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Factors influencing individual therapeutic goal attainment of patients with somatic symptom disorder from the perspective of professionals: A concept mapping study

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Note

This thesis was completed as part of a requirement to attain a MSc degree in Clinical Psychology at the Utrecht University. It was part of a larger research project studying the individual therapeutic goals of patients from the perspective of professionals and the factors that played a role in attaining them. The core research group was made up of Prof. Dr. Rinie Geenen (RG) and two Master students Isabella Boon (IB) and Luisa Kühlmann (LK).

Additionally, an expert group composed by Saskia van Broekhuysen-Kloth (SvB), Peter Lucassen (PL), Michel Reinders (MR), and Saskia van Es (SvE) participated in parts of the research. These initials are used throughout the text to refer to their respective roles that were not carried out solely by the author.

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Preface: Word of thanks

This thesis was carried out in collaboration with Altrecht Psychosomatiek Eikenboom in Zeist, the Netherlands. Thank you to the experts involved for their commitment to this research: Saskia van Broekhuysen-Kloth, Peter Lucassen, Michel Reinders, Peter Westdijk, Lineke Tak, and Saskia van Es. Also, thank you to all other participants for their time.

This thesis is not solely a product of mine. Therefore, on a more personal note, thank you to Rinie for going beyond being a supervisor, for exemplifying passionate work in academia, for your patience with your students, and for the conversations that have gone past the academic and into the world beyond. And thank you to Isabella for the co-pilot role you played while we navigated this adventure of data collection, including an unexpectedly extensive relationship with reciting numbers. Thank you to both my parents for making this trajectory possible by enabling me to be where I am. And, last but not least, a big thank you to my friends, my brother and sister, for keeping me (relatively) sane and grounded in the process. You know what this means to me.

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Abstract

Background: The low to moderate effect sizes of current psychotherapeutic treatment of patients with somatic symptom disorder (SSD) may be improved by insight into factors that impact individual therapeutic goal attainment. Professional knowledge is often not included in the limited studies available on this topic.

Objective: To develop a list of factors assumed to act as barriers and facilitators of therapy success for patients with SSD from the professionals' perspective, and to have professionals sort these factors according to how commonly they occur on a scale of individual to general factors.

Method: This pilot study used a concept-mapping procedure. Participants were professionals experienced in working with SSD. Based on a scoping literature review and individual interviews with professionals, a list of factors was derived. Then, two card-sorting tasks were carried out: (1) grouping factors into clusters based on commonality of contents and (2) sorting factors based on how individual to general they appear amongst patients with SSD. A hierarchical cluster analysis (squared Euclidean distances, Ward's method) was used to identify the structure of the first sorting. A one-tailed analysis of variance (ANOVA) with a post hoc comparison according to Student-Newman-Keuls (SNK) was done to analyze the second sorting.

Results: The literature review and 17 interviews led to 55 factors that are considered to play a role in attaining therapy success. Fifteen professionals sorted these factors twice. A cluster analysis of the first sorting task yielded a nine-cluster solution, which was divided into three overarching groups: individual context, social context, and therapeutic relationship. In the second sorting, the clusters rated more individual were psychopathology, low self-esteem, externalization, system, and societal factors, and the clusters rated more general were experiences of self and body, resilience, structure, and therapeutic relationship. A significant difference ($p < .001$) between these two groups of clusters was found.

Conclusion: The overview of nine clusters that influence patients in attaining therapy success from the perspective of clinicians, and the frequency with which they appear in patients with SSD, provide a first step in addressing the diversity of SSD patients. This insight may enable therapists to enhance the assessment of vulnerabilities and strengths of patients in order to develop more personally tailored care, thereby increasing therapy success.

Somatic symptom disorder (SSD), the successor of the DSM-IV diagnostic category somatoform disorder, is a complex illness (Witthöft & Hiller, 2010). It is marked by persistent physical symptoms that are distressing or result in disruption of normal functioning, and includes excessive and disproportionate amounts of thoughts, feelings, and behaviors regarding these symptoms (American Psychiatric Association, 2013). Despite high frequency of health care use, adequate treatment of the psychological symptoms of patients with SSD or somatoform disorder remains problematic. Symptoms, such as persistent pain or fatigue, are rarely sufficiently treated or improved (Toft et al., 2005). Additionally, during treatment there was a 55% drop out rate (Kashner, Rost, Cohen, Anderson, & Smith, 1995 in Timmer, Bleichhardt & Rief, 2006). Meta-analyses confirm these conclusions, consistently finding small to moderate effect sizes of therapies (e.g., Gerger, Hlavica, Gaab, Munder, & Barth, 2015; Kleinstäuber, Witthöft, & Hiller, 2011; Koelen et al., 2014; van Dessel et al., 2015).

The inadequate treatment may be partially due to the diversity of the target group. Somatoform disorders have already been shown to be highly heterogeneous (Noyes, Stuart, & Watson, 2008). They have, for example, high comorbidity with other disorders (Barsky, Orav, & Bates, 2005; Hamilton, Campos, & Creed, 1995). As patients can differ from each other to a large extent, there are no generally valid treatment goals within SSD (Klemm, van Broeckhuysen-Kloth, van Vliet, Oosterhuis, & Geenen, 2018). Treatment therefore may be inadequate because the goals set for the patients do not reflect the unique set of individual factors that impact them.

This inefficacy may also be due to the fact that the instruments used to measure treatment outcome of SSD, such as the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983) and the EuroQoL-5D (EQ-5D; Brooks, 1996), have been developed to measure general psychopathology, not SSD symptoms specifically. These instruments may consequently omit factors that impact SSD treatment explicitly, be it factors that manifest for very few patients or for almost all.

A number of theories attempt to distinguish factors that influence the therapeutic process and results. The common factors theory maintains that identifying these types of factors are an essential element in successful psychotherapeutic treatment. It divides the factors in two categories. First are general factors that are fundamental across all therapies and therefore inherent in all patient-professional relationships; second are unique factors that are dependent on the specific treatment

applied, such as the role of homework in CBT (Laska, Gurman, & Wampold, 2013). Only when linking both categories can the full complexity of treatment be recognized and, consequently, therapeutic change facilitated (McAleavey & Castonguay, 2015). This theory has not been applied to research on SSD or somatoform disorders.

While the common factors theory underlines the role of specific factors that influence therapy outcome on two levels, it may miss patient-specific factors due to its focus on treatment of illness. In contrast to an illness-centered approach, a patient-centered approach addresses the patient from a holistic perspective (Balint, 1969). It focuses on treatment that connects directly to the patient's "person, circumstances, and relationships in health care" (Berwick, 2009, p. 560). Thus, factors playing a role for one patient may not be significant for another. The role of addressing individuality in treatment results is also emphasized by the self-determination theory: Maximizing the patient's experience of autonomy, competence, and relatedness during an intervention will more likely lead to adherence and better health outcomes (Ryan, Patrick, Deci, & Williams, 2008). These theories fall in line with the biopsychosocial perspective on chronic pain, which underlines the unique and complex interaction of these factors. Similar to a hanging mobile toy, the factors are described as being "dynamic and reciprocal, with mutually influencing pathways [...], in which movement of one component may induce change in all others and back", where different factors weigh differently per individual (Da Silva, Geenen, & Jacobs, in press, p. 1). Applied, patient-specific factors may be addressed by making a distinction between (1) factors that predispose an individual to developing a disorder and (2) factors perpetuating the disorder (Deary, Chalder, & Sharpe, 2007). SSD may then be a crucial element that distinguishes general factors relevant to most SSD patients from more individually occurring factors that appear less common.

Together, the common factors theory, patient-centered approach, and self-determination theory under the biopsychosocial perspective of chronic pain emphasize the importance of personalizing treatment in order to improve treatment outcome. This study suggests that personalization can be achieved by broadening the focus from the patient identity (general factors) and treatment type (unique factors), to including the individual factors that affect the patient's experience of her or his disorder, and treatment thereof. Identifying which factors are significant, and how general they appear amongst patients, is the first step in doing so.

A scoping literature review to obtain insight into the types of factors that a patient with SSD and similar disorders can face while receiving treatment from a mental health practitioner yielded nine studies (see: Appendix A for literature review, Appendix B for studies). A total of seven categories of factors were developed based on the articles studied, namely emotional, cognitive, behavioral, interpersonal relationships (exclude therapeutic relationship), societal factors, therapeutic context, and demographic factors (see: Table 1, full table in Appendix B). It is notable that of the nine studies, only three (Heijmans et al., 2011; Janssens et al., 2017; Kleinstäuber et al., 2011) explicitly addressed the role of the professional and the clinician-patient relationship in achieving treatment outcome. Only two articles focused specifically on the perspectives of clinicians (Heijmans et al., 2011; Janssens et al. 2017). Furthermore, there were contradictory findings regarding the roles of comorbid disorders, education, and gender in treatment. No literature studied how common these factors were amongst their population.

Table 1
Categories of Significant Factors Impacting Treatment of SSD Found in Literature With Examples.

Emotional factors
Feelings of shame or frustration resulting from experiencing the symptoms
Experiencing high amounts of psychological stress due to the symptoms
Cognitive factors
Openness to receiving psychotherapy before starting the treatment
Excessive concerns about the symptoms
Behavioral factors
Carrying out avoidance behavior
Making unrealistic demands of oneself
Interpersonal relationships outside of the therapeutic context
Lack of a relationship one can trust in
Maladaptive relationship patterns
Societal factors
Pension claims
Vocational integration
Therapeutic context
Negative relationship with the therapist that includes lack of trust
High quality diagnostic procedure
Demographic factors
Age
Education level

Note. All factors that had no significant impact to be found in Appendix B.

In line with the theoretical background and knowledge gaps, this study aims to answer the following questions: (1) From the perspectives of professionals, what barriers and facilitators can be identified for

patients with somatic symptom disorder in their path towards attaining their (individual) goals in therapy? (2) How common are these factors amongst patients with somatic symptom disorder?

Firstly it is expected that factors relating to emotional, cognitive, behavioral, interpersonal relationships, societal, therapeutic, and demographic context will be found in this study. They are expected to include both barriers as well as facilitators and be relevant for patients with SSD in reaching their therapy goals. Secondly, it is expected that factors related specifically to SSD will be rated as occurring generally.

This pilot study makes several new contributions to the field of treatment of SSD. Firstly, it focuses on SSD specifically. Although factors are initially based on various somatic disorders in the literature review, the concept mapping phase and expert opinion will ensure all factors are relevant to SSD. Secondly, the current study contributes a ranking of factors on a scale from individual to general. Lastly, this research will utilize the perspectives of professionals, i.e. individuals who have experience carrying out therapeutic interventions for patients with SSD.

Method

Procedure

Concept mapping is a methodology that utilizes group processes, such as sorting and group interpretation, and multivariate statistical methods (Trochim & Kane, 2005). In this study, the concept mapping procedure consisted of four steps: (1) interviewing, (2) selection of statements, (3) card-sorting, and (4) statistical analysis. Participants were experienced professionals working with patients with SSD. These professionals gave statements through oral and written interviews. The results were reduced to a more manageable amount of factors in several phases. Professionals then categorized these factors through a card-sorting task. Using these results, a hierarchical cluster analysis was carried to identify a final set of clusters.

Before carrying out the research, the board of the Faculty of Social and Behavioural Sciences of Utrecht University granted ethical approval for the research (FETC17-099). All participants gave written informed consent.

Participants

The participants were professionals working with patients with SSD in the Netherlands. All had to be 18 years or older and capable of giving consent. Participants were contacted by email via a network of active professionals working with SSD in the Netherlands, NOLK (*Netwerk Onvoldoende Verklaarde Lichamelijke Klachten*). The specific institutions were Altrecht, PsQ, de Gezonde Zaak, Dimence, and GGZinGeest in the Netherlands. All communication and data collection were carried out in Dutch.

Interviews

In the first phase, data was collected through both oral and written interviews. They included the same questions (see: Appendix C). An example question was: "To start off, can you please note what factors could hinder and support the attainment of a goal?" [*Wilt u allereerst opschrijven welke belemmeringen en succesfactoren het bereiken van een doel zouden kunnen beïnvloeden?*"]. In order to obtain a concrete example, participants were asked to think of their most recent patients as well as their most and least difficult-to-treat patients. A minimum of ten interviews was set as the aim. Should saturation

of information not be reached with the last two interviews, more interviews would be needed. Two researchers (IB and LK) conducted all interviews.

Participants were asked to provide statements of all factors that influenced patients in reaching their therapeutic goals. All questions were open ended. The first set of questions addressed facilitating factors; the second set addressed barriers. During the oral interviews, one researcher carried out the interview while the other typed the answers.

Selection of statements

In order to achieve a representative and manageable number of statements, the initial number of statements was reduced. The aim was to end up with about 50 statements. This process consisted of three steps.

First, the statements collected through the interviews were reduced. This included: (1) removal of duplications and components with the same content, (2) removal of very general statements (e.g., "biopsychosocial problems"), (3) modifications including splitting of double statements into two single statements, (4) removal of negative words like "*geen*" and "*niet*" to have only positive phrases, and (5) removal of any non-indicative words such as "*te*" and "*hoog*".

Second, a project group composed of four experts (SvE, SvB, PL, MR) from different institutions continued with the statement selection in two-phased Delphi procedure. In the first phase, the experts rated each statement with a 1 ("remove from set"), 2 ("unsure"), or a 3 ("keep in set"). They were asked to ensure that about the same number of ones, twos, and threes were present in their results. On the basis of the sum scores given per statement, the author made a provisional list of factors. Factors to be included were marked green (8 points or higher), those with no clear choice were marked orange, and finally, those to be excluded (5 and lower) were marked red. In the second phase of this step, the experts revised the list of colored statements with the aim of (1) confirming their provisional decisions while (2) ensuring as varied a set as possible. They marked all statements they agreed to retain as well as those statements that they did not agree with being excluded. Additionally, they were encouraged to comment on their decisions. A final list of statements was made of all factors with a mark of nine or higher from the first round. All remaining factors that had no decision but had two

or three marks in the second round were kept as well. The remaining “red” factors that had convincing arguments as to why they should be included were kept as well.

In the third and last step of the statement reduction phase, three researchers (IB, RG, LK) independently sorted all factors into groups in a card-sorting task based on similarity of content. All factors categorized in the same group were combined by means of more inclusive reformulation; those redundant were taken out. This ensured both clarity and variety of the remaining factors.

Card-sorting task

The final factors were printed out, with one factor per card in a random order. Each card started off with: “The attainment of treatment goals is influenced positively or negatively by...” [*Het bereiken van behandeldoelen wordt positief of negatief beïnvloed door...*] followed by the factor. These cards were sent out to the professionals along with an information letter, informed consent, and a task instruction booklet. Previous research indicates that a minimum of 20 to 30 respondents are needed for valid results (Wood & Wood, 2008), but - based on the experience of the researchers - the aim was to reach around 50 participants in order to obtain consistent results.

Each respondent was requested to complete two tasks. Firstly, all cards had to be grouped according to similarity of contents and a common, overarching theme. These groups were to be given a meaningful name according to their theme, and they had to consist of minimally two factors each. Secondly, the cards had to be re-grouped in five columns according to highly individual (rated with a "1") to highly general (rated with a "5") factors. Each column had to have the same number of cards in them.

All cards had to be sorted in both tasks; none could be left out. In case participants failed to group 10% or more of the cards, their results would not be used as they failed to fully follow the instructions. If less cards were not sorted or sorted faultily, the following rules were applied in the first task: If a card was placed into two groups, a new group was made consisting of this single card; if cards were not grouped at all, new separate groups was made for each unsorted card. In the second task, the following rules were applied: If a card was placed in two or more groups, the average of these groups was taken for the card; in the case that a card was not sorted at all, it did not receive a score.

Analysis

To analyze the data and obtain a set of influencing factors, SPSS (version 24, Chicago, IL) was used to carry out a hierarchical agglomerate cluster analysis with the results of the first card-sorting task. All individual factors were clustered step by step, all steps being irreversible, ultimately leading to a single cluster. As a criterion for clustering, Ward's method was used. Squared Euclidean's distance was utilized as the similarity measure, because this emphasized the commonalities and differences. Clusters were initially considered by visually analyzing the dendrogram (see: Appendix C) and then discussed amongst the researchers before agreeing on the final cluster division. Both two clusters more and less than the final solution were to be considered again, and if they had (more) meaningful themes.

The means and standard deviations of the grouping of the factors along the individual – general spectrum were calculated with SPSS. Additionally, a one-tailed analysis of variance (ANOVA) analysis with a post-hoc Student-Newman-Keuls (SNK) test was carried out with the means of the individual-general scores per cluster.

After these tests, the researchers and a group of five experts, part of whom had participated in earlier steps of statement selection as members of the project group, discussed an additional hierarchical cluster analysis made up of a larger sample size. The aim was to confirm and extend the earlier results.

Results

Participants

Seventeen people participated in the interviews and 15 in the card-sorting tasks. After the analysis deadline, an additional six participants contributed responses to the card-sorting task. This 21-participant analysis was used to confirm and extend earlier results and is explicitly mentioned in the text when referred to. No responses were removed. Table 1 presents the characteristics of the participants in the interviews and card-sorting task.

Interviews

The 17 interviews were carried out either orally or written. Saturation was not reached due to time constraints. One interview was in person, one via the phone, and the rest were conducted via email questionnaires. Based on the length of the oral interviews, it is estimated that the questionnaires took around 60 minutes to complete. In combination with factors from the literature study, a total of 310 statements were derived.

Table 1
Characteristics of Participants.

	Interview (N = 17)	Card-sorting (N = 15)
Sex		
Male	11	9
Female	6	6
Mean age in years (min-max)	47.5 (32-65)	47.4 (24-65)
Place of work		
Altrecht	6	11
Other health institutions	11	4
Profession		
Psychologist	10	9
Psychiatrist	2	2
Medical doctor	3	2
Physical therapist	1	1
Occupational therapist	1	0
Mean number of hours working with SSD patients per week (min-max)	21.4 (0.5-36)	24.0 (2.5-36)
Years experience working with SSD patients (min-max)	13.1 (6-35)	12.3 (2-30)

Note. Missing values for demographic information of card-sorting task. One participant (interview) did not fill in any demographic information. Three participants (card-sorting) did not respond to hours working with SSD patients per week.

Selection of statements

Figure 1 gives a visual representation of the full selection procedure. The 310 statements were reduced to 170 factors in Step 1. With the input of the project group of four experts, and as shown in steps 2 and 3, the 170 factors were reduced to result in a final set of 55 factors.

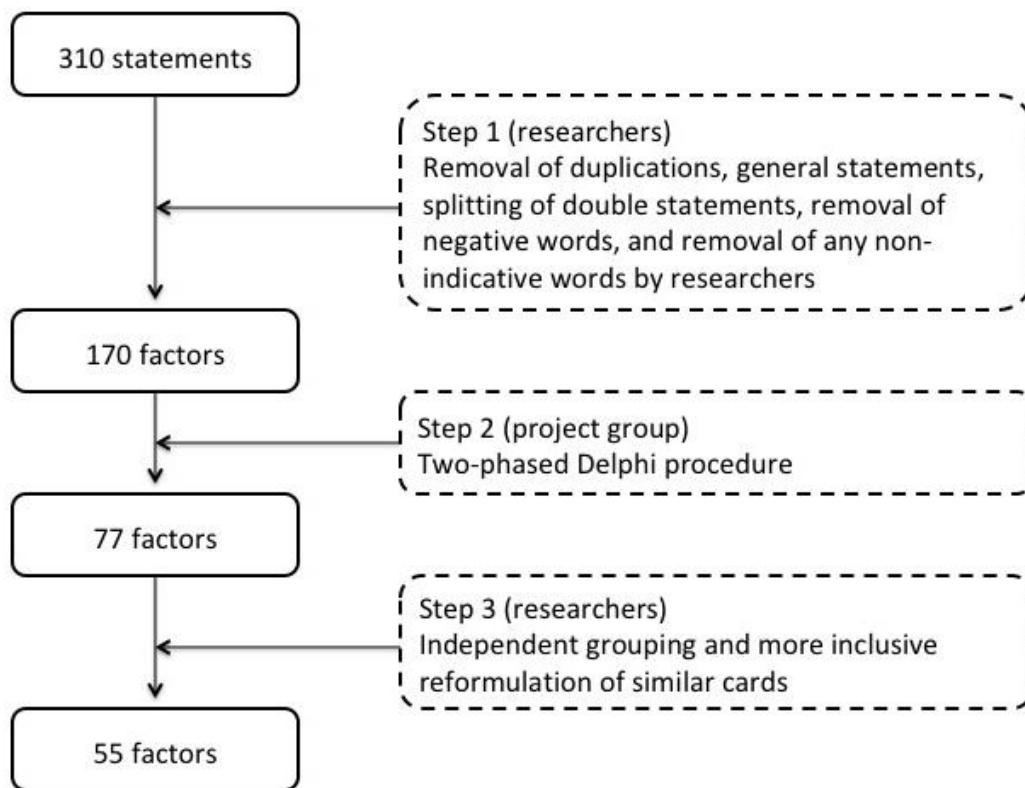


Figure 1. Flowchart of selection procedure of factors for the card-sorting task. Parentheses indicate if the specific step was carried out by the researchers carrying out the study (researchers) or by the group of four experts (project group).

Card-sorting task

Of the 62 professionals that were contacted, a total of 15 responses were received in time for the analysis deadline. This is below the set number of minimally 30 participants. A schematic representation of the cluster structure according to the sorting is shown in Figure 2. The full dendrogram along with a list of all items as presented to the participants can be found in the Appendix D and E.

The research group initially had an eight-cluster solution, but decided on a nine-cluster solution after considering the following options. Decreasing the number of clusters from 8 to 7 would combine clusters 6 (structure) and 7 (societal factors). Although both partially overlap in terms of structure in daily life, the two clusters were kept separate because the structure cluster represents positive influences that are connected with the immediate family environment whereas the societal cluster represents negative factors that play a role especially outside the home.

Decreasing the number of clusters from 7 to 6, the clusters 3 (externalization) and 4 (resilience) would be combined. They were kept separate because externalization refers to a lack of cognitive resilience where solutions are sought through elements outside of the self. Resilience, on the other hand, points to a person's stance and relationship with oneself when facing difficulties. Furthermore, decreasing externalization may help develop acceptance, understanding, and resilience.

Increasing the number of clusters from 8 to 9, cluster 2 (vulnerability) would be separated into two clusters. One new cluster (factors 21, 55, 22, 24, 34; see: Table 2) revolved around low self-esteem, while the other new cluster (factors 10, 45, 51) centered on the experience of the self and body. The construct that underlies these three latter items may be dissociation, i.e. a lack of connection with the self and external reality in thoughts, emotions, and memory. As low-self esteem and experiences of the self and body are useful distinctions, it was decided to keep the 9-cluster solution.

Increasing the number of clusters from 9 to 10 would lead to a division of cluster 8 (therapeutic relationship) into two clusters: One would be made up of a single factor (50), and the remaining factors would make up the second new cluster. A single cluster has little validity. Content-wise both clusters are distinctly related to the therapeutic context so no additional information can be obtained by dividing these two.

The additional analysis carried out with 21 participants, along with the feedback from the group of experts, confirmed these divisions and that they connected to the practical experience in working with SSD patients. This added qualitative confirmation of validity of these findings.

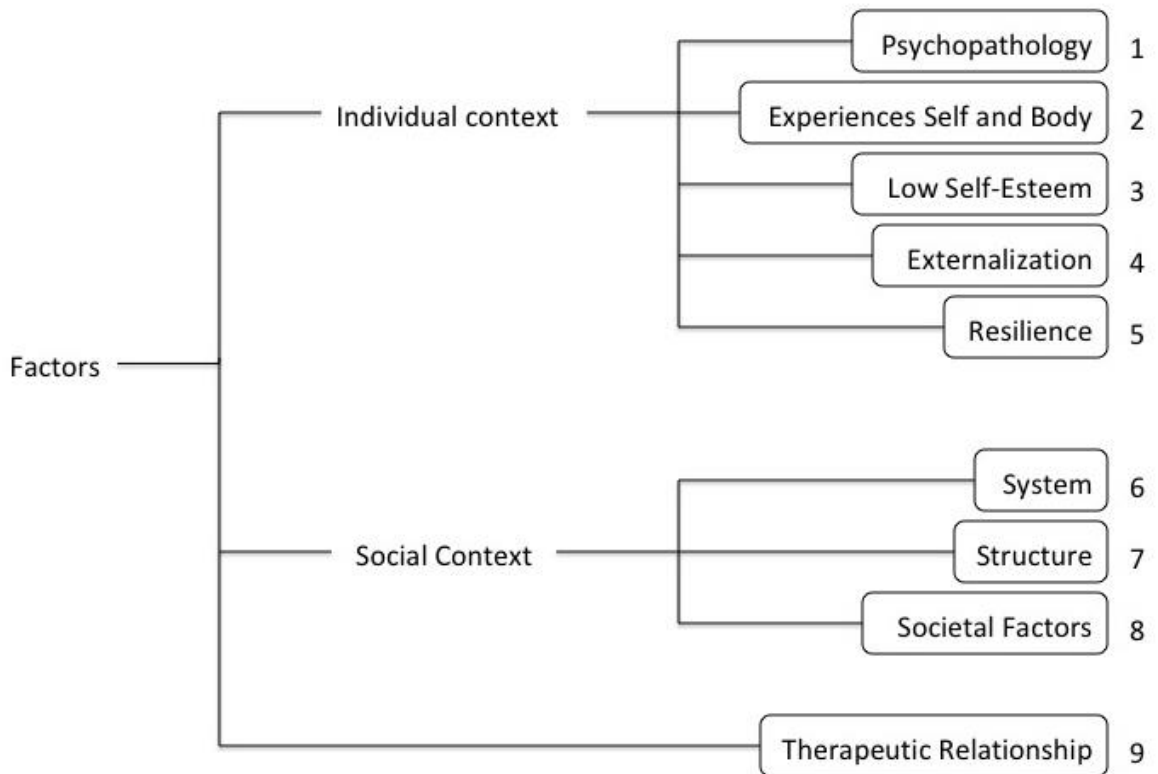


Figure 2. Schematic representation of the 9-cluster hierarchical structure of the components of factors influencing attainment of individual therapy goals according to professionals. The numbers on the right refer to the respective cluster number.

Based on the final interpretation and guided by the dendrogram, the three overarching categories of clusters were divided into individual context (clusters 1, 2, 3, and 4), societal context (clusters 4, 5, 6, and 7), and therapeutic relationship (cluster 9), as seen in Figure 2.

Once the final clusters were identified, all factors specifically characteristic of SSD were identified (see: Table 2). These were: The type and seriousness of the physical complaints (54), not being able to feel one's own boundaries (10), willingness and ability to experience and share emotions and associated physical indications (45), continued search for physical explanations or solutions (operation or medication) by the patient (20), and knowledge and insight into the connection between symptoms and (chronic) stress (32). The averages of all five factors were higher than the mean, i.e. they were rated as general factors amongst patients. Not all factors rated as general were particular to SSD.

Individual versus general factors

The means of individual-general ratings per factor and per cluster are shown in Table 2. The means of the separate items ranged between the most individual factor with $M = 1.67$ (suicidality, $SD = 1.11$) and the most general factor with $M = 4.40$ (feeling seen and taken seriously by the practitioner, $SD = 0.74$).

Table 2

The Mean Individual-General Rating and Standard Deviation of Each Factor as well as the Mean and Standard Deviation of the Overarching Clusters. The Lowest Possible Score is 1 (Highly Individual) and the Highest Possible Score is 5 (Highly General).

'The attainment of the therapy goal is influenced positively or negatively by...'	Individual vs. General Rating by Professionals	
	<i>M</i>	<i>SD</i>
Cluster 1: Psychopathology	2.70	0.81
... (14) a disturbed day-night rhythm	2.67	1.29
... (36) comorbidity, such as depression, anxiety, ADHD, personality disorders, eating disorders, PTSD, autism, dissociation	3.20	1.32
... (37) suicidality	1.67	1.11
... (38) addiction (to alcohol, drugs)	2.20	1.47
... (53) excessive use of medication (pain relief, calming, sleeping medication)	2.73	1.33
... (54) the type and seriousness of the physical complaints *	3.73	1.10
Cluster 2: Experiences Self & Body	3.40	0.69
... (10) not being able to feel one's own boundaries *	3.33	1.05
... (45) willingness and ability to experience and share emotions and associated physical indications *	3.80	1.26
... (51) being able to remember and integrate what is discussed during a therapy session	3.07	1.39
Cluster 3: Low Self-Esteem	2.61	0.87
... (21) having a negative self-image and a punishing style of thinking over oneself	2.40	0.99
... (22) attachment problems in the patient	2.73	1.49
... (24) being anxious, especially regarding contact with others	2.07	1.16
... (34) emotion regulation problems	2.73	1.33
... (55) having a vulnerable personality	3.13	1.06
Cluster 4: Externalization	2.47	0.48
... (06) a patient's continued hope that an external solution will be found or that someone else will have a solution	2.80	1.32
... (20) continued search for physical explanations or solutions (operation or medication) by the patient *	3.07	1.03
... (26) not letting go of the past (when one was still healthy)	2.13	1.06
... (35) victimization	1.87	0.83
Cluster 5: Resilience	3.42	0.73
... (07) acceptance of life with symptoms	4.13	1.06
... (17) a patient who invests in exercises at home	2.60	1.30
... (18) a patient who understands the perpetuating factors	3.53	1.36
... (19) motivation	3.67	1.45

... (28) a patient who sees the ability for recovery	3.07	1.44
... (32) knowledge and insight into the connection between symptoms and (chronic) stress *	3.73	0.83
... (33) the coping style of a patient	1.73	1.10
... (39) the openness to change	3.80	1.01
... (40) the introspective and reflective ability of a patient	3.80	1.37
... (42) the ability to take on another perspective by the patient	3.20	1.26
Cluster 6: System	2.67	0.97
... (01) problems in the family structures such as addiction problems or illness of a family member	2.13	1.24
... (08) a supportive system	3.40	0.91
... (09) social isolation	2.53	1.60
... (23) stability within the family	2.73	1.22
... (44) relationship problems	2.53	1.30
Cluster 7: Structure	3.27	0.87
... (02) the content and structure of the day	3.33	1.18
... (29) a patient having a future perspective	2.93	1.28
... (46) having stable and meaningful occupations	3.53	1.36
Cluster 8: Societal Factors	2.31	1.00
... (11) financial problems	2.20	1.32
... (12) ongoing legal procedures such as personal injury or alimony procedures	3.07	1.53
... (27) work related problems	2.53	1.46
... (43) language barriers	1.93	1.39
... (47) re-integration in profession	2.13	1.25
... (48) experience of loss or other large life events during the treatment	2.00	1.51
Cluster 9: Therapeutic Relationship	3.49	0.43
... (03) feeling seen and taken seriously by the practitioner	4.40	0.74
... (04) a good working relationship between patient and assessor	4.07	1.28
... (05) treatment goals taken into the treatment plan that are suggested by the patient	3.80	1.42
... (13) a trust between patient and practitioner	4.20	1.26
... (15) how well contact can be made with the patient	3.33	1.40
... (16) agreement between patient and practitioner on the goals	3.71	1.27
... (25) overestimation of the abilities of the patient	2.27	0.80
... (30) a difference in view on perpetuating factors between patient and practitioner	3.07	1.44
... (31) setting achievable goals	4.07	0.88
... (41) a practitioner who is open for what really occupies a patient internally	4.00	1.31
... (49) accordance with the rationale of the therapy	3.50	1.40
... (50) techniques that give hope that some improvements can be achieved quickly (e.g., EMDR, dosed daytime schedule)	2.40	1.35
... (52) doctors who are on the same page so that there is clarity regarding the diagnosis	3.00	1.00

Note. Translations of the components are preliminary. Items were translated solely by author, without forward or backward translation. Factors marked with an asterisk (*) were considered to be characteristic of SSD.

In terms of clusters, the most individually rated was cluster 8 (societal factors, $M = 2.31$, $SD = 1.00$), a medium difference to the average of all items in terms of Cohen's definition (Cohen, 1988). The

most general cluster was cluster 9 (therapeutic factors, $M = 3.49$, $SD = 0.45$), a small difference from the average. These cluster means of individual-general ratings are visually represented in Figure 3. In terms of effect sizes, all but two clusters had a small difference to the average of all items ($-0.20 \leq d < 0.20$), and therefore rated neither very individual nor general. Cluster 8 (societal factors) was an exception, as well as cluster 7 (structure), which had no difference to the average of the items and therefore rated average on the scale individual to common. Analysis of variance (ANOVA) was carried out to test the difference between the means.

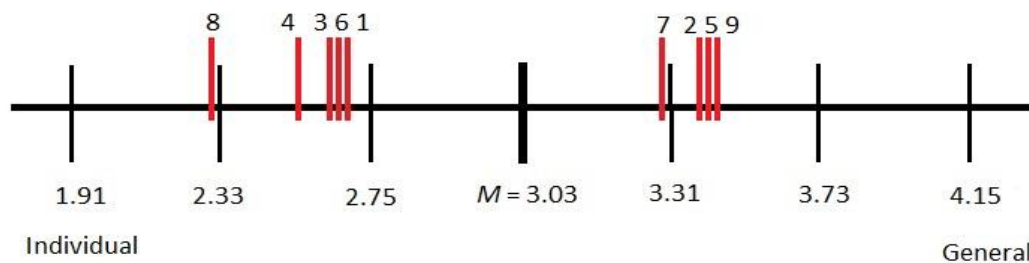


Figure 3. Schematic representation of results of effect size calculations, not to scale. The mean of all items was $M = 3.03$, $SD = 1.40$. Each cluster number is noted above a red line. The numbers below the line represent the application of Cohen's division into small (0.2), medium (0.5), and large (0.8) effect sizes (Cohen, 1988).

The results of the one-tailed analysis of variance (ANOVA) indicated a significant difference of means between groups $F(8, 815) = 12.77$, $p < .001$. A post hoc comparison using the Student-Newman-Keuls (SNK) test was carried out, which indicated a significant division of the clusters into two groups: One group of factors rated more individual (clusters 8, 4, 3, 6, and 1) and the other group of factors rated more general (clusters 7, 2, 5, and 9).

Discussion

This concept mapping study was guided by the theoretical contributions of the common factors theory, the patient-centered approach, and the self-determination theory under the biopsychosocial perspective of chronic pain. These all underline that a personal set of interacting factors impact therapy. The study resulted in 55 factors that influence a patient's attainment of individual therapy goals from the perspective of professionals. Nine clusters, namely psychopathology, experiences of the self and body, low self-esteem, externalization, resilience, system, structure, societal factors, and therapeutic relationship were found under the three overarching domains of individual context, social context, and therapeutic relationship. Five factors were considered to be uniquely characteristic of SSD and not found in other disorders. The first hypothesis was mostly met but, contrary to expectations, no demographic factors were found to influence therapy outcome. The second hypothesis was met, as all factors related specifically to SSD were rated as general. Two groups of individual and generally occurring clusters were identified.

The main contribution of this study is a list barriers and facilitating factors that are considered to influence SSD patients in their attaining their therapeutic goals. The contents of the cluster solutions are consistent with the results of the literature. The professionals did not mention demographic factors such as gender and education level, which are typical moderators. Perhaps, due to professionals being asked what might obstruct or facilitate for therapy outcome, they focused on listing factors that can be either (a) directly changed or (b) indirectly changed by addressing the patient's perspectives within the therapeutic context.

The influencing role of two clusters, namely resilience and low self-esteem, stands out in relation to the literature. The content of the resilience cluster, which includes motivation and openness to change, was found to be moderators in previous studies (Timmer et al., 2006 and Heider, Köck, Sehlbrede, & Schröder, in press, respectively). Yet, they may be influenced by a number of other clusters found in this study, such as societal factors. This hints at a mediating effect. Additionally, these two factors reflect the complexity of treating SSD. Patients have often been through a long trajectory of unsuccessful treatments that can have a detrimental impact their motivation and belief in possible change, which in turn lowers chances of therapy success. Therapeutic intervention can be adjusted

accordingly, such as explaining the rationale behind a highly specialized approach to treatment during an intake session. Yet, this does not address motivation *during* therapy. Heider and colleagues (in press) address this differentiation of phases during treatment. They argue that not the overall "readiness to change" is decisive, but its subcomponents based on time. This distinction in time, i.e. the role of these factors before and during treatment, has not been made in this study and would be valuable to investigate the future.

The other noteworthy cluster is low self-esteem, which can also be conceptualized as self-compassion. A number of the factors identified in this study may connect with Neff's (2003) definition of self-compassion, such as acceptance of life with symptoms and the ability to take on another perspective by the patient. Self-compassion has been identified as a "potential clinically relevant factor" that may influence the outcome of therapy when treating somatoform disorders (Dewasaran-van der Ven et al., 2018, p. 38). Self-compassion may be relevant especially for patients with SSD as it focuses on acceptance of the self and one's experiences, thereby lowering the levels of pain experienced (Dewasaran-van der Ven et al., 2018). As self-compassion appears to be more easily improved than self-esteem (Barnard & Curry, 2011; Neff, 2003), addressing self-compassion may have a significant facilitating impact both before and during treatment.

Another finding of this study is the division of the clusters into two groups, general and individual. All clusters labeled as general were either specific to SSD or related to factors all patients in need of mental health support are expected to face. Therefore, these should be discussed with all incoming SSD patients not in terms of "if" these elements are present, but "how" and "to what extent". These can be assumed to play moderating roles in treatment success and, in line with Deary, Chalder, and Sharpe's (2007) approach, both a predisposing and perpetuating role. In contrast, all clusters labeled as individual appear to play a role *if* they are present. As they appear to play a perpetuating role, they can be addressed through therapeutic intervention. The specific form would depend on if they are helpful (e.g. a supportive system) or hindering (e.g. language barriers) in attaining therapy goals.

A notable observation is the lack of reflection of the particular role of the professional, with only one factor (41) referring to a purely therapist characteristic. This falls in line not only with the illness-orientation in treatment, but also to what has been referred to as the "uniformity assumption" where the therapists' personality characteristics, technique factors, differences in skill and experience, and ability

in interpersonal skills are not considered (Kiesler, 1966). The lack of reflection of therapist diversity may be due to the general attitude of psychotherapists to put the responsibility for change in the patient's hands and seeing oneself as a "mere" facilitator. Furthermore, as a professional answering the question of what factors play a role in therapy goal attainment, it may also be confronting for them to reflect on differences in skills or roll of experience between oneself and colleagues, whom they may have never observed to begin with. This element would be interesting to compare in future research utilizing the perspectives of patients instead of professionals, where more therapist characteristics may come forth.

A strength of this pilot study is that professionals were involved in every phase of this concept mapping study. The factors found are empirically grounded in practice, and therefore highly relevant for practitioners. This was enhanced by the hierarchical cluster analysis, which analyzed qualitative data to give objectively derived output. Furthermore, both resilience and vulnerability factors were studied, giving a broader perspective than a problem-focused approach. The rating of individual to general factors is a new contribution, as no earlier research in the area of somatic disorders has studied this.

The limitations of this study include the small sample size. Saturation was also not reached with the interviews. Additionally, due to the majority of interviews being carried out by email instead of in person, participants did not appear to understand instructions clearly. Furthermore, internal validity is problematized due to causality: It is not clear if the clusters identified occurred parallel with SSD without influencing therapy, or if the clusters actually impacted therapy success rates directly. Finally, a problem with external validity remains due to potential selection bias, as the majority of respondents were psychologists, of whom many worked in the same institute.

This study provides a first step in addressing the full diversity of SSD patients and to developing more individualized interventions and measurement instruments. This insight into (potential) influencing factors, where the vulnerabilities and strengths of the individual patient mold the intervention, can enable therapists to individualize their treatment. This falls in line with the patient-centered care that, through increased personalization, improves therapy outcomes. Patients with somatic symptom disorder face many challenges due to their illness, and placing them at the center of treatment by incorporating their idiosyncratic circumstances, both past and present, may be an important step to improve their quality of life.

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Appendix A

Literature Review

A scoping literature review was carried out in order to obtain more insight into the types of factors that a patient with somatic symptom disorder and similar disorders can face while receiving treatment from a mental health practitioner. This was done in order to formulate a clear hypothesis regarding factor types. The review additionally provided a preliminary set of factors that were used for the concept mapping part of the study.

The literature review was completed utilizing the *Web of Science*, performed in September and October of 2017. Key search terms included, but not limited to: "Somatoform", "somatic symptom disorder", "barriers", "facilitators", and "outcome". The "view related records" option was used to find additional articles, as well as relevant sources cited in the articles read. Meta-analyses, articles, and reviews were included.

No difference was made between studies with regard to in-patient or outpatient status or if there were specialized facilities or general practitioners. Whereas the study revolves specifically around SSD, the literature review also included related disorders such as "functional somatic symptom" (FSS), "medically unexplained symptoms" (MUS), and "unexplained physical symptoms" in order to ensure a broad basis of factors. Although these are not strictly speaking the same diagnoses, the psychological burden the somatic symptoms carry in these disorders relates them sufficiently to the current SSD diagnoses as to make relevant contributions to the review. Specifically, FSS contains less severe cases and lower amounts of mental comorbidities than SSD, but both FSS and SSD overlap in terms of both being comprised of a complex interaction between psychological, social, and biological elements next to their somatic symptoms. MUS was included because the psychological burden the somatic symptoms are sufficiently similar to SSD and also because MUS treatment faces similar limitations in effectiveness as described for SSD (Heijmans et al., 2011), which suggests there may be similar underlying factors playing a role. "Somatoform disorder" was also included as it is the previous DSM conceptualization of SSD and therefore has a high symptom overlap. Therefore the barriers revealed in treatment of these populations are expected to be similar to the ones experienced by people with SSD.

Studies were excluded if they referred to the treatment of children or teenagers, if SSD was an element of another diagnoses (such as PTSD with somatic symptoms or predictors of somatic symptoms in depressive disorder), and if only SSD diagnosis was discussed, without treatment or outcome results. Furthermore, no studies regarding tinnitus were included as it is considered to required specialized treatment (Hiller, Fichter, & Rief, 2003) and therefore outside the scope of this study.

A specific focus was set on finding studies indicating the relevant factors from the perspective of the professionals themselves, in contrast to patient perspective or academic analysis.

Results

Few studies have addressed the question of what factors influence therapy outcome within the framework of psychosomatic treatment. This underlines the "limited success" of obtaining an overview of individual factors as noted earlier (Beutel et al., 2005).

Of the nine studies included, two included the perspectives of mental health professionals. The first examined perpetuating factors for functional somatic symptoms in relation to self-help using a concept mapping method (Janssens et al., 2017). The results indicate 16 clusters such as "preoccupation with the symptoms" and "frustration or despair regarding the symptoms". The second study was a systematic review with qualitative analysis of editorials and narrative reviews combined with focus group interviews for medically unexplained symptoms (MUS) (Heijmans et al., 2011). The research identified the most important elements in the management of MUS from the perspective of general practitioners. In contrast to the study by Janssens and colleagues (2017), this study focused on the management of the disorder, implying that individual factors of patients were not addressed.

The rest of the literature review was made up of seven studies that determined barriers and facilitating factors for patients' therapy outcome from the perspective of patients or as determined by the results of research such as meta-analyses. The results can be reviewed in Appendix A.

Appendix B

Overview of factors derived from literature

Cluster	Factor	Authors
1. Emotional		
1.1	Sense of shame or failure due to the symptoms perpetuates the illness	Janssens et al., 2017
1.2	Frustration or despair regarding the symptoms perpetuates the illness	Janssens et al., 2017
2. Cognitive		
2.1	Difficulty perceiving and interpreting emotions and physical processes perpetuates the illness	Janssens et al., 2017
2.2	Somatic fixation perpetuates the illness	Janssens et al., 2017
2.3	Excessive concerns about the symptoms perpetuates the illness	Janssens et al., 2017
2.4	High preoccupation with the symptoms perpetuates illness	Janssens et al., 2017
2.5	Non-acceptance of symptoms as a barrier to successful treatment outcome perpetuates the illness	Janssens et al., 2017
2.6	Higher psychological stress due to symptoms before treatment improves motivation for therapy	Timmer, Bleichhardt, & Rief, 2006
2.7	Readiness to change: low pre-contemplation ("individual does not yet perceive the problem and, therefore, has no intention of changing his or her behaviour", p. 2) were related to higher chances for positive therapy outcomes; lower <u>action</u> values ("the individual has already actively started to apply strategies for changing his or her behaviour", p. 2) was associated with higher chances for positive therapy outcome	Heider, Köck, Sehlbrede, & Schröder, in press
2.8	Openness to psychotherapy before starting treatment implied higher motivation towards therapy and therefore better results in long-term	Timmer, Bleichhardt, & Rief, 2006
3. Behavioral		
3.1	Avoidance behavior perpetuates illness	Janssens et al., 2017
3.2	Adverse physical factors or counterproductive lifestyle perpetuates illness	Janssens et al., 2017
3.3	Making unrealistic demands on self perpetuates illness	Janssens et al., 2017
3.4	Excessive use of care facilities perpetuates illness	Janssens et al., 2017
4. Interpersonal relationships (excluding therapeutic relationship)		
4.1	Maladaptive interpersonal relationship patterns have a negative impact on long-term therapy outcome	Janssens et al., 2017 Beutel et al., 2005
4.2	If a patient has a relationship they can confide in , this is also a positive predictor of long-term outcome	Beutel et al., 2005
4.3	Problems fulfilling roles perpetuates illness	Janssens et al., 2017
4.4	Feeling too little acknowledgement of suffering or restrictions perpetuates illness	Janssens et al., 2017
4.5	Difficulty asking for help perpetuates illness	Janssens et al., 2017

5. Societal		
5.1	If claims for invalidity pensioning before starting treatment, then a lower willingness to change and lower motivation for treatment was found	Timmer, Bleichhardt, & Rief, 2006
5.2	Vocational reintegration as predictor of positive long-term outcome	Beutel et al., 2005
6. Therapeutic context		
6.1	General practitioner (GP) less successful in positive outcome than mental health care professionals (aside from addressing overuse of health care)	Kleinstäuber, Witthöft, & Hiller, 2011
6.2	* Comorbidity MDD, social phobia or panic disorder better therapy improvements than patients without additional disorders But MDD noted in 'no effects', see Leibbrand, 1999	Hiller, Fichter, & Rief, 2003
6.3	Type of therapy: reattributional training improves therapy outcome for UPS (unexplained physical symptoms), specifically reducing health care utilization and for reducing physical symptoms vs. BMI (behavioral medical intervention) for reducing general psychopathology	Kleinstäuber, Witthöft, & Hiller, 2011
6.4	Higher number of therapy session improved reduction of physical symptoms, disorder specific cognitions, emotions and behaviors, and depressive symptoms of UPS (but increased health care utilization)	Kleinstäuber, Witthöft, & Hiller, 2011
6.5	A high quality of diagnostic procedure was associated with a positive change of disorder specific cognitions, emotions, and behaviors of UPS; authors assume this "facilitates a fit" between patient needs and therapy content	Kleinstäuber, Witthöft, & Hiller, 2011
6.6	Outpatient more effective in treating disorder specific cognitions, emotions and behaviors (vs. inpatient more effective in reducing health care utilization)	Kleinstäuber, Witthöft, & Hiller, 2011
6.7	High psychotherapeutic treatment expectations before starting treatment leads to higher motivation, which leads to more (long-term) improvement	Timmer, Bleichhardt, & Rief, 2006
6.8	Bad relationship with healthcare professionals including lack of trust perpetuates illness	Janssens et al., 2017
6.9	Multi-component approach including (1) creating a safe therapeutic environment (i.e. doctor-patient relationship & communication), (2) generic interventions (i.e. motivational interviewing, explanation of symptoms, reassurance, regularly scheduled appointments), and (3) specific interventions (i.e. cognitive approaches, esp. CBT, pharmacotherapy, activating therapy, complementary and alternative medicine) important in managing MUS (medically unexplained symptoms)	Heijmans et al., 2011
7. Demographic		
7.1	Younger age improved motivation for therapy and greater benefit from therapy	Timmer, Bleichhardt, & Rief, 2006; Kleinstäuber et al., 2011
7.2	* Higher education improved motivation for therapy but others found greater improvements in people with lower education	Timmer, Bleichhardt, & Rief, 2006; Kleinstäuber et al., 2011
7.3	* Women benefit more from therapy (UPS) than men	Hiller, Fichter, & Rief, 2003

No impact

- | | |
|---|--|
| 1. Existence of personality disorders | Leibbrand, 1999; Hiller, Fichter, & Rief, 2003 |
| 2. Having MDD and anxiety | Leibbrand, 1999 |
| 3. Comorbid ("concurrent") disorder | Yasky, 2016 (but see Hiller, Fichter, & Rief, 2003 above) |
| 4. Negative illness consequence , i.e. illness experiences and symptom-related suffering | Timmer, Bleichhardt, & Rief, 2006 |
| 5. Psychosocial lay etiology , i.e. degree of psychosocial vs. somatic causal illness attributions | Timmer, Bleichhardt, & Rief, 2006 |
| 6. * Gender (no difference in motivation) | Timmer, Bleichhardt, & Rief, 2006; Yasky, 2016; Kleinstäuber et al. 2011 |
| 7. Previous psychotherapy experience makes no difference in motivation | Timmer, Bleichhardt, & Rief, 2006 |
| 8. Family status , neither divorced nor married makes a difference | Hiller, Fichter, & Rief, 2003 |

Note. Factors marked with an asterisk (*) have been found to play opposing role as well.

Appendix C

Instructions and questions that guided the interview (oral and through e-mail)

Interview *"Individuele doelen en factoren die doelen belemmeren en bevorderen bij patiënten met somatisch-symptoom stoornis vanuit het perspectief van de professional"*

Er zijn twee doelen van dit onderzoek: Ten eerste willen we meer kennis verkrijgen over de individuele doelen die patiënten bij een behandeling kunnen hebben. Ten tweede willen wij ook graag horen wat voor belemmeringen en succesfactoren een rol kunnen spelen bij het bereiken van deze doelen. Hierbij zoeken wij naar factoren die gelden voor specifieke personen en naar meer algemeen geldige factoren.

We vinden het fijn dat u zo veel ervaring heeft in het behandelen van patiënten met somatisch-symptoomstoornis en willen daarom graag van u expertise gebruik maken. Dus noemt u vooral alles op wat u kunt bedenken.

Dit interview (per e-mail) gaat ongeveer 60 minuten duren. Wij vragen u om dit in een keer in te vullen en de tijd te nemen om goed over uw antwoorden na te denken.

We willen nu graag horen wat voor belemmeringen en succesfactoren een rol kunnen spelen in het bereiken van deze doelen. Wilt u allereerst opschrijven welke belemmeringen en succesfactoren het bereiken van een doel zouden kunnen beïnvloeden?

[Deel 1: vragen m.b.t. individuele therapie doelen: MSc thesis on therapy goals written parallel to this thesis by Isabella Boon]

Deel 2: Opening vraag

U heeft net diverse individuele doelen genoemd. We willen nu graag horen wat voor belemmeringen en succesfactoren een rol kunnen spelen in het bereiken van deze doelen. Wilt u allereerst opschrijven welke belemmeringen en succesfactoren het bereiken van een doel zouden kunnen beïnvloeden?

Deel 2: Ondersteunende vragen

- Welke belemmeringen kwam u bij de laatste vijf patiënten tegen?

- Welke succesfactoren kwam u bij de laatste vijf patiënten tegen?

- Als u aan uw meest complexe / zwaarste patiënten terugdenkt, welke belemmeringsfactoren en succesfactoren hebben een rol gespeeld in het bereiken van hun individuele doelen?

- En bij de minst complexe / makkelijkste patiënten?

Deel 3: Opmerkingen

Mocht er iets buiten de boven gestelde vragen zijn dat u graag wilt meedelen, dan kunt u het hier invullen.

Dit is het einde van het interview.

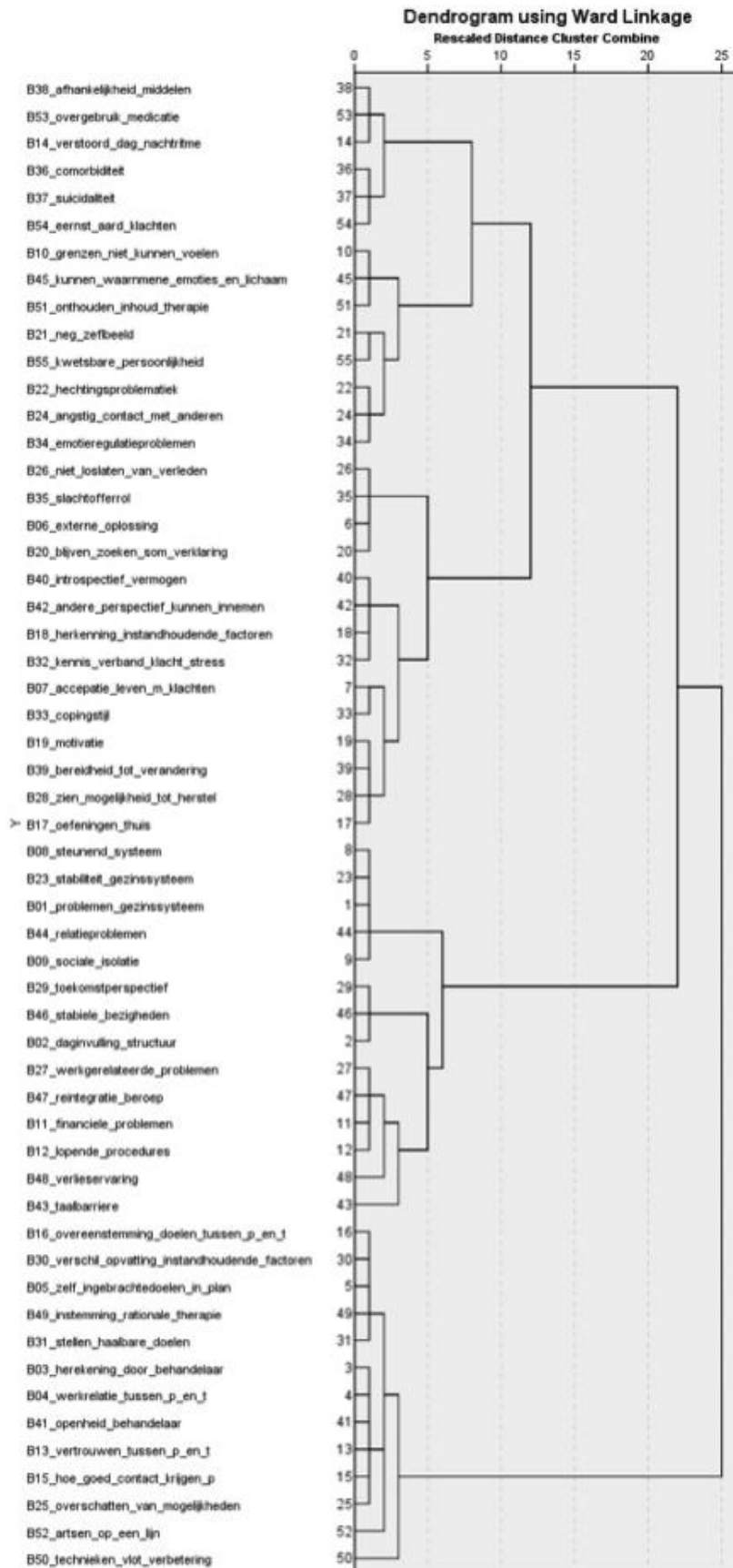
Er zijn nog een aantal vragen over persoonlijke gegevens. Deze gegevens zijn nodig omdat we de groep van onderzoekdeelnemers moeten karakteriseren; we presenteren in publicaties uitsluitend gemiddelden en aantallen.

Vragenlijst demografische gegevens

1. Geslacht:
2. Leeftijd: (jaren)
3. Beroep:
4. Jaren werkervaring met somatisch-symptoom stoornis: (jaren)
5. Aantal uren per week werkzaam met patiënten met somatisch-symptoom stoornis: (uren per week)
6. Naam instelling waar u werkt

Appendix D

Dendrogram



Appendix E

Full name of factors (as received by participants)

Het bereiken van behandeldoelen wordt positief of negatief beïnvloed door...

- 1) problemen in het gezinssysteem zoals verslavingsproblematiek, ziekte van een familielid
- 2) de invulling en structuur van de dag
- 3) het zich herkend en serieus genomen voelen door de behandelaar
- 4) een goede werkrelatie tussen patiënt en behandelaar
- 5) door de patiënt zelf ingebrachte behandeldoelen in het behandelplan opnemen
- 6) de hoop die een patiënt blijft houden op een externe oplossing of dat iemand anders met een oplossing komt
- 7) acceptatie van het leven met klachten
- 8) een steunend systeem
- 9) sociale isolatie
- 10) zijn of haar grenzen niet kunnen voelen
- 11) financiële problemen
- 12) lopende procedures zoals letselschade procedure of procedure over uitkering of UWV
- 13) vertrouwen tussen patiënt en behandelaar
- 14) een verstoord dag-nachtritme
- 15) hoe goed contact te krijgen is met de patiënt
- 16) overeenstemming over doelen tussen behandelaar en patiënt
- 17) een patiënt die in oefeningen voor thuis investeert
- 18) Het herkennen van instandhoudende factoren door een patiënt
- 19) motivatie
- 20) het op zoek blijven naar een somatische verklaring of oplossing (operatie of medicatie) door de patiënt
- 21) Het hebben van een negatief zelfbeeld en straffende stijl van denken over zichzelf
- 22) hechtingsproblematiek bij de patiënt
- 23) stabiliteit binnen het gezinssysteem
- 24) angstig zijn, met name in contact met anderen
- 25) het overschatten van de mogelijkheden van de patiënt
- 26) het niet loslaten van het verleden (toen men nog gezond was)
- 27) werkgerelateerde problemen
- 28) het zien van een mogelijkheid tot herstel door de patiënt
- 29) het hebben van een toekomstperspectief door de patiënt
- 30) een verschil in opvattingen over instandhoudende factoren tussen patiënt en behandelaar
- 31) het stellen van haalbare doelen
- 32) kennis en inzicht over het verband tussen klachten en (chronische) stress
- 33) de copingstijl van een patiënt
- 34) emotieregulatieproblemen
- 35) in een slachtofferrol zitten
- 36) comorbiditeit, zoals depressie, angstklachten, ADHD, persoonlijkheidsstoornis, eetproblematiek, PTSS, autisme, dissociatie
- 37) suïcidaliteit
- 38) afhankelijk zijn van middelen (alcohol, drugs)
- 39) de bereidheid tot verandering
- 40) introspectief en reflectief vermogen van een patiënt
- 41) een behandelaar die durft open te staan voor wat de patiënt echt bezighoudt van binnen
- 42) een ander perspectief kunnen innemen door de patiënt
- 43) een taalbarrière
- 44) relatieproblemen
- 45) Het kunnen en willen waarnemen en delen van emoties en bijbehorende lichaamssignalen

- 46) stabiele, betekenisvolle bezigheden
- 47) re-integratie in beroep
- 48) verlieservaring of andere grote levensgebeurtenis tijdens de behandeling
- 49) instemming met de rationale van therapie
- 50) hoopgevende technieken waarmee vlot enige verbetering kan worden bereikt (zoals EMDR, gedoseerd dagschema)
- 51) het kunnen onthouden en integreren van wat er in een therapiesessie is gezegd
- 52) artsen die op één lijn staan zodat er duidelijkheid over de diagnose bestaat
- 53) overmatig gebruik van medicatie (pijnstillend, kalmerend, slaapmedicatie)
- 54) de ernst en aard van de lichamelijke klachten
- 55) het hebben van een kwetsbare persoonlijkheid