INTRODUCTION

Patients who have somatic complaints which are not fully medically explained, which are sometimes referred to as MUS or Medically Unexplained Symptoms (Nimnuan, Hotopf & Wessely, 2001), or Medically Unexplained Physical Symptoms or MUPS (Burton, 2003) may take up considerable health service resource and time from investigations and other interventions, yet these can have relatively little impact on their presenting symptoms. They can continue to have signiýcant levels of functional impairment and socioeconomic disadvantage and how to best help them poses a major challenge to modern healthcare systems. MUS patients may also have substantial psychiatric co-morbidity, which may not always receive appropriate treatment. Psychological interventions have been studied in this group, with varying results and one of the major therapeutic models that have been studied in MUS is cognitive behaviour therapy (CBT). Although this can be a successful intervention, there may be difýculties in intervention in patients with more chronic and complex MUS problems. A possible modiýcation of the standard CBT models is discussed here, which is inþuenced by narrative exposure therapy (NET, narrative CBT and trauma-focused CBT models.

MEDICALLY UNEXPLAINED SYMPTOMS

De f nition

Who are the patients who have MUS? (Creed, Henningsen & Fink, 2011). Firstly, there can be many different views on how to deýne (an/or quantify) this problem and this has led some to consider whether this is any longer a useful concept. It can have marked negative connotations of ñdifýcultò and ñimpossible to helpò patients who make a lot of demands on the health system.

Secondly, this term may encompass a range of different syndromes or disorders and may not be a homogeneous entity. (Bridges & Goldberg, 1985; Henningsen, Jakobsen, Schiltenwolf & Weiss, 2005; Wessely, Nimnuan & Sharpe, 1999; Aggarwal et al., 2006; Creed & Barsky, 2004). It is unclear whether this is could represent a "spectrum" of disorders, with milder, less differentiated forms with better outcome presenting in primary care settings e.g. health anxiety related; and more chronic and complex presentations in secondary care such as what used to be termed “somatisation disorderò. In the spectrum concept, potentially different intensities of an intervention may be needed. However, this does not explain why certain patients may be more likely to have better outcome and others not respond or even show some deterioration with an intervention. In other words, if this is the case, as say with depression, what determines your particular severity point on the spectrum or moving within the spectrum? Alternative views are that these may be superýcially similar, overlapping, but intrinsically different issues e.g. symptom overlap rather than diagnostic overlap (Kroenke et al., 1997; Kirmayer & Robbins, 1991). This would imply that certain groups may need different interventions, despite superýcial similarities in their presenting complaints.

Thirdly, the formulation may be greatly delayed and the problem may not be correctly identiýed until many investigations and referrals have been undertaken without beneýt. Thus the recognition and diagnosis of an MUS problem can also pose a major challenge to mental health professionals and be the source of professional disagreement (Li et al., 2003)

is how we can treat it?ò Other issues are how exhaustively somatic complaints are investigated, a low attitude to risk and therefore diagnostic uncertainty, can lead to preparedness to over-investigate i.e. rarer possibilities that are remotely, but theoretically possible are considered, even if highly unlikely. At the other end of the spectrum there can be refusal to consider investigations, even if there is a signiýcant change in presentation, denigration of the patient and complete denial of their needs.

Intolerance of uncertainty in the medical team can be communicated to the patient and escalate unhelpful help seeking behaviours (Henningsen, Zipfel & Herzog, 2007). This can interplay with the patient's own intolerance of uncertainty and escalated safety behaviours (more investigations, fresh opinions) (Howard et al., 2005; Petrie et al., 2007; Salmon et al., 2007).

Patients may have quite marked self-stigma about mental health issues and unwillingness to engage in assessment or treatment. We are not clear whether, or how, they experience any self-stigma about their medically unexplained somatic complaints and the most useful interventions for this aspect of their problems (Stone et al., 2002; Salmon, Peters & Stanley, 1997). Self-stigma may cause delay in help seeking for psychological distress even if this is recognised by the patient and is entirely appropriate clinically.

New Terminology

Concern about the diagnostic status of ñMUSò and what it cannot tell us about the patient, has spurred on the development of newer diagnostic criteria such as ñsomatic symptom disorderò or SSD in DSM-V (Regier, 2007; Fink & Schröder, 2010). The rationale is that both medically explained and medically unexplained symptoms can increase the risk of psychological morbidity and associated marked functional impairment. Some criticisms have come from the DSM task force itself, that these concepts may be too broad and inclusive (Frances, 2013), but on other hand may be easier to justify in terms of research evidence and to operationalise. As yet it is unclear whether this has any connotations for the most appropriate interventions for each construct.

Health Economic Impact

The MUS patient group can have signiýcant costs in care, often without marked improvement in health, social or day to day function (Bermingham, Cohen, Hague & Parsonage, 2010; Barsky , Orav & Bates, 2005; Akehurst, 2002). Only part of this cost is direct investigations and procedures, much is from time in consultation, emergency attendances and inpatient care. Opportunity costs in terms of "lost" productivity or capacity that could have been used to care for other patients e.g. On waiting list, has not often been assessed (Hiller, Fichter & Rief, 2003; Hillila, Färkkilä & Färkkilä, 2010; Konnopka, 2012)

Interventions

No conclusive evidence is available that any one therapeutic model is superior in MUS to date, but CBT has been more frequently evaluated (Allen et al., 2002; Sumathipala, 2008, Champaneroa et al., 2005; Sumathipala et al., 2008). CBT models have now been proposed for most of the FSS (Suraway, Hackmann, Hawton & Sharpe, 1995; Moss-Morris, Spence & Hou, 2011; Hou et al., 2011; Spence & Moss-Morris, 2007, Williams, Eccleston &Morley, 2012; Zijbendos et al., 2009; Ford et al., 2009). Individual CBT has been extensively evaluated (Nezu, Nezu & Lombardo, 2001; Barsky & Ahern, 2004; Bleichard, Timmer & Rief, 2004; Kroenke, 2007; Kroenke & Swindle, 2000) and group-based CBT (Moreno et al., 2013; Hellman et al., 1990). Some have advocated multimodal or multi-faceted approaches to help MUS e.g. in ýbromyalgia (Hauser et al., 2009). Psychodynamic models have been evaluated and have some support (Kleinstäuber, 2011; Lackner et al., 2004; Sollner & Schussler, 2001) and some of these have had increasing focus on attachment theory (Taylor et al., 2012; Adshead & Guthrie, 2015; Guthrie, 1999; 2008). Currently, briefer psychodynamically based therapies are being developed and evaluated. There is increasing interest in some other therapy models, but most have so far, involved small studies, such as for CAT (cognitive Analytical Therapy) which has been subject to preliminary study (Jennaway, 2011) and so called ñthird wave therapiesò such as ACT ì

physical symptoms: a review of the literature. *Psychosomatic Medicine*, *64*, 939-950.

Andersson, E., Ljotsson, B., Smit, F., Paxling, B., Hedman, E., Lindefors, N., et al. (2011). Cost-effectiveness of internet-based cognitive behavior therapy for irritable bowel syndrome: results from a randomized controlled trial. *BMC Public Health*, *11*, 215.

Barsky, A.J., Orav, E.J., & Bates, D.W. (2005). Somatization increases medical utilization and costs independent of psychiatric and medical comorbidity. *Archives of General Psychiatry*, *62*, 903-910.

Barsky A.J. & Ahern D.K. (2004). Cognitive behavior therapy for hypochondriasis. *Journal of the American Medical Association* (*JAMA)*, *291*(12).

Bermingham, S.L., Cohen, A., Hague, J. & Parsonage, P. (2010). The cost of somatisation among the working-age population in England for the year 2008–2009. *Mental Health in Family Medicine*, *7*, 71–84.

Bleichhardt, G., Timmer, B., & Rief, W. (2004). Cognitive-behavioral therapy for patients with multiple somatoform symptoms - a randomized controlled trial in tertiary care. *Journal of Psychosomatic Research*, *56*, 449ï454.

Bridges, K.W. & Goldberg, D.P. (1985). Somatic presentation of DSM-III psychiatric disorders in primary care. *Journal of Psychosomatic Research*, *29*, 563-569.

Brown, R.J. (2013). Explaining the unexplained. *The Psychologist*, *26*, 868-873.

Brown, R.J. (2013). Dissociation and somatoform disorders. In: F. Kennedy, H. Kennerley & D. Pearson (Eds.) *Cognitive behavioural approaches to the understanding and treatment of dissociation* (pp.133ï147). London: Routledge.

Brown, R.J., Danquah, A.N., Miles, E., Holmes, E., & Poliakoff, E. (2010). Attention to the body in non-clinical somatoform dissociation depends on emotional state. *Journal of Psychosomatic Research*, *69*, 249–257.

Brown, R.J., Schrag, A. & Trimble, M.R. (2005). Dissociation, childhood interpersonal trauma and family functioning in somatization disorder. *American Journal of Psychiatry*, *162*, 899–905.

Brown, R.J., Skehan, D., Chapman, A., Perry, E.P., McKenzie, K.J., Lloyd, D.M. et al. (2012). Physical symptom reporting is associated with a tendency to experience somatosensory distortion. *Psychosomatic Medicine*, *74*, 648–655.

Burton, C. (2003). Beyond somatisation: iv g l א ʽ

group behavioral medicine interventions for patients with psychosomatic complaints. *Behavioural Medicine, 16*, 165ī173.

Henningsen, P., Zipfel, S., & Herzog, W. (2007). Management of functional somatic syndromes. *Lancet, 369*, 946-955.

Henningsen, P., Jakobsen, T., Schiltenwolf, M., & Weiss, M.G. (2005). Somatization revisited: diagnosis and perceived causes of common mental disorders.

Roos, J. & Wearden, A. (1999). 'What do we mean by "socialization to the modelò? A Delphi study. *Behavioural and cognitive psychotherapy*. Cambridge: Cambridge University Press

Rosendal, M., Blankenstein, A.H., Morriss, R., Fink, P., Sharpe, M., & Burton, C. (2013). Enhanced care by generalists for functional somatic symptoms and disorders in primary care. *Cochrane Database of Systematic Reviews*, *10*, CD008142.

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

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

Sollner, W. & Schussler, G. (2001). Psychodynamic therapy in chronic pain patients: a systematic review. *Zeitschrift Fuer Psychosomatische Medizin und Psychotherapie*, *47*

, 571-577.