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Changes after multicomponent group-based treatment in patients with medically unexplained physical symptoms

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ABSTRACT

Psychological treatments for patients with medically unexplained physical symptoms (MUPS) reduce somatic symptom severity only moderately. However, patients may profit from changes other than that of symptom reduction. The aim of the present study was to capture the changes that patients with MUPS experience after a multicomponent group-based treatment. Semistructured interviews with 30 patients with MUPS were undertaken after the treatment. Thematic analysis was used to identify the changes the patients reported. The changes included developing a different view of their somatic symptoms, learning how to fulfill their needs, modifying their lifestyle, and becoming open to painful experiences. The patients also noted changes in their somatic symptoms and their quality of life. Multicomponent treatment helps patients with MUPS achieve a variety of changes that reach beyond physical symptoms reduction. Patients' symptoms often worsen after a return to normal life, which calls for continual care.

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The term medically unexplained physical symptoms (MUPS) has been used for symptoms that cannot be explained by a diagnosable organic disease (i.e. a disease that can be classified using measurable biological markers) or whose presentation is not consistent with a diagnosed disease (Smith & Dwamena, 2007). Overall, the assessment of MUPS is a complex and epistemologically complicated matter (Anjum, Copeland, & Rocca, 2020). We adopted Kroenke's (2006) definition of MUPS as having at least one somatic symptom that has not been explained by somatic and psychiatric examinations and that persists for at least six months. MUPS serves as an overarching concept that subsumes the categories of somatic symptoms and related disorders (American Psychiatric Association, 2013) and somatoform disorders (WHO, 1992), as well as various functional somatic syndromes such as fibromyalgia (FM; Clauw, 2014), chronic fatigue syndrome (CFS; Whiting et al., 2001), irritable bowel syndrome (Chey, Kurlander, & Eswaran, 2015), chronic pain (Duenas, Ojeda, Salazar, Mico, & Failde, 2016), and psychogenic nonepileptic seizures (Brown, Syed, Benbadis, LaFrance, & Reuber, 2011). However, some patients with MUPS do not receive any diagnosis at all (Burton, 2003). Given this heterogeneous nature, MUPS pose obstacles

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for both patients and practitioners (Creed et al., 2010). A common characteristic of MUPS is that their recognition is based on patients' experience of symptoms for which objective organic causes are missing (Smith & Dwamena, 2007). The experience of MUPS is also culturally based, since patients' social context plays an important role in making sense of the condition (Kirmayer, Groleau, Looper, & Dao, 2004).

Experiencing MUPS is frequent, as up to 49% patients in primary care report at least one unexplained symptom within 12 months (Haller, Cramer, Lauche, & Dobos, 2015). While a majority of patients with MUPS spontaneously recover, approximately 3–10% suffer from persistent symptoms requiring long-term care (Rosendal et al., 2017), which leads to a high use of healthcare services, elevated healthcare costs, a higher risk of iatrogenic harm, and a poorer quality of life in patients (Konnopka et al., 2012). A more detailed overview about MUPS can be found in comprehensive sources, such as Olde Hartman et al. (2009).

Patients' experience of living with MUPS and changes that they may experience after psychological treatment can help us focus psychological treatments on relevant areas. Lives of people suffering from MUPS are negatively impacted in many aspects. For instance, they may feel like nobody understands them, they struggle with isolation, and they desperately search for explanations of their condition, which is accompanied by feelings of uncertainty and may often lead to disappointment regarding the healthcare system (Polakovská & Řiháček, 2021). These negative impacts of MUPS may represent possible treatment targets apart from the symptomatic change. However, treatment may help patients beyond mere remediation of the impacts that MUPS have on patients' lives.

Several mechanisms of therapeutic change in adult patients with MUPS were identified in a recent systematic review (Pourová, Klocek, Řiháček, & Čeveliček, 2020), of which, the most empirical support gained: increasing symptom acceptance, development of coping strategies, catastrophizing reduction, increasing self-efficacy, reduction of avoidance and safety behavior and positive treatment expectations. However, the authors believe that a combination of several such mechanisms is needed in a successful psychotherapeutic process.

Multicomponent psychological treatment has been recommended as the best option for patients with MUPS by experts (Heijmans et al., 2011). Such treatment should offer a safe therapeutic environment combined with generic interventions (e.g. motivational interviewing, providing reassurance and tangible explanations) and specific evidence-based interventions for MUPS (e.g. cognitive-behavioral, psychodynamic, and problem-solving psychotherapies) (Kleinstäuber, Witthöft, & Hiller, 2011; van Dessel et al., 2015). Multicomponent psychological treatments most often emphasize psychotherapy as the specific core component. The effectiveness of multicomponent treatment has not been examined in meta-analyses for MUPS in general, but there is evidence for its efficacy in patients with specific syndromes. In FM patients (Häusner et al., 2009), the treatment reduced pain, fatigue, depressive symptoms and improved self-efficacy and physical fitness at posttreatment. In CFS patients (Thomas, Sadler, & Smith, 2006), multicomponent treatment led to improvements in sleep and increased levels of activity. Group interventions within treatment may have additional advantages, as they enable patients to learn coping strategies from other patients and develop interpersonal skills (Claassen-Claassen-van Dessel et al., 2015), which were identified as therapeutic factors "imitative behavior" and "interpersonal learning/development of socializing techniques" by Yalom

and Leszcz (2020). The remaining list of therapeutic factors in group therapy include instillation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, group cohesiveness, catharsis, and existential factors.

Even though the effectiveness of psychological treatments for patients suffering from MUPS has been studied, patients have rarely been asked about the areas of changes experienced after the treatment. We identified a single study on patients' perceptions of outcome after a psychological treatment for MUPS (Claassen-Claassen-van Dessel et al., 2015). The authors reported that people suffering from MUPS achieved changes in their coping strategies such as taking control of their own wellbeing by regulating their level of activity and learning to relax. Coping was also connected with patients' acceptance of symptoms. Importantly, patients whose symptoms worsened after the treatment had stressors in their life that made them unable to cope in a newly learned way.

Claassen-van Dessel et al.'s (2015) study is limited in several ways. A small sample (nine patients) could have limited the range of identified changes. More importantly, the patients received heterogeneous treatments that ranged from primary care interventions (e.g. physiotherapy or psychological support) to specialized psychological treatments. A study focused on changes reported by patients after an intensive multicomponent treatment that integrates tools addressing psychological, physical, and social aspects of patients' symptoms within a single framework is lacking. Examining changes that patients with MUPS experience after such multicomponent treatment can provide us with a comprehensive overview of changes that benefit these patients.

Study Goals

The goal of the present study was to explore the broad spectrum of changes that patients with MUPS experienced during and after a multicomponent group-based treatment. By "group" in this paper, we refer to a group setting of the treatment as opposed to an individual one. A qualitative approach was chosen to investigate the experience of 30 patients who completed a multicomponent treatment in four outpatient therapeutic centers in the Czech Republic. Due to the explorative nature of the study, no hypotheses were defined a priori.

Method

Participants

This study was a part of a bigger project exploring the topic of MUPS. For more information about the project see (Pourová et al., 2022a). The sample comprised $N = 30$ Czech patients (19 females, 11 males). The age of the participants ranged from 25 to 59 years ($M = 38.97$; $SD = 8.03$). All participants completed the whole course of a multicomponent group-based treatment at one of the outpatient centers. The number of MUPS in individual patients ranged from one symptom up to 12, with an average of four. Most patients' difficulties were polysymptomatic ($n = 20$), while some presented with a single symptom ($n = 10$). The most frequent MUPS included various types of pain ($n = 20$), fatigue ($n = 19$), and sleep problems ($n = 9$). The symptom severity ranged from mild to severe; most patients had mild to moderate symptom intensity, as measured by

the Patient Health Questionnaire-15 (Kroenke, Spitzer, & Williams, 2002). Comorbidities included mood disorders (13%) and personality disorders (10%). At the pretreatment assessment, 19 (63%) of the patients were taking antidepressants, eight (27%) anxiolytics, four (13%) antiepileptics, and four (13%) antipsychotics; 27% did not use any psychiatric medication. While there were minor changes in medication at the posttreatment assessment, the overall number of patients who were taking psychiatric medication did not change.

Treatment

The patients in the present study completed an intensive outpatient multicomponent treatment at one of four centers in Prague, Czech Republic. The treatment was non-manualized, mostly psychodynamic, with the integration of humanistic and experiential approaches. Since not all patients participating in the therapeutic groups suffered from MUPS, the treatment was not exclusively focused on somatic symptoms. Instead, somatic symptoms were treated as one of possible types of patients' reactions to life distress (Pourová et al., 2022a). The treatment focused primarily on patients with MUPS, but it was open to patients with anxiety, depressive, and stress-induced disorders as well. The treatment did not specifically aim at the somatic symptom improvement since somatic symptoms were conceived as manifestations of distress in patients' lives. The treatment was not guided by a written step-by-step manual, and, therefore, no adherence checks were employed. The authors had no influence on the intervention.

The core of the treatment consisted of daily group psychotherapy sessions with a maximum of 11 participants and lasted from six to 12 weeks across the clinics (the modal length was eight weeks). The therapeutic groups were led as process groups and were typically cofacilitated by two therapists. Three of the four clinics provided five sessions of group psychotherapy per week, whereas one provided four sessions per week. The duration of one session was 90 minutes except for one clinic, where it lasted 75 minutes. The real number of group therapy sessions attended by the patients varied from 16 to 56 ($Mdn = 33$) depending on the outpatient center. Patients did not receive individual psychotherapy at the clinics, but they were not discouraged from continuing with their individual psychotherapy elsewhere if they had been seeing a psychotherapist before the beginning of the group therapy. None of the participants, however, attended individual psychotherapy during the treatment at the outpatient centers.

The therapists who led the group psychotherapy used a mixture of experiential, CBT, interpersonal, and suggestive-hypnotic techniques, as well as clarification and interpretation (encouraging new insights). The overarching goal of the treatment was to induce change in patients' maladaptive cognitive, emotional, and behavioral patterns.

Apart from the group psychotherapy, the same groups of patients participated in supplementary activities delivered in a group format, including art therapy (30 patients), therapeutic community meetings (28 patients), relaxation training (28 patients), movement therapy (24 patients), thematic group (20 patients), physiotherapy (16 patients), cognitive training (16 patients), drama therapy (15 patients), occupational therapy (eight patients), bibliotherapy (four patients), and music therapy (two patients). The time allocation of these supplementary activities was approximately 10 hours a week ($Mdn = 9.5$), and they were delivered by different professionals than the group psychotherapy. The

program had a unified schedule and, therefore, patients' preferences of the supplementary activities were not taken into consideration.

Psychotherapists

The group therapy was performed by 13 female and seven male therapists. Their age ranged from 25 to 59 years ($M = 42.89$, $SD = 10.58$) and their length of practice varied between 1 and 25 years ($M = 12.75$, $SD = 7.69$). Psychotherapists' self-identified theoretical orientations included psychoanalysis and psychoanalytic psychotherapy ($n = 9$), psychodynamic psychotherapy ($n = 4$), person-centered approach ($n = 3$), Gestalt therapy ($n = 2$), Daseinsanalysis ($n = 1$), and integrative psychotherapy ($n = 1$). The authors of this study did not work at the treatment centers and they were not in contact with the patients during treatment.

Recruitment

The patients were referred to the outpatient centers by a health care professional (MD or a clinical psychologist) or their psychotherapist if they had one prior to the treatment. A few patients sought the outpatient centers on their own. Once patients applied for the treatment, the clinics evaluated their suitability in an interview with a psychiatrist, clinical psychologist, or psychotherapist who worked at the clinic. The following criteria were used by the clinics to exclude patients from the treatment program: (a) a diagnosis of a severe mental disorder (e.g. schizophrenia, major depression); (b) acute suicidal tendency; and (c) a diagnosis of substance addiction. Consecutively, we used the following criteria to select participants for interviews: (a) age over 18 years, (b) the occurrence of at least one somatic symptom with a duration of at least six months not fully explained by any somatic or psychiatric diagnosis, and (c) completion of the treatment. No participants who met the selection criteria were excluded.

A total of 80 patients were contacted by e-mail three months after the end of their treatment. We chose this time point to explore not only the immediate changes patients experienced after treatment completion but also a more long-term perspective on the 3-month impact of the treatment. The e-mail outlined the research objectives, and the patients were asked for an interview undertaken either in person or via Skype. The patients who agreed to participate were interviewed ($N = 30$). The remaining fifty patients either declined to participate or did not respond to the invitation e-mail. Only one patient listed a reason for declining the interview, which was her not feeling comfortable speaking to a researcher. Patients received no compensation for participation in our study. They signed an informed consent form and were informed about their right to withdraw from the research at any time. The project was approved by the Research Ethics Committee of Masaryk University (ref. no. EKV-2017-029-R1).

Data Collection

A semistructured interview schedule was developed for the purpose of this study. It was based on the Client Change Interview (Elliott & Rodgers, 2008), from which questions related to perceived change, attributions of change, resources, and helpful/hindering

factors were used; and Change After Psychotherapy (Sandell, 1997) schedules, which guided the process of conducting the interviews itself, for instance, by advising to ask participants about specific examples of changes in order to get richer data. Additionally, our interview schedule also included questions specifically focused on somatic symptoms. Before starting the data collection, the schedule was piloted with a former psychotherapy patient who suffered from MUPS. Based on this interview, several questions were removed from the schedule due to redundancy.

The patients were asked the following broad questions: What were the reasons that led you to enter psychotherapy? What changes have you noticed since the beginning of the treatment until now? What changes related to your somatic symptoms have you noticed? What do you think caused the changes you noticed in your somatic symptoms? How did the changes progress after you returned to your daily life? Is there anything else related to your experience that you find important enough to mention? Each of these broad questions was followed by more specific probes with the intention to elicit more detailed information. The patients could also express any additional thoughts about their experience with the treatment and changes in their symptoms. To distinguish changes that could be caused by other variables than the treatment, the questions emphasized that the participants were asked about changes connected with the treatment. The participants were also repeatedly asked whether they thought that the identified changes would happen even without the treatment.

The interviews took place between July 2018 and June 2019, lasted from 60 to 90 minutes, and were audiotaped. The first author, who conducted 25 out of 30 interviews, had previous experience with conducting interviews and qualitative analysis. The remaining five interviews were undertaken by a research assistant trained by the first author. The interviews, their transcriptions, and the analysis were conducted in Czech.

Data Analysis

The audio-recorded data were transcribed verbatim, any identifying information about patients was removed, and then thematic analysis was used according to Braun and Clarke (2006).

There were seven analysis steps: (1) The first author repeatedly read the entire transcripts to become familiar with the data. (2) She coded meaning units (i.e. paragraphs containing distinct changes identified by participants) in the transcripts using ATLAS.ti software (version 8) in 26 transcripts. (3) The codes were grouped across the interviews based on their content similarity and reorganized into themes and subthemes (Clarke & Braun, 2018). The themes captured distinct changes in different areas of patients' lives (such as changes in patients' views of symptoms vs. changes in their actions used for managing symptoms). The themes were considered saturated after the analysis of 26 interviews, at which point further interviews ceased to contribute new meanings. (4) The second author audited the previous steps. He carefully read the entire transcripts, reviewed the codes and their fit with the meaning units, and provided feedback. (5) The first and the second authors revised and consolidated the themes and together wrote out a definition of each theme. (6) Four interviews that had been put aside and not coded in the previous steps were used for checking the completeness of the themes by the second author. This step did not result in any changes in the themes. (7) The first author wrote the

final descriptions of the themes, after they were revised by all authors for groundedness in the data, as well as for their clarity and organization.

Analysts

Lucia Polakovská is a psychologist and a doctoral student. Her previous area of research was related to the negative effects of psychotherapy and psychotherapy on patients with MUPS. Michal Čevelíček is a psychologist and researcher focusing on psychotherapy and specializing in qualitative methodology, with specific interest in psychotherapy integration. Jan Roubal is a psychotherapist and psychiatrist with 20 years of psychotherapeutic practice. He was trained in Gestalt therapy and involved in the psychotherapy integration movement. Tomáš Řiháček is a psychologist and psychotherapist with 14 years of part-time psychotherapeutic practice. Initially, he was trained in Gestalt therapy and endorsed a humanistic/experiential orientation. However, both his clinical and scholarly activities have been considerably influenced by the psychotherapy integration movement.

Results

The changes reported by the participants were organized into seven themes. Each of these themes captured a different area of change. The first theme showed the changes in patients' **views** of their somatic symptoms. The second and third themes captured the changes in the patients' **actions**, specifically changes in how they satisfied their needs and changes in their lifestyle. The fourth theme showed the changes related to **painful events** with which patients dealt in psychotherapy, including traumatic events and unpleasant realizations about themselves. The fifth theme revealed the changes in patients' **experiences** related to somatic symptoms, specifically the experience of not being alone with the symptoms anymore and the experience of being cared for and understood. Finally, the sixth and seventh themes captured the changes in **somatic symptoms** and broader changes connected to the improvement of patients' **quality of life**.

Theme 1: Developing a Different View of Symptoms (n = 27, 90%)

One of the changes reported by most patients with MUPS after psychotherapy was recognizing the connections between their somatic symptoms and the processes taking place in their body, mind, and lives, which, in their view, enabled them to understand their symptoms in a broader context. Patients felt that this new understanding made their symptoms more controllable and helped them reduce the symptom severity or the impact on their lives. Another change of view that patients reflected on was accepting that they could live their life well even though they had some somatic symptoms and perceiving their symptoms as being less threatening than before.

Understanding the Link Between Symptoms and Psychosocial Aspects (n = 23, 77%)

During treatment, most patients seemed to have expanded their understanding of the link between their symptoms and the processes taking place in their mind, body, and

life. Some patients started the treatment completely unaware of the possible psychosocial origins of their symptoms and ended it with a new view of their problems' nature. Some patients were already aware of this connection at the beginning of the treatment. Those patients reported deepening their understanding, i.e. they shifted from a general acceptance that symptoms sometimes may have some psychosocial connections to a very specific understanding of these connections in their own life. As reported by some patients, a prerequisite for developing a better understanding was their ability to capture and name their emotions and the ability to notice signals coming from their body, which they gradually acquired during treatment. The outpatient centers offered the patients a variety of activities that led them to experience connections between their mind and body. For example, relaxation techniques helped patients observe that releasing tension in their body positively impacted their physical state.

(...) the [name of the outpatient center] gave me ... regarding the physical problems ... I don't know if I should say reassurance, but rather ... that, when the soul is ill, then the soul can talk through the body.

Perceiving Somatic Symptoms as Influenceable (n = 20, 67%)

As a result of the better understanding of how their mind influences their body, patients started to perceive their symptoms as being more manageable, and they started to use this understanding to their own benefit. For instance, when their symptoms suddenly emerged, the patients applied learned techniques, such as breathing exercises, imagination, or releasing bodily tension with exercise. Meeting a close person and sharing their troubling experiences was also noted as being an efficient approach. Some patients used these helpful strategies not only when symptoms appeared but also as a preventive measure.

Uhm, so, for example, when you go through a stressful period, the difficulties can let themselves be heard. Like sleep, you cannot sleep at night. But, of course, you know how to work with that, so it does not exacerbate ... you just know how to prevent it and not let it start.

Accepting Symptoms and Perceiving Them as Being Less Threatening (n = 9, 30%)

Instead of desperately trying to make symptoms disappear, some patients reported that they gradually accepted the symptom existence and started to think of them as a stable part of their lives. Moreover, they started to consider that reliving their symptoms was less important than they may have previously thought because life went on even though they had symptoms. Some patients came to this realization after having heard other patients' stories. In turn, the patients' own symptoms seemed less threatening.

Well, you know it's - I learned to live with it, and I somehow accepted it, and when I am careful enough, sometimes it [falling down due to vertigo] won't happen, sometimes it will (...). So, these are the situations that I simply can't anticipate, and I learned to live with it; it just happens.

Theme 2: Learning to Satisfy One's Needs (n = 29, 97%)

A crucial part of the experience most patients had during the treatment was learning how to better satisfy their needs based on their narratives. The first step in this process was noticing and recognizing what it was they wanted regardless of all the “shoulds” that they adopted from their significant other or created for themselves. As a result, the patients lowered the demands they put on themselves. There were two main directions in which patients changed their behavior, i.e. some of them learned how to express their needs and thus became more proactive, whereas others withdrew from conflicts and became calmer and more sensitive toward other people.

Listening to One's Own Needs (n = 21, 70%)

A frequent behavioral change perceived by patients was listening to their own needs more than before. They started to pay more attention to their feelings and body signals, which helped them make decisions, as these sensations helped them recognize unpleasant aspects in situations connected to the emergence of somatic symptoms. The adopted opinions of other people, which are often used to guide patients' behavior, had less influence on patients as they became more self-reliant on their own perceptions. Attending more to one's needs was also paired with being more authentic to oneself and others and behaving in sync with one's own needs, which was perceived as liberating by the patients.

But it is that moment, when I stop in that situation and wonder whether it is my usual pattern, in which I have to handle everything on my own, that I think “Why am I doing it – am I doing it to please someone else or to please myself as well?”

Lowering Demands on Oneself (n = 15, 50%)

During the treatment, many patients reported recognizing that the emergence of their somatic symptoms was related to their tendency to become overburdened with tasks and in social interactions. Better recognition of their own needs in strenuous situations led them, little by little, to be able to make changes in their activity patterns. They learned to slow down, rest more and reduce the expectations they had for themselves. As a result, they often realized that the consequences of doing less were far less serious than they had originally thought. One such experience was described by one of the patients as follows: “And I just try ... to slow down because they taught us here that we don't have to overperform, we don't have to ... the laundry will simply wait until tomorrow and that calms me down a lot.”

Demarcating One's Boundaries (n = 22, 73%)

Most patients noted that they struggled with an inability to express their needs and to refuse others' demands, which put them under strain and could lead to the emergence of symptoms. Group psychotherapy and assertiveness training helped them to gain the ability to act in accordance with their needs, even if it meant rejecting other people or setting up clear boundaries. After practicing this ability with other patients and therapists

in an outpatient center, the patients started applying it in their daily life as well, such as with family, friends, and colleagues.

I simply told my friend, "Look, I need to be with my family, with my brother, and I cannot come right now." . . . and she got mad at me and hasn't spoken to me since then. And I tell myself: "She doesn't talk to me . . . well, I don't need a friend like this."

Increasing Sensitivity Toward Others (n = 14, 47%)

While some patients reflected on becoming more proactive in expressing their needs, other patients became aware that getting in conflicts with other people prevented them from satisfying their own needs. Increasing the sensitivity to others helped them reduce the conflicts, enabling the patients to satisfy their own needs in a more agreeable contact with other people. Therefore, these patients decided to be more sensitive, less judgmental, and more careful in their expressions. This was especially the case for patients who were used to acting as leaders and who spoke their mind without taking other people's feelings into consideration or who were even unaware of the pain they could be causing to others.

I realized that the problem is in me . . . not just in others, where I always saw the problems . . . this is a pretty big step . . . that I try to listen to other people more and change my expressions. I used to show them right away that I was not interested in them or that something was not alright and that - that I . . . 'despised' them.

Theme 3: Modifying One's Lifestyle (n = 25, 83%)

The patients noted that psychotherapy led to specific changes in their everyday routines. These changes represented a practical means of satisfying the patients' needs. Motivated by new insights, the patients started to either slightly update or completely change their, often deep-rooted, lifestyle. These modifications manifested as either one-time decisions or repeated activities.

One-time Decisions (n = 19, 63%)

Better understanding of the origin of somatic symptoms often prompted one-time changes in important areas of patients' lives. For instance, some patients quit their job or left their partner, whereas some patients changed their lifestyle less radically, for example, by continuing with some form of psychotherapy or enrolling in a course. A majority of patients came up with new decisions as a result of the treatment, while in some patients, the treatment encouraged them to realize changes they had been already planning. An example of such a decision was provided by the following patient: "After this treatment I wanted to make a change . . . and I needed to, so I quit my job, and I actually left my apartment as well."

Regular Activities (n = 16, 53%)

As a result of the treatment, many patients reported engaging in new habits. Some patients returned to pursuing activities that they used to engage in, but for some

reason, somatic problems had resulted, and they stopped. Others pursued new activities. The integration of physical exercise into patients' lifestyle was one of the most common habits; other activities included relaxation, pursuing more social interactions, or reading. (Re)starting regular activities was usually a consequence of gaining new energy and an increased desire to live. A patient stated that "(...) thanks to the treatment, I started to, for example, ride a bike this year and do some other things, I started to do sports and so on."

Theme 4: Opening to and Dealing with Painful Issues (n = 17, 57%)

Psychotherapy was challenging for some patients because it revealed sensitive issues connected with how other people viewed them and difficult experiences they had had in the past. Some of these issues had not been processed by patients, and sometimes the patients were not even aware of them. After these issues had surfaced, the patients then had to deal with them. This resulted in either changing their view of themselves or processing their trauma.

Struggling With Unpleasant Self-Realizations (n = 11, 37%)

The patients described developing a different view of themselves in psychotherapy, which sometimes resulted from being confronted by other patients or therapists. When others pointed out that they perceived some patients' behavior as negative, the patients had to deal with strong negative emotions. Typically, after the initial denial, the patients took some time to process this experience and became less resistant to re-evaluating and accepting others' views. Afterwards, some patients were grateful for the chance to understand how other people may perceive them and to modify their self-concept and behavior. Other situations triggering emotional responses were related to stories shared by other patients, which patients compared with their own personal history.

(...) and of course those conversations when the others react to you ... they will really tell the truth straight to your face and that's the other thing, right ... that they simply got out of their comfort zone and said right away how they saw it (...) it wasn't pleasant all the time; I have to admit that it took me two or three days to process it.

Dealing with Difficult or Traumatic Experiences (n = 12, 40%)

Psychotherapy was perceived as helpful by patients, especially when dealing with difficult or traumatic experiences they had been struggling with. They started to process these difficult experiences after receiving feedback from others, which they sometimes perceived as being quite harsh, or after identifying aspects of their own life story in others' narratives. The emergence of difficult experiences, which had often been repressed, was usually followed by intense emotions, and in some cases, it also temporarily triggered somatic symptoms. For some patients, difficult experiences emerged gradually as if they were "slowly taking the lid off", while other patients experienced sudden emergence, frequently related to a moment when they told their life story for the first time. The patients who managed to process these experiences felt very relieved afterwards. Some

patients considered their difficult experiences to be resolved, but more often, they considered reaching closure to be a long-term process.

(..) my grandma had passed away (..), and it was painful. And some of my issues started to emerge [in group psychotherapy] ... because that story was shared in a way, because she [another patient] experienced some similar things. So, it triggered issues that I had gone through (..). I had never realized how much I blamed myself for some things and only in that mirror, when the person was sitting in front of me talking about their experience, did it come out.

Theme 5: Experiencing Belonging (n = 29, 97%)

The patients identified two important changes in their experience related to MUPS. They noted obtaining the legitimization of their problems, and they felt the sincere interest of other patients and therapists, which made them feel understood and less alone in their struggles. They related these changes to the group psychotherapy setting, since they had an opportunity to witness that other people had similar problems and that someone was willing to listen and understand them.

Legitimizing One's Condition (n = 22, 73%)

Being in a group of people facing similar problems or life situations seemed to give the patients a chance to normalize their experience of MUPS. Many of them expressed this acquired legitimization with words such as "I feel like I am not alone in this." This was alleviating for them, since they were not used to be understood by others, including family and close friends. Apart from other patients in the group, the therapists also seemed to play an important role in generating feelings of legitimization by providing reassuring statements, confirming the strenuousness of one's problems, and showing their deep understanding.

(..) it helps you to see that people around you have the same problems as you do. For example, I said that I had this problem and two, three, five people said, "Oh, yeah, that happened to me too, it is alright." So, I feel relieved that I am not alone ... crazy.

Experiencing Interest and Care (n = 26, 87%)

Many patients felt that other patients and therapists were genuinely interested in them, as they paid attention, listened actively when the patients were speaking, provided support, and helped each other in difficult moments. This made them feel understood and less alone, which contrasted with the reactions they often encountered in their lives. At times, friendships formed between group members that endured after the treatment program ended.

(..) we all let out issues that were painful, and it was relieving, and the group held you, right ... for example, someone hugged you when you needed it ... or you shared things you considered shameful in your life, but no one would judge you.

Theme 6: Changing Symptoms (n = 30, 100%)

Patients noted that changes in their somatic symptoms during and after psychotherapy did not follow a straightforward path. One of the most common experiences was the worsening of symptoms or the emergence of new symptoms after they started to focus on their issues in the treatment. Furthermore, patients' symptoms often worsened after the treatment ended because it was difficult for them to retain the changes achieved in the therapy when confronted with the conditions of their daily life. Overall, however, many patients reported that their somatic symptoms were reduced.

Deterioration During Psychotherapy (n = 24, 80%)

During the first days and weeks in the treatment, many patients reported experiencing a worsening of symptoms. According to the patients, this worsening resulted from the effort they put into opening issues in their life and working through them. Focusing on one's past and current life and trying to resolve associated problems represented the very first introspective work for some patients, and their body may have reacted to the effort by intensifying their symptoms or the emergence of new symptoms. While most patients felt that their symptoms worsened at the beginning of the treatment, some of them reported worsening toward the end, and some experienced fluctuating symptoms.

(...) I had a terrible headache during the first week of the [attendance at the] treatment and on top of that, I started to bleed between periods for the first time in my life (...). So, when we started to intensively work with our psyche ... it all became stormy ... the body.

Deterioration After Returning to Daily Life (n = 21, 70%)

Going back to normal life represented a challenge for the patients because the stressful events they encountered in their life contrasted with the sense of safety experienced in psychotherapy. Consequently, the patients' symptoms worsened after they returned to their daily life. They also frequently encountered difficulties related to persisting to apply newly learned strategies, such as exercises or relaxation techniques. This was attributed mostly to the lack of time after going back to their usual routine.

There [in the outpatient center] I really felt that I was under a protection, nothing could happen to me here. I felt great there, I could do exercises there, I felt fine, alright' and so on; but when I returned to the world out there and to those problems, I wasn't ready for them, and the back pain came back.

Improving Symptoms (n = 25, 83%)

As a result of psychotherapy, many patients experienced an improvement of their physical symptoms that was either temporary or permanent. The following experience illustrates such a positive change: "that pain was sort of released, I don't know how to – as if there were a bottle full of pain and now a lot of that has been released ... like released out". This improvement meant either that the patients did not experience symptoms anymore or that their frequency and intensity had diminished. The patients usually

attributed this change to the stress-free environment of the outpatient center with many opportunities for relaxation, releasing bodily tension, physiotherapy, and physical exercise. However, some of them had no clue what had caused their symptoms to improve.

Theme 7: Opening Possibilities (n = 29, 97%)

Apart from symptomatic relief, the patients also reported an improved quality of life toward the end of the treatment. An improved quality of life was represented by feelings of new energy and strength, a hope for a better future and a determination to improve their life. The reduction in the patients' suffering and a sense of new energy enabled them to look forward to and think about further changes they were willing to make in their life.

Experiencing Mental and Physical Relief (n = 26, 87%)

Many patients felt on the edge when they started the treatment. Several weeks of working through their issues and using relaxation techniques led to relief from the physical and mental tension that hindered them in fulfilling their goals in life. One of the patients described this relief as follows: "I would say that I was relaxed in that outpatient center, meaning that (...) it was a load off my mind, when I felt simply so safe in there". Managing to feel calmer enabled the patients to turn their attention from suffering to planning their future life. Experiencing this relief seemed to be a source of energy, hope, and determination. This change was reported even by patients who did not experience any change in their somatic symptoms: these patients, too, reported improved wellbeing as a result of the treatment.

Gaining Physical Strength and Energy (n = 15, 50%)

The problems and unresolved issues with which patients came to the treatment were often taking much energy away from them, as they said. A few patients experienced a rush of new strength at the beginning of the treatment, which was linked to their initial hope of getting help. More typically, however, patients experienced an increase in energy after some time had passed, and they started to deal with their issues. Some patients were also able to better understand the causes of their low energy levels and found methods to keep them higher.

And suddenly halfway through the [stay in the] outpatient center, I felt a huge relief ... and suddenly I started to ... see things positively and at the same time, my energy was coming back to me, because I was like ... I could barely get out of bed before.

Finding Hope for a Better Life (n = 18, 60%)

During the treatment, patients reported finding hope that their lives could improve. Specifically, they gained confidence that their problems could be solved, they started to see the world in a more positive perspective, they believed more in their abilities to overcome obstacles, and their mood was improved. For instance, one patient summarized the treatment gains as follows: "I would say it [the treatment] has given me hope that it is

possible to work with it and that the positive approach can be purposely learned, and one can work on it." Whereas some patients gained more hope that their somatic symptoms could disappear for good, others hoped to be able to live with them. Coping strategies obtained in the treatment also helped them build hope by being available in times of need.

Gaining Determination (n = 19, 63%)

As the patients experienced more energy, strength, and hope, they became motivated to work toward achieving their goals, mostly related to wellbeing. Even if they had not taken the steps necessary for such changes to happen yet, they at least began creating plans of how to start them. Unlike in the previous subtheme (i.e. finding hope for a better life), patients who gained determination reported a resolution to act actively in their current life situation. An important aspect of this determination was the patients' motivation to rise to the challenges coming their way, which was a consequence of acquired strength. For example, a patient summarized this change as follows: "Communication with one's family is important; it was my ambition here. I really want to work on that ... and especially with my boyfriend."

Discussion

The present study explored changes that patients suffering from MUPS experienced as a result of multicomponent treatment based on group psychotherapy. Interviews with 30 patients were conducted to discover which changes they experienced in addition to the changes in the degree of their somatic symptoms.

The change reflected by most patients was that of developing a different view of their symptoms. There were different levels at which this change occurred. Some patients reported they started to notice that their somatic symptoms were connected to various aspects of their life; others were already aware of this connection, and they deepened their understanding. This finding illustrates changes that might fit those patients with MUPS who tend to adhere to medical explanations of their somatic symptoms (Nettleton, Omalley, Watt, & Duffey, 2004). However, most patients have psychological theories regarding their somatic symptoms (Kornelsen, Atkins, Brownell, & Woollard, 2016), and they are willing to develop alternative explanations in psychological treatment despite an initial skepticism (Gerskowitch, Norman, & Rimes, 2015).

The standpoint from which patients perceive their symptoms is important when adjusting treatment to patients' needs (Balabanovic & Hayton, 2019). While some patients have no idea about body-mind connections, others may already be aware that there is some connection but may not know how it works. Interventions that lead patients to observe the bodily effects of their emotional experiences facilitate this understanding by providing evidence of connections between their body and mind (Town, Lomax, Abbass, & Hardy, 2017).

Another difference that patients with MUPS reported was how they attempted to satisfy their needs. A majority of patients in this study reported that they entered the treatment with an inclination to prioritize others' needs above their own, which corresponds with the characteristics of patients who tend to develop chronic pain (Blumer &

Heilbronn, 1982). They tend to be submissive in their interpersonal relationships with a strong need to be socially accepted, display little emotionality, act as a solid citizen, and overload themselves with relentless work. These characteristics could also be related to higher levels of neuroticism and harm avoidance as personality traits (Katon, Sullivan, & Walker, 2001). The changes these patients reported enabled them to stand up for themselves and resist others' overburdening demands.

Other patients attempted to withdraw from conflicts with other people. These individuals perceived themselves as easily getting caught up in arguments, often at the expense of others. Repeated conflicts distressed them and prevented them from satisfying their needs in relationships. This group of patients has been mentioned much less in the MUPS research thus far (Dwamena, Lyles, Frankel, & Smith, 2009). MUPS patients who are prone to conflict benefit from different changes, which should be reflected in the treatment.

Some changes reported by patients can also be achieved in individual psychotherapy. For example, experiencing care and belonging are important in psychotherapy regardless of the setting (Levitt, Pomerville, & Surace, 2016). However, the group setting in which the multicomponent treatment was delivered also offers changes beyond what individual psychotherapy can offer. The legitimization of patients' experience with somatic symptoms represents such a change because interacting with other patients who struggle with MUPS allows patients to directly witness that their issues are in fact quite common. Unless a therapist suffers from MUPS as well, this impact would be difficult to achieve in individual psychotherapy. Moreover, the patients could also adopt coping strategies developed by others, which is an important benefit that has already been formulated by Claassen-Claassen-van Dessel et al. (2015). In this way, the group psychotherapy format expands the range of changes that patients can achieve.

A strength of the present study is that the patients were asked about the changes they experienced in connection with the treatment three months after the treatment ended. Consequently, patients' difficulties with maintaining changes they achieved were captured, including perceived causes. These causes included a lack of time for the use of learned helpful strategies and a lack of support from their social environment, which did not accept the changes in patients' behavior. Treatment guides that target a wide range of changes reported by patients (e.g. Henningsen, Zipfel, Sattel, & Creed, 2018) acknowledge that MUPS tends to be chronic and that long-term outcomes are poor (Rask et al., 2015). Unfortunately, treatment guides often lack plans to reinforce treatment gains, for instance, by offering follow-up care that works against forces identified by patients as those leading to losses in the changes they achieved in the treatment. Although the patients do not manage to retain all of the changes, it might be useful to emphasize that the experience of change is helpful, as patients learn what helped them before, and they gain hope that getting better is possible, which may reduce the uncertainty that permeates their existence (Kornelsen et al., 2016).

Treatment recommendations should also reflect that the somatic symptoms of patients with MUPS may temporarily worsen because of treatment. This deterioration may be explained by the assumption that patients with MUPS have a general tendency to react to stress with somatic symptoms (Salkovskis et al., 2016). For example, any treatment that requires patients to change their dysfunctional attitudes, increase their activity, or develop a different understanding of their symptoms (Řiháček & Čevelíček, 2019) may cause some

stress, potentially leading to more intense symptoms or an emergence of additional symptoms. This finding can be seen from two perspectives. First, there is an assumption that patients in psychotherapy “need to get worse before they get better” (Owen et al., 2015). Second, it is possible that the present study identified negative effects reported by patients as a result of treatment for MUPS (Pourová, Řiháček, Chvála, Vybíral, & Boehnke, 2022b). In any case, these expected impacts should be considered when patients are informed about treatment progress. Moreover, aftercare should be thematized more carefully after patients’ discharge from outpatient centers, as it may help reduce their reasons for deterioration (Claassen-Claassen-van Dessel et al., 2015).

Limitations

The multicomponent treatment length and supplementary interventions were heterogeneous across the treatment sites. As a result, the changes that the patients described could be attributed to diverse aspects of treatments. However, this heterogeneity can be seen as an advantage because the goal of the current study was to capture the variety of changes that patients may experience.

Although we included a heterogeneous sample of patients who were exposed to diverse treatment components, some areas of patients’ experience of change may be omitted or underrepresented in our findings. For instance, patients in our sample are more likely to share the assumption that psychotherapy may be effective in the treatment of their symptoms. Furthermore, the sample comprised only patients who completed and, thus, were more likely to profit from the treatment compared to those who dropped out. Another limitation regarding our sample is insufficient information about the strategies used by the treatment centers to acquire patients.

We scheduled the interviews for three months after the end of the treatment to explore not only the immediate changes patients experienced after treatment completion but also a more long-term perspective on the impact of the treatment. However, patients’ recollection of changes during the treatment could have been affected by memory biases (Neusar, 2014). To overcome this limitation, future studies may implement a repeated interviewing schedule to capture both the immediate experience of and a long-term reflection on the therapeutic change.

The extent of the identified changes could be reduced by the limited variability of the theoretical orientations of the psychotherapists who facilitated the group therapy within the multicomponent treatment. CBT is a prolific treatment and, in fact, is the most-researched treatment for MUPS (van Dessel et al., 2015).

The changes that patients with MUPS consider important are also influenced by cultural and social factors (Kirmayer et al., 2004). For example, the idea of lowering demands on oneself might be more acceptable for patients in Central Europe than in other cultures, such as highly achievement-oriented Asian cultures that consider high-stress work environments to be the norm. Social factors such as gender may also play a role. Women in Western societies have often been socialized to assume the social role of a carer, suppressing their own needs in favor of others. This idea has been revised within the culture, which is why learning to satisfy one’s own needs showed as important, but this might not be the case for studies conducted in other cultures.

Another limitation of the study is the inability to explore the identified changes more in-depth. This may be achieved through a follow-up case-study research design with the aim of exploring the patients' perceptions of specific elements of the program, as well as various pathways through which patients may achieve change in treatment.

Conclusion

Patients with MUPS are frequently encountered by treatment providers, and these patients are frequently disappointed by the treatments they receive, since the reduction in somatic symptoms that they achieve is limited. This may be a frustrating experience for both the patients and the treatment providers. Even though patients with MUPS cannot always be given what they want, i.e. they might not have their somatic symptoms relieved, treatment providers may try to offer a variety of changes that respond to what patients need. The present study provided an overview of a broad range of changes that patients with MUPS experience after multicomponent treatment.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author, L.P. The data are not publicly available due to their containing information that could compromise the privacy of research participants.

Disclosure Statement

No potential conflict of interest was reported by the author(s).

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