long-term condition management where there is a super-imposed anxiety or depression or
 78 somebody with COPD who's got anxious and that affects their breathing. [I: Mm Mm] So, they have
 79 both a medical condition and they have something on top. And that's often forgotten. Cos we're
 80 concentrating on that. And then there's the red, complex patients. And they are the sort of
 81 traditional kind of labelled. You know. Heart sink or [I: Mmhm] frequent attender. Fat file patient.
 82 That are very difficult for GPs. In all senses. Management. Emotional. Er, you know just draining.
 83 Very draining
- Comment [MS14]: ""**
- Comment [MS15]:** Personal discourse
- Comment [MS16]:** MUS as normal
- Comment [MS17]:** Personal discourse
- Comment [MS18]:** Psychosocial discourse
- Comment [MS19]:** MUS as originating in anxiety
- Comment [MS20]:** Parag. MUS as psychological?
- Comment [MS21]:** Challenge. Test.
- Comment [MS22]:** Satisfaction, taking in, food, satisfaction, reward...
- Comment [MS23]:** MUS as unclear/confusing
- Comment [MS24]:** Underlying. Ordering, privileging. It's deeper/hidden. Drawing on structure – psyche under soma. Positions MUS client.
- Comment [MS25]:** MUS as psychological
- Comment [MS26]:** Constructs MUS as not serious. Psychological rather than serious.
- Comment [MS27]:** Need. Want. Discourse of want and need. Relates to appetite of satisfaction and enjoyment.
- Comment [MS28]:** MUS as psychological
- Comment [MS29]:** MUS as psychological

In order to attempt to demonstrate how I analysed the transcripts, I shall describe how I applied Willig's guidelines for FDA to lines 35 to 41 of the above extract. Following Willig's guidelines I identify the discursive construction of "MUS" as difficult or challenging (line 37). In this extract it is constructed as challenging because the models and pathways cannot appropriately accommodate it. I use this notion to attempt to locate the challenge within wider discourses. The use of "management pathways" and "medical model" for me resonates with biomedical, institutional and management discourse. These seem the most appropriate choices available to me, all slightly different, but overlapping and influential on each other as well. I will need to reflect further on which to use.

I then ask what the function of constructing "MUS" in this way might be? It appears to highlight management restraints and limit the options available to Helen, to other doctors and to patients as well. It also appears to guide expectations. Within these restrictions there appear to be no free agents. These discursive constructions seem to position both patients and doctors as objects within a correct way of working. It seems as if these constraints require doctors to take up the position of dutiful protocol driven practitioner. Helen seems to both take up this subject position and resist it, perhaps in order to emphasise the limitations on her (how she is pushed into a medical model) but also to highlight the problems with them.

A biomedical discourse seems to require Helen to apply a medical model to the symptoms her patients are presenting to her and to follow protocol in her practice. However, at this point I identify alternative discourses that might be available to Helen. She seems to draw on a biopsychosocial discourse to recognise the complexity of the challenge – "there's a whole lot of stuff going on" – and this opens up the option of resisting the biomedical frameworks and considering what else might be going on. A discourse of patient satisfaction also seems to be driving her practice: the patient wants an MRI. To this extent it seems the patient is aligning his or herself to a biomedical discourse which is promoting a cultural version of headaches which suggests they must have a biological cause and need biomedical investigation. The biomedical and satisfaction discourses put pressure on Helen to do an MRI, even when she thinks the patient does not have the symptoms to require it. However, she does not do this without recognising the conflict between surrendering to the biomedical discourse or opening up the situation to working within a broader holistic framework. All this in turn leads back to and sustains the construction of "MUS" as challenging and, when considering subjectivity, may involve senses of both duty and frustration.

The diagram below is an illustration of my workings at one stage in the process of analysing lines 35 to 53 of Helen's transcript.

