

**Patient's Perspective on Influencing Factors on Goal Fulfilment in Treatment of
Somatic Symptom and Related Disorders: A Thematic and Text Mining Study**

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Abstract

Background: Somatic Symptom and Related Disorders (SSRD) have a negative influence on the quality of life. The preferred treatment, cognitive behavioural therapy, is limited in achieving symptom reduction. Understand influencing factors on treatment goal fulfilment can improve treatment.

Objective: This study aims to contribute a comprehensive overview of influencing factors from the perspective of patients. Goal fulfilment literature is evaluated and the clinicians' perspective is compared. In clinical application, these factors can support shared decision-making, optimise customised treatment and ultimately increase treatment effects for patients with SSRD.

Method: Following Delphi procedure, 154 individual influencing factors are provided by patients ($N = 12$) and a card sorting task is fulfilled by patients ($N = 2$). Thematic analysis is applied on the sorted categories. Text mining analysis triangulates the method, selecting keywords from the statements.

Results: Thirteen categories are specified in the card sorting task, sorted further into four themes: The treatment, therapist, social context and the client's situation. Through text mining twelve regularly recurring words emerged, highlighting three keywords: health care, environment and therapist (frequency ≥ 14).

Conclusion: The findings point out different areas to be cautious of during treatment. The findings comply goal striving theory. Multiple differences are brought to light with the clinicians' perspective such as more awareness of the practical side of treatment and a nuance in the responsibility for treatment goal achievement. The constructed overview can form a base for further research to improve SSRD treatment.

Patient's Perspective on Influencing Factors on Goal Fulfilment in Treatment of Somatic Symptom and Related Disorders: A Thematic and Text Mining Study.

In the group of somatic symptom and related disorders (SSRD) bodily symptoms are experienced combined with excessive thoughts, feelings or behaviours (American Psychiatric Association [APA], 2013). The somatic symptoms can be part of a diagnosed physical illness or be (partly) medically unexplained (Van der Feltz-Cornelis & Van Houdenhove, 2014). They can be persistent and appear in different ways, like pain or loss of bodily symptoms (APA, 2013). The disorder can involve disproportionate and persistent thoughts about the symptoms, a continuing high level of anxiety about the symptoms or excessive time and energy devoted to one's symptoms or health (APA, 2013). SSRD symptoms can cause substantial functional impairment and negative influence on the daily life of patients (De Waal et al., 2004). Additionally, SSRD are frequently comorbid with anxiety or depressive disorders, adding to the severity of the symptoms (De Waal et al., 2004). Previously called somatoform disorders, the group of SSRD currently includes somatic symptom disorder, functional neurological disorder, illness anxiety disorder and more in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; APA, 2013; Van der Feltz-Cornelis & Van Houdenhove, 2014).

SSRD is a common group of disorders, estimated to be prevalent in 6% of the general population, 16% in primary care and up to 33% in secondary care (Houtveen et al., 2015). Cognitive behavioural therapy (CBT) is the preferred treatment for SSRD (GGZ Standaarden, 2011). The rationale in CBT is that thoughts and behaviours have a big influence on symptoms, for instance that dysfunctional thoughts and misjudging symptoms can magnify physical symptoms (Tak & Ludden-Loman, 2018). CBT aims to alter these thoughts and behaviours (Korrelboom & Ten Broeke, 2013; Tak & Ludden-Loman, 2018). Other effective treatments include insight-focused psychotherapy, acceptance-based interventions, or a

mindfulness-based form of CBT (Abbass et al., 2009; Houtveen et al., 2015; Lakhan & Schofield, 2013). Despite being seen as an effective treatment by improving quality of life with SSRD symptoms, CBT is limited in the reduction of complaints (Kroenke, 2007; Spaans & Van der Boom, 2018). So far, SSRD are still seen as difficult to treat (Klemm et al., 2018).

To improve SSRD treatment, research into patients' preferences is needed (Van der Feltz-Cornelis et al., 2018). Generally, the therapist and patient establish *treatment goals* at the start of treatment: target points for the desired outcomes of therapy (Kunnemann et al., 2016; Michalak & Grosse Holtforth, 2006). When these are fulfilled, the therapy is considered successful. Examples of treatment goals include gaining resilience, self-confidence, or psychological adjustment to the situation (Klemm et al., 2018). Currently, these treatment goals are derived from a general questionnaire which do not always fit the patients' needs, especially considering comorbid disorders (Houtveen et al., 2015). As a result, it is challenging to assess barriers and facilitators to treatment goals, when a patient makes insufficient progress. Such barriers and facilitators are *influencing factors* to goals. To current knowledge no prior research focussed influencing factors from the perspective of SSRD patients. In line with patient-centred care, patients' competence should be trusted to know what they need and the patients' perspective needs to be considered (Deci & Ryan, 1985; Pelzang, 2010).

A preceding study, highly similar to the current one, was conducted from the perspective of clinicians aiming to identify the most important goals and factors in treatment success of SSRD (Hijne et al., 2022). Clinicians have knowledge about treatment effects and possible barriers and facilitators (Charles et al., 1997). Consequently, it is expected that the factors given by clinicians will be named as influencing factors by patients as well. The results are divided into four categories: the therapeutic alliance, social and everyday context, the ability to change and psychological vulnerability (see Appendix A). In this study it would

be interesting to find differences between the clinicians' and patients' responses, as this could show a gap in the shared understanding of influencing factors to successful treatment.

General goal striving theory provides a background on influencing factors. Four elements are indicated for well-being in goal striving: commitment to goals, goal realisability, the fit of goals and progress (Michalak & Grosse Holtforth, 2006; based on Brunstein & Maier, 2002). See Appendix B for a model. These four elements increase motivation in goal striving. Hence, in psychological treatment is important to make goals personally realisable, fitting to the individual and keep track of progress to increase motivation and commitment (Klemm et al., 2018; Pelzang, 2010; Westermann et al., 2019). Therefore shared decision-making between patient and therapist is essential (Michalak & Grosse Holtforth, 2006). In compliance with self-determination theory, the patient's competence should be trusted, they should be given autonomy and relatedness needs to be created by therapists (Deci & Ryan, 1985; Ryan & Deci, 2000). The patients' statements on influencing are expected to relate to goal striving theory.

Summarising, this exploratory study aims to identify and structure influencing factors on the fulfilment of treatment goals from the patient's perspective. These factors could reflect elements of the general goal striving theory, namely commitment, realisability of goals, progress and fit of goals contributing to motivation (Michalak & Grosse Holtforth, 2006). Comparable factors to those indicated by clinicians can be expected to be found, being the therapeutic alliance, social and everyday context, the ability to change and one's psychological vulnerability (Hijne et al., 2022). Making patients' influencing factors comprehensive for practical application could support shared decision-making, optimise customised treatment and ultimately increase treatment effects for patients with SSRD.

Method

Procedure

The setup of this study is based on Delphi-procedure and uses mixed methods (Hsu & Sandford, 2007; Nasa et al., 2021). Patients' statements are collected through a survey or interview. As the goal was to thematically organise the statements, guidelines from the concept mapping technique were adhered in the filtering of the statements (Selten et al., 2017). Then a workgroup seeks a consensus on qualitative categories of influencing factors in a card sorting task (Trochim, 1989). After, these categories are analysed in thematic analysis (Braun & Clarke, 2008; Neuendorf, 2018). Next, all the statements are evaluated in quantitative text mining analysis by selecting frequently occurring words. This way, keywords from the statements can be determined (Dreisbach et al., 2019; Silge & Robinson, 2017). Ethical approval was granted by the board of the faculty of social and behavioural sciences of Utrecht University (*FETC21-0335*) and by the local participating health care institutions. Ethical guidelines were followed concerning personal data (Utrecht University, n.d.)

Participants

A few requirements were set to participate. Participants ought to be 18 years or older, speak Dutch, have a SSRD diagnosis and follow or have followed treatment. To find participants, collaborating mental health care institutions were contacted. The contributing institutions were GGZ Ingeest, GGZ Breburg and Altrecht Eikenboom, which all treat SSRD. For participants, treatment at one of these institutions was likely, but not a requirement. Interested patients received the information letter from a local colleague with the option to sign up for the study. The response rate to the study was low, out of 150 letters sent, 5 responses were received. The focus on institutions working with severely challenged populations where many of the patients already followed intensive therapy may have

contributed to the lack of response (Stichting Topklinische GGZ, n.d.a.). Furthermore, 3 out of 5 patients decided to discontinue participation. This may have been due to time between sending the letter with interest and receiving the survey or interview date response.

Considering difficulties finding participants, previously gathered data (outcomes of the survey and interviews) by colleague researchers was included in this study to provide a more reliable sample size. They used corresponding methodology and this extended the sample to 12 participants.

Instruments

A short questionnaire of eight questions on demographic characteristics was answered by participants, including age and received treatments. Then the survey or interview was conducted: face-to-face, online or as online survey. Following a short explanation, two open-ended questions were asked to indicate which factors can help to reach one's goals in treatment and which factors can form a barrier. These were asked separately to enable the participants to identify and expand on different influencing factors. In the interview the same questions were asked as in the survey, differing in the increased opportunity to ask clarifying questions to the participant.

Statistical Analysis

Qualitative approach: Card sorting and thematic analysis

The qualitative analysis is split into multiple steps, where the collected statements will be subdivided into categories and overarching themes.

Step 1. Pre-filtering. To select representative statements the researchers -two students of the clinical psychology master's programme at Utrecht University- filtered the statements. The factors were filtered using criteria set in concept mapping by which duplicate statements, non-applicable statements and incomprehensible statements were eliminated (Selten et al., 2017). For example, a participant stated "to clutch a spikey ball during sessions

helps me to stay in contact with my body” which was attributed as non-applicable because it was too specific. Another participant indicated “too much focus on certain elements of life and letting other things go because of it” to be a barrier, which allocated as incomprehensible as the researchers interpreted it differently.

Step 2. Card sorting task. A workgroup was put together including two SSRD patients -one at the start of treatment, one already ended treatment- two researchers and a supervisor. The task was to categorise the filtered statements and remove any other statements if deemed non-applicable. Three guidelines were used: Between 4 and 15 categories ought to be made, consisting of 2 to 20 statements and each statement could only be placed in one category (Trochim, 1989). During this task, the patients discussed and agreed on titles for all the categories. The researchers had a guiding role.

Step 3. Thematic analysis. All the categories were reviewed by the researchers and through an inductive approach, the categories were sorted into overarching themes of influencing factors on goal fulfilment (Braun & Clarke, 2008; Neuendorf, 2018).

Quantitative approach: text mining

The quantitative analysis is done by text mining, where all unfiltered 154 statements are re-evaluated to triangulate the data. This method heightens the reliability and validity of the results.

Step 1. Tidying the statements in R studio. All statements were put into the R Studio programme (RStudio Team, 2020). All the words from the statements were listed and tidying steps were taken including removing punctuation and removing stop words such as ‘and’ or ‘I’ (Silge & Robinson, 2017).

Step 2. Selecting words named at least twice. To clear the list and find frequently named words, a first selection was made (frequency ≥ 2). This eliminated words that were too specific to one person.

Step 3. Testing sensitivity. The next step was to find several words that represented the diversity of statements while keeping a list that is comprehensive to use in research (between 10 and 20 words). For this purpose, it was tested what number of words would be presented at different cut-off scores, as the sensitivity of that score.

Step 4. Finalising the selection. Finalising steps were taken by merging a common combination and visualising the results.

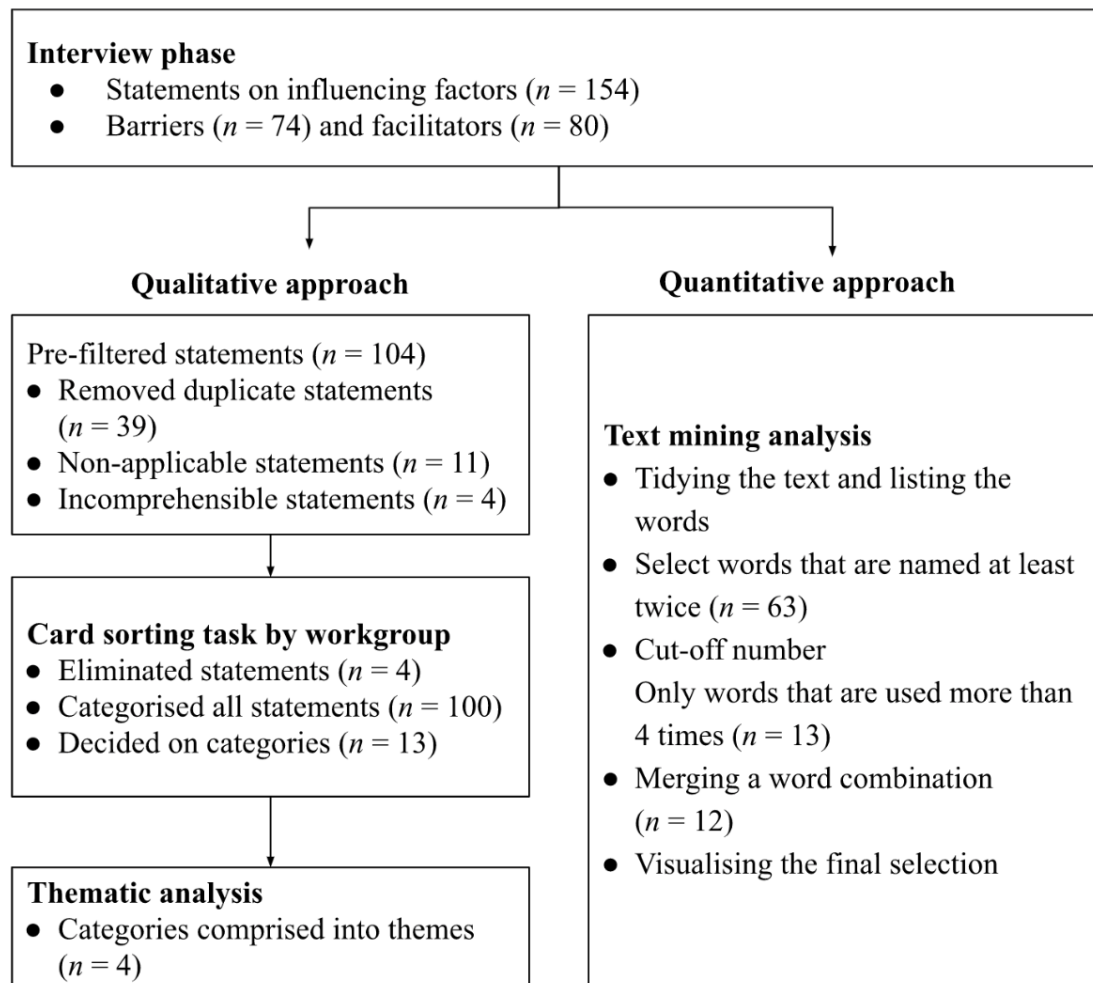
Results

Participants

12 participants were included in this study, eight participated through the survey and four in an interview. Most participants were women ($n = 11$). The participants had varying ages, most being between ages 30 and 39 ($n = 5$). The participants were diagnosed with a SSRD and 83.3% have had symptoms for 10 years or more. The participants followed CBT (67% of participants), physiotherapy (67%), received medication (50%), EMDR (17%) or other treatments like psychosomatic physiotherapy, ACT or psychomotor therapy (see Appendix C for all demographic information). The participants provided 154 influencing factors on goal fulfilment. These factors were filtered and categorised with the card sorting task and thematic analysis. Additionally, they were scanned through the text mining analysis, see Figure 1 for a flowchart of the method and resulting numbers.

Figure 1

Flowchart of statements into categories and word selection

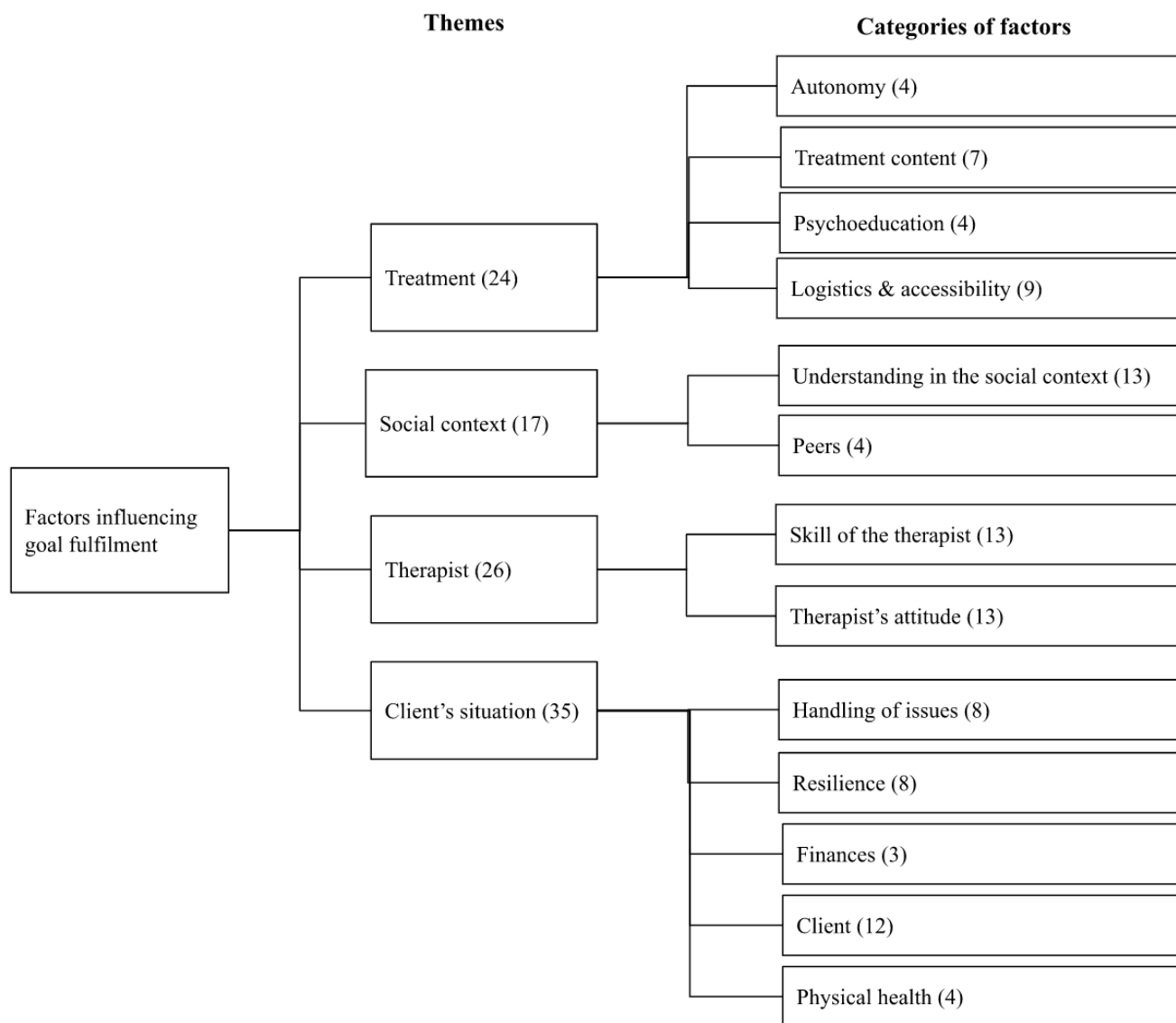


Qualitative approach: Card sorting task and thematic analysis

First, the data collection resulted in 80 facilitating factors and 74 barriers to treatment goals. In the first step, these 154 are reduced to 104 (see Figure 1). Second, during the card sorting task 4 more statements were eliminated, resulting in 100 statements divided into 13 categories. Third, in thematic analysis the 13 categories were placed into 4 themes. See Appendix D for an overview of all statements in Dutch and Appendix E for a table of themes, categories and examples in English. Figure 2 provides the results of the card sorting task and thematic analysis as an overview of the categories and themes

Figure 2

Diagram of themes and categories of factors influencing treatment goal fulfilment.



Note. The number in brackets is the number of statements within the theme or category, to give insight into the variety of the category.

Quantitative approach: Text mining analysis

After the first round of text tidying, 8 words were removed: “things”, “helps”, “factors”, “able”, “get”, “back”, “e.g.” and “certain” as these words did not indicate influencing factors on goal attainment. Multiple cut-off points were tried. Selecting a minimum of 4 mentions showed 24 words. This selection of words was considered too

ambiguous by the researchers. Selecting a minimum of 5 mentions provided 13 words, a minimum of 6 provided 10 words, and a minimum of 7 mentions provided 7 words. For the goal of finding diverse influencing factors, while keeping the amount comprehensive, the cut-off of minimum 5 mentions was chosen, selecting 13 words. Allowing combinations showed ‘health’ and ‘care’ (respectively named 22 and 20 times) to be mentioned together 19 times. Thus, these words were merged, finalising the list to 12 key terms in influencing factors. The most mentioned terms were “health care”, “environment” and “therapist”. Followed by the terms “therapy”, “feeling”, “complaints”, “understanding”, “goals”, “assistance”, “treatment”, “questions” and “physical”, named between five and eight times. Figure 3 shows the relative importance of these words. See Appendix F for the specific times words are mentioned and example statements.

Figure 3

Word cloud showing the relative importance of words mentioned at least five times



Discussion

This study aims to identify and structure influencing factors on treatment goal attainment for patients with SSRD. By trusting patients’ competence, understanding their views and taking the influencing factors into account during treatment, treatment can become

more customised and treatment success can be improved (Deci & Ryan, 1985; Pelzang, 2010). Following Delphi procedure 13 categories of factors were found, fitting into four themes: the patient's situation, therapist, treatment and social context.

The first theme from the qualitative approach is the personal situation, containing the widest range of factors. This includes the handling of issues, resilience, finances, client-specific factors and physical health. This category shows patients' self-awareness of their own role in goal attainment, for example through their coping style. Resilient coping has been shown to be important in alleviating SSRD symptoms (Kuhar & Zager Kocjan, 2021). The category physical health includes surprisingly few different statements. Like previously mentioned, SSRD symptoms can appear in many ways (APA, 2013). SSRD patients generally get referred to psychological help through medical institutions because of their somatic symptoms and less than 10% of people with SSRD accept psychological treatment (Payne, 2019). Given this main somatic component of SSRD, it is remarkable that (poor) physical health does not emerge as a broad category of influencing factors compared to the different factors relating to the client's thinking and behaviours, see Figure 2. An explanation can be that all participants in this study follow or have followed psychological treatment for SSRD and many received CBT (67%, Appendix C). This group could have learned that by adapting psychologically, physical symptoms can be influenced and possibly relieved, directing their answers (Henningsen, 2018). Another explanation may be that the questioning in this study has led to psychologically focussed answers, although intended to be open and objective. Further research may compare these findings when using differently worded questions or patients that are not already undergoing psychological treatment.

The therapist's role is the second most diverse theme. The variety of categories and influencing factors in this theme reflects the therapist's far-going responsibility (see Statements 17-28, 47-59, Appendix D; E). The therapist's responsibility has been widely

discussed in research. Kendall et al. (1992) already brought the therapist's responsibility to light, arguing that the therapist should be aware of which patients are not progressing adequately and be responsible for an alternative treatment plan. The broad responsibility of the therapist is also reflected in the code of ethics by the Dutch Institute of Psychologists (Nederlands Instituut van Psychologen [NIP], 2015). The four guiding values are responsibility, integrity, respect and expertise. One of the elements of 'expertise' for example, is for psychologists to comply with limits of their experience and expertise (NIP, 2015). This wished skill of a therapist is reflected by the statement "giving recognition from the health care when mistakes are made" (Statement 22). In addition to the category "skill of therapist" the patients separated the category "attitude of the therapist". One of the factors within the therapist's attitude is to be taken seriously by therapists (Statement 53), which seems particularly essential for this group of patients. When symptoms cannot somatically be explained, SSRD patients often hear comments like "it is all in your mind" or "it is nothing" from medics, leading to common feelings of not being taken seriously (Lucassen et al., 2007; Olde Hartman & Tak, 2019). For treatment, it is essential that the patient does feel taken seriously by the therapist to have a trusting alliance (Henningsen, 2018). This is central to more change and success in treatment (Baier et al., 2020).

The third theme covers the treatment consisting of autonomy, treatment content, psychoeducation and logistics and accessibility. Concerning treatment content, statements on goal setting and individualised treatment are made (e.g. Statements 29; 30, Appendix D; E). These elements increase motivation, in line with goal striving theory (Michalak & Grosse Holtforth, 2006). The only theoretical element that is not stated by participants is commitment. This may be due to this study's questions. However, if in clinical practice patients do not seem aware of the influence of their commitment, it can be beneficial to make this apparent. One's commitment can positively influence goal attainment and can for

example be shown through an intervention that informs on self-determination theory (Ntoumanis et al., 2021). This can have positive influences on physical and psychological health by affecting one's motivation and health behaviours (Ntoumanis et al., 2021).

Within the treatment theme, patients encourage flexibility in therapy sessions to adapt the content to the individual and allow their autonomy (Statements 26; 75). The current CBT protocol aims to be adapted to the individual. For chronic SSRD symptoms, a personalised model may be applied by mapping out all personal consequences of the symptoms to optimise the circumstances allowing symptom reduction, named the consequences model (Korrelboom & Ten Broeke, 2013). The patient is free to modify the model, giving some autonomy (Korrelboom & Ten Broeke, 2013). The diverse types of SSRD symptoms require flexible treatment (Statements 29; 31). A proposed model to select fitting treatment is to use a hybrid approach (Hodges, 2019). Here, priority domains are selected by which psychological and physical treatments are proposed accordingly. The study by Hodges focuses on different types of low back pain, which can be a somatic symptom, often being medically unexplained (Zhu et al., 2019). Adapting flexible treatment can reduce over-treatment in certain areas and allows personalising. This should be agreed upon through shared decision-making and by asking patients' preferences. Multidisciplinary treatment can also allow personalised treatment. This is standard in third-line health care where patients with severe, rare or complex disorders are treated (Keuning & Bühring, 2013). Multidisciplinary treatment includes cooperation between various medical specialists, psychologists, physiotherapists and others (Keuning & Bühring, 2013). The various psychological treatments may include acceptance and commitment therapy, hypnotherapy or body-mentalisation techniques. Multidisciplinary treatments have shown positive treatment outcomes (Keuning & Bühring, 2013).

The fourth theme is the social context. This splits up into contact with peers in treatment and understanding from others in the personal social context. In the biopsychosocial model, for example, interpersonal difficulties and relationship dysfunction show to negatively affect treatments (Pick et al., 2019). Like other disorders, SSRD encounters stigma. Lack of willpower was attributed as a cause of SSRD symptoms by a quarter of respondents from the general public in a recent study (Von dem Knesebeck et al., 2020). This attribution was associated with an increased wish for social distance from SSRD patients, shown as a reduced acceptance of that person in different social relationships (Von dem Knesebeck et al., 2020). SSRD can affect a person's whole social system, underlining the importance of understanding from others (Morabito et al., 2020). Malas et al. (2017) urge to include the family, possibly the school or workplace and other health care providers in psychoeducation. Moreover, systems therapy can be helpful to improve influencing factors within the social context. For instance when vexed communication between the patient and a significant other interferes with treatment goals (Spaans et al., 2017). Systems therapy is part of multidisciplinary treatment for various severe disorders (Spaans et al., 2017). This study highlights the importance of inclusion of the social context in treatment (e.g. Statement 64).

Furthermore, positive contact with peers is a category of influencing factors in this study (Statements 77-80). Although it is generally found that patients are hesitant to start group therapy, group-based treatment is one of the factors that make CBT particularly beneficial (Liu et al., 2019; Shay, 2021). Pointing this out to new patients can be useful. Overall, the social context is a significant fourth theme in influencing factors for SSRD treatment. Stigma can form obstacles for which it may help to include significant others in the treatment. Positive social contact with peers in SSRD treatment can facilitate goal fulfilment.

In this study, text mining was applied as a quantitative method to triangulate the data. Where the previous method shows the variety of topics within a theme or category, this

method places importance on specific aspects of the statements. This identified three keywords that underline previously noted aspects from the thematic analysis. The first keyword that emerged is “health care” regarding practical and relational aspects of treatment as influencing factors, such as the quality of health care and the importance to be seen as a person. Also the frequent use “therapy”, “treatment” and “questions” indicate the strong need for adapted treatment, without placing people under ready-made labels. There is a wish for flexible, multidisciplinary treatment as previously discussed. The second keyword in the statements is “environment” which includes the social environment and the physical environment, like feeling safe in the physical environment (e.g. Statements 39; 66; 72). The repeated attention for the environmental aspects supports the use of the previously mentioned consequences model as these factors are contributing factors to SSRD (Korrelboom & Ten Broeke, 2013). These environmental factors could be optimised with this model to benefit treatment goal fulfilment. Differing from the thematic analysis, the word “physical” comes forward as a frequently named word in patients’ statements. Although the way the physical problems do not seem to impact SSRD in very different ways, it is a central element of this disorder and SSRD cannot be treated without regard for the physical state (APA, 2013). Finally the third keyword “therapist”, magnifies the perceived responsibility of the therapist by patients. To discuss this responsibility, the clinician's perspective will be considered.

Clinicians in the study by Hijne et al. (2022) divide influencing factors into two types of categories, being the “therapeutic alliance” and “social and everyday context” as interpersonal factors and “the ability to change” and “psychological vulnerability” as personal factors. The therapeutic alliance also comes forward in the patients’ perspective in the category of the therapist (e.g. Statement 59). This topic is widely discussed in literature and seen as a mediating factor for treatment goal fulfilment (Baier et al., 2020). Therefore, the notion that both groups agree on the importance of a positive therapeutic alliance is

reassuring. By evaluating the influencing factors presented in those categories it seems that clinicians mostly identify client-specific factors. The ability to change, vulnerability and even context are all specific to the client and only the therapeutic alliance also relates to the therapist. In contrast, patients include more elements of the treatment like the content and logistic or accessibility issues. This may show that clinicians are less aware of the importance of practical elements and their impact, apart from the therapeutic alliance, as influencing factors in treatment. Working with patients with SSRD can be described as ‘arduous’ and ‘exhausting’ when a patient is somatically fixated until they start to understand their symptoms (Weigel et al., 2020). Gelfand and Irwin (2020) warn against subconsciously blaming the patient when results stagger, specifically when advised lifestyle interventions are not followed. In SSRD such advice on lifestyle interventions could be focused on learning to respect the limits of the body to avoid more symptoms, yet often clients keep overstepping their limits (Lunter & Boonstra, 2019; Tak & Ludden-Loman, 2018). Considering frustrations that may be present in treating SSRD patients, it can be wondered whether clinicians tend to give the client most of the responsibility to fulfil treatment goals. This is not necessarily negative, attributing most of the responsibility to the patient could contribute to symptom improvement (Lai et al., 2022). However, the attribution of responsibility should not overshadow other possibly influencing elements. For instance the importance of peers in treatment, the content of the treatment and logistical issues named by patients. These categories do not come forward from the clinician's perspective in the study by Hijne et al. (2022). Additionally, although the responsibility of treatment goal fulfilment is attributed mostly to patients, their autonomy is not named in this study. Following goal striving theory, giving autonomy helps to increase motivation and commitment, leading to better treatment outcome (Michalak & Grosse Holtforth, 2006). Clinicians should be aware of the balance

between the responsibility and autonomy they give patients be alert on the range of possible influencing factors.

Both clinicians and patients acknowledge the influence of psychoeducation: the process of informing and learning about disorders of a patient and involved other parties as part of a treatment (Bhattacharjee et al., 2011). Clinicians categorise “understanding perpetuating factors” as a psychological skill of patients (Hijne et al., 2022). However, patients in this study stress the importance of psychoeducation during the treatment, making psychoeducation the responsibility of the therapist. It may be challenging to give psychoeducation to SSRD patients. Many healthcare providers explain the symptoms using different labels (SSRD; psychosomatic symptoms; functional disorder; etc.) and different explanatory models while in research general terms like medically unexplained symptoms are used, that can fit a broad range of disorders (Jones, 2019; Weigel et al., 2020). These different labels and explanatory models can make SSRD symptoms confusing to explain and understand. However, this confusion makes it even more important to give psychoeducation in SSRD. Giving psychoeducation as a therapist is a core element of CBT treatment for SSRD (Spaans & Van der Boom, 2018). Clinicians should be aware of its influence on goal attainment from the patient's perspective and their role in explaining SSRD.

This study has multiple applications. Similar research suggests turning such categories of influencing factors into a screening list for the intake and follow-through (Hijne et al., 2022; Kalisvaart et al., 2012; Kan et al., 2020). Acknowledging these factors from the beginning can support customised treatment. This study encourages clinicians to reflect on their influence on treatment goal fulfilment in clinical practice. This includes their responsibility on giving psychoeducation and to be cautious not to disregard influencing factors other than the patient's responsibility. Additionally, the clinician should follow the patient's motivation, allow their autonomy and ensure shared decision-making (Deci & Ryan,

1985; Westermann et al., 2019). These applications aim to increase treatment goal fulfilment in SSRD.

This study has some limitations. For instance, this study collaborated with three specific institutions to gather participants. Two of those three institutions specifically treat severe and rare cases of SSRD (Stichting Topklinische GGZ, n.d.a; n.d.b.). The studied influencing factors may be specific to severe forms of SSRD (Van der Boom & Houtveen, 2014). As noted earlier, relatively mild SSRD is commonly treated in primary and secondary care (Houtveen et al., 2015). Research on depression with a similar method found that treatment goals and their influencing factors can change over time after a recurrence of symptoms (Kan et al., 2020). It cannot be disregarded that in the same way, influencing factors for SSRD patients may differ with a longer or worsening experience of symptoms. Inviting more primary and secondary SSRD treatment facilities in further research could clarify possible differences. Another limitation is the sparse group of five persons in the card sorting task. A minimum of 20 participants is shown to provide robust results and allow a variety of opinions (Wood & Wood, 2008). Due to time restrictions this minimum was not obtained. However, this study is part of larger research and more patients will be asked to participate. Meanwhile, the current paper provides preliminary results. This study also shows major strengths. SSRD patients provided the influencing factors and fulfilled the card sorting task. This Delphi-based method ensures that the data is analysed cooperatively, respects the patient's view on important factors and minimises the researchers' interpretation. Moreover, following the qualitative approach by text mining analysis adds to the reliability and validity of the results.

In conclusion, by finding and structuring a set of influencing factors on treatment fulfilment from the perspective of patients, this exploratory study has made its aimed contribution. The outcomes are in line with goal striving theory, although disregarding the

importance of commitment. Differences are found from the clinician's perspective concerning the therapist's responsibility for psychoeducation, the importance of the treatment content and other elements of the treatment like logistics. This study encourages clinicians to remain critical of treatment progress. Enhancing customised treatment can ultimately increase treatment goal fulfilment for patients with SSRD.

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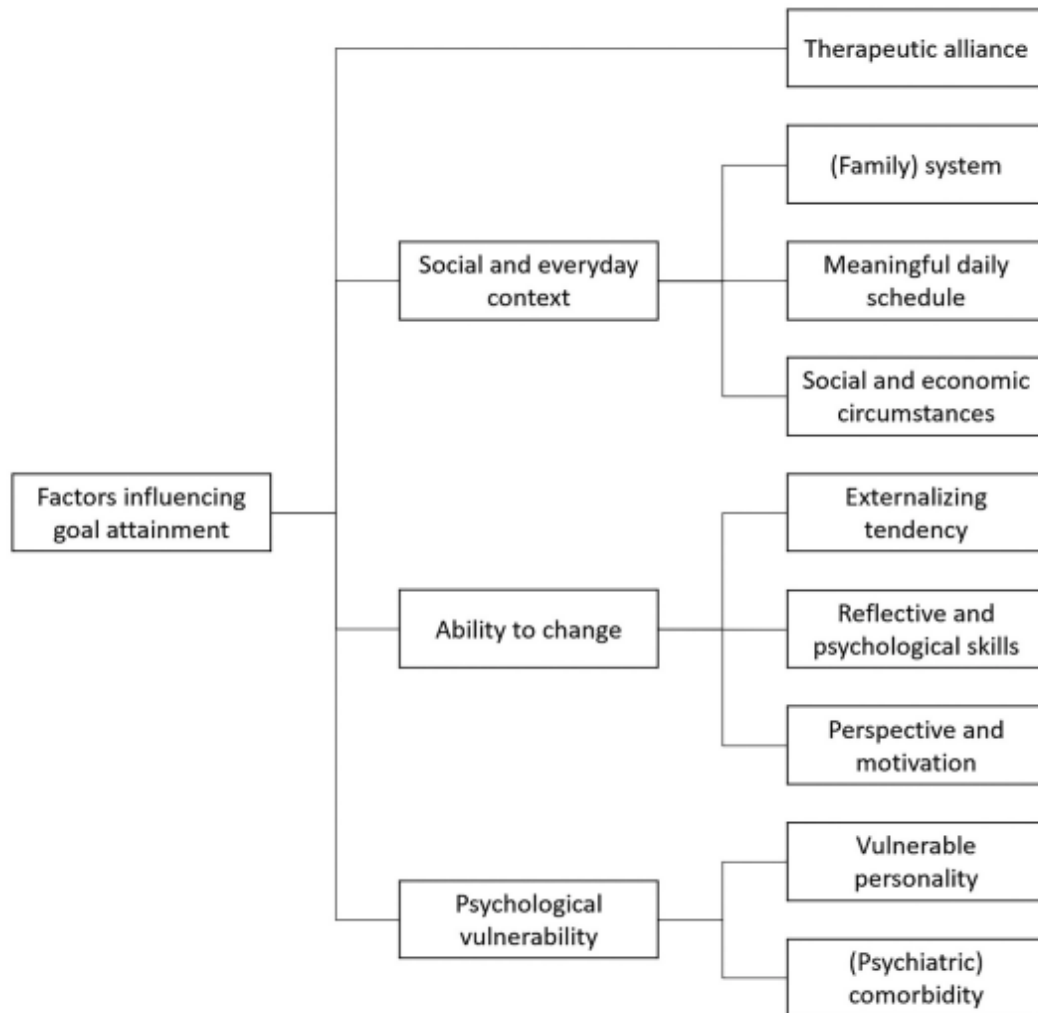
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Appendix A

Schematic representation of influencing factors according to clinicians

Hierarchical structure of influencing factors for goal fulfilment

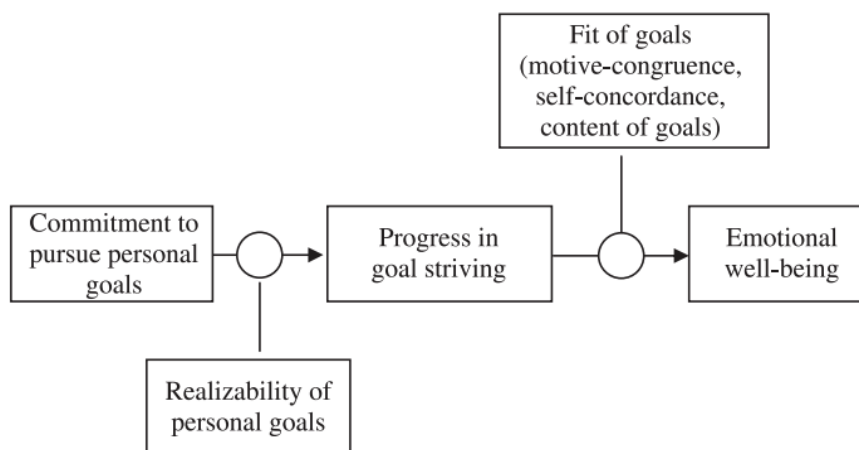


Note. Schematic representation according to clinicians working with somatic symptom disorder by Hijne et al. (2022).

Appendix B

Figure of the teleonomic model

Teleonomic model of the effect of goals on subjective well-being



Note. Model by Michalak and Grosse Holtforth (2006) as modified from Brunstein and Maier (2002).

Appendix C

Demographic information of participants

Information	Participants (<i>N</i> = 12)	Percentage
<i>Gender</i>		
Men	1	8.3%
Women	11	91.7%
<i>Age category</i>		
18-29 years old	2	16.7%
30-39 years old	5	41.6%
40 - 49 years old	3	25%
50-59 years old	1	8.3%
60 years and older	1	8.3%
<i>Duration of symptoms</i>		
1 to 3 years	2	16%
3 to 10 years	0	0%
10 or more years	10	83.3%
<i>Received treatment</i> ^a		
CBT	8	66.7%
Physiotherapy	8	66.7%
Medication	6	50%
EMDR	2	16.7%
Other treatments ^b	1	8.3%

Note. ^a Different participants have received multiple types of treatment and some participants have added ‘etcetera’ at the end of their description. Therefore, this list gives an indication of the most common and important treatments and is not a complete summary.

^b Other treatments include the following: Breathing therapy; psychosomatic physiotherapy; exposure therapy; NET; hypnosis; mindfulness; ACT; Artistic therapy; psychomotor therapy; ergo therapy; sessions with a medical psychologist. Each of the diverse treatments is named once by one of the participants.

Appendix D

Overview of all statements in Dutch divided into categories

Het bereiken van de behandeldoelen wordt beïnvloed door de volgende kenmerken:

C1 Client

1. het opleidingsniveau van de client
2. je reflectieve vermogen
3. het kunnen voelen, herkennen en uiten van emoties
4. vastgeroeste overlevingsstrategieën
5. eerdere ervaringen in de hulpverlening
6. het hebben van een uitdagende aandoening
7. te rationaliseren
8. hoe je in je vel zit
9. het doorslaan van focus op één bepaald onderdeel in het leven (waardoor andere dingen losgelaten worden)
10. uitstelgedrag
11. terugvallen in valkuilen
12. de grootte van het sociale netwerk

C2 Psychoeducatie

13. het ontvangen van informatie om begrip te krijgen voor wat er in het lichaam gebeurt
14. uitleg te krijgen over waar de klachten mogelijk vandaan komen
15. biofeedback; zien dat er fysiek verbetering plaatsvindt (zoals spieren die sterker worden)
16. het visueel maken van dingen door de therapeut

C3 Kunnen van de behandelaar

17. inzicht en verstand van de hulpverlening over de klachten
18. de kundigheid van de therapeut
19. de intelligentie van de therapeuten
20. het goed uitvragen van de lichamelijke klachten door de hulpverlening
21. een hulpverlening die meedenkt, zoals op praktisch gebied
22. erkenning vanuit de hulpverlening wanneer er fouten worden gemaakt

23. het inlevingsvermogen van de therapeut, zoals in het lijden van de cliënt
24. het spiegelen van de therapeut: emoties van cliënten verwoorden en stilstaan bij lichamelijke signalen
25. het accepteren van de klachten (zoals mogelijke aanvallen door zichzelf en de therapeut)
26. weerstand tegen gemakzuchtige therapeuten 'die de boeken napraten'
27. een keuze om wel of niet te behandelen omdat het ontwrichting kan betekenen
28. een wens voor 'pasklare etiketten' vanuit behandelaren, met vragen streng volgens protocollen

C4 Behandeling inhoudelijk

29. behandeling die wordt aangepast op het individu, het is maatwerk
30. het opdelen van grote stappen in kleine haalbare doelen
31. een combinatie van verbale en non-verbale therapieën
32. intensievere vormen van hulp als nodig, zoals verblijf in een kliniek
33. het opschrijven van alle doelen en deze concreet te maken
34. medicatie
35. het maken van dagschema's en een strakke structuur

C5 Logistiek & toegankelijkheid

36. de mogelijkheid om de therapeut te mailen en daarop terug te komen in gesprek
37. laagdrempelige hulpverlening zoals een makkelijk aanspreekpunt voor vragen
38. een flexibele omgang rondom een therapie sessie, zoals na de sessie even in de ruimte kunnen blijven zitten of tijd krijgen tussen verschillende afspraken om spanning te reguleren.
39. zich veilig voelen in de fysieke omgeving

40. wachtlijsten voor therapie
41. heen en weer geslingerd worden tussen verschillende afdelingen
42. therapeuten die vertrekken, voordat een therapie traject aan zijn einde is
43. tijdgebonden behandelingen

C6 Geldzaken

44. financiële uitdagingen
45. wantrouwen over 'zichtbare ziekte' van het UWV
46. angst voor het UWV, zoals een vrees om afgekeurd te worden

C7 Houding van de therapeut

47. de oprechte interesse van therapeuten
48. zelfvertrouwen en authenticiteit van de hulpverlening
49. hulpverlening die jouw verhaal kent en begrijpt
50. hulpverlening die de cliënt ziet als mens, als individu
51. het geduld van hulpverlening
52. humor van de behandelaar
53. serieus te worden genomen door de hulpverlening
54. een goede band met de hulpverlening en behandelaar
55. positieve bekrachtiging vanuit de zorgverlening
56. het respecteren van je grenzen door de therapeut
57. de interpretatie van de motivatie van een cliënt door de therapeut
58. de invulling die een therapeut geeft aan ervaren klachten van de cliënt
59. de vertrouwensrelatie tussen de therapeut en cliënt

C8 Begrip omgeving

60. begrip in de werkomgeving en privé omgeving
61. erkenning krijgen voor de onmacht door de klachten, zien dat het geen onwil is
62. gehoord en gezien te worden
63. te kunnen praten over de behandeldoelen met je omgeving
64. voorlichting aan je sociale netwerk en andere hulpverlening (zoals thuishulp)

65. positieve bekrachtiging vanuit de privé omgeving
66. een omgeving waar verandering mogelijk is
67. ervaring van steun van de directe omgeving en motivatie te krijgen
68. te kunnen praten over je behandeldoelen met je omgeving
69. onbegrip van de omgeving
70. een gevoel dat anderen je een aansteller vinden
71. stigma over de stoornis
72. het meedenken of tegenwerken van personen in de werkomgeving of privé omgeving

C9 Autonomie

73. de vrijheid om op je eigen tempo te gaan
74. zelf aan de slag te gaan met klachten, buiten de behandeling om
75. zelf inspraak te hebben in de stappen van de therapie waar de therapeut ruimte voor biedt
76. actie te ondernemen bij het ervaren van lichaamssignalen om deze te verlichten

C10 Lotgenoten

77. groepstherapie
78. lotgenotencontact
79. het gedrag van mede-cliënten zoals begrijpend naar elkaar zijn
80. lotgenoten die persoonlijke dingen vertellen en hun gedachtegang uitleggen

C11 Omgang met de klachten

81. het vermogen spanning te controleren, zoals zichzelf af te leiden wanneer de spanning oploopt
82. manieren te vinden om in contact te blijven met zichzelf, zoals het gebruik van een prikkel bal of te zuchten
83. angst om controle te verliezen, waarbij je overspoeld wordt door emoties
84. stress en spanning over de klachten
85. stress over opgeroepen worden voor de behandeling
86. vermijding van hulpverlening uit angst voor verhoging van spanning en mogelijke aanvallen

- 87. veel binnen te zitten in dezelfde omgeving
- 88. schaamte en schuldgevoelens die de cliënt voelt rondom de klachten

C12 Weerbaarheid

- 89. Kleine successen vieren
- 90. success ervaringen, bijvoorbeeld weer een uur kunnen wandelen zonder pijn
- 91. verbetering wel of niet te merken
- 92. het accepteren van de situatie
- 93. het zelfbeeld
- 94. je wel of niet naar waarheid te weergeven, zoals je beter voor te doen dan je bent (lichamelijk of psychisch)

- 95. geloof, zoals dat het zorgt voor een mentaliteit van 'ik moet doorgaan'
- 96. te weten wat je leuk vindt om te doen en waar je ontspanning vindt

C13 Fysiek Welzijn

- 97. Meerdere diagnoses
- 98. Hoe je er fysiek aan toe bent
- 99. Fysieke belemmeringen, zoals onvoldoende energie om met de doelen aan de slag te gaan
- 100. De algehele gezondheidstoestand, zoals door comorbide (fysieke) problemen

Appendix E

Outcomes of thematic analysis in English

Overview of categories in themes, with the number of statements and examples.

Category	Number of statements	Examples
<i>Treatment</i>		
Autonomy	4	Having a say in the steps of the therapy Taking action when experiencing bodily signals
Treatment content	7	Treatment that is customised: adapted to the individual Writing down the specific treatment goals
Psychoeducation	4	Receiving information about possible origins of the symptoms Receiving information to understand what is happening in the body
Logistics & accessibility	9	Having the possibility to email the therapist Feeling safe in the physical environment
<i>Therapist</i>		
Therapist's attitude	13	Having a good relationship between the therapist team and the client Being taken seriously by the therapist team
Skill of the therapist	13	Completeness of questions on physical problems by therapists Acknowledging possible mistakes by therapists
<i>Social context</i>		
Understanding in the social context	13	Being able to talk about your treatment goals with the social context Lack of understanding in social context
Peers	4	The behaviour of peers in treatment, like being understanding towards each other Having group therapy sessions
<i>Client's situation</i>		
Handling of issues	8	The clients' feelings of shame and guilt because of the symptoms Fear of losing control where one could be overflowed by emotions
Resilience	8	Celebrating small successes

Category	Number of statements	Examples
		Noticing improvement
Finances	3	Financial challenges Fear of the UWV ¹ like being afraid to be rejected for insurance
Client	12	Reflective capabilities Falling back into pitfalls
Physical health	4	The personal health overall, due to comorbid (physical) problems Physical barriers, like insufficient energy to work on the treatment goals

Note. The categories given in italics are the themes, the following categories are part of that theme. The number of statements included in each category give insight into the variety of responses given on that topic.

¹ UWV: Uivoeringsinstituut Werknemersverzekeringen is the Dutch employee insurance, which evaluates who is to be covered by insurance when one is unable to work.

Appendix F

Text mining results as table

Outcome of most recurring words through text mining including times recurring and examples

Term	Times recurring	Example statement (quotes)
Health care	19	Previous negative experiences in health care
Environment	16	The boundary of the environment's support
Therapist	14	A good relationship with the therapist
Therapy	9	It helps me if others also tell personal things about themselves in therapy
Complaints	7	Shame that a client feels about complaints
Feeling	7	Getting the feeling that you are not taken seriously
Assistance	6	Assistance remains calm
Goals	6	Divide steps into small achievable goals
Understanding	6	Receiving information about complaints, resulting in understanding what is happening in the body
Physical	5	It helps me if the therapist sometimes reflects on physical symptoms
Questions	5	Practitioners who only ask questions from the books hoping for a ready-made label
Treatment	5	Adapt treatment to the individual