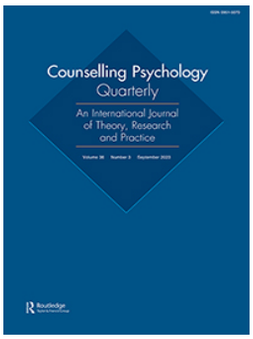

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What works in the treatment of medically unexplained physical symptoms? The psychotherapist perspective

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ABSTRACT

People with medically unexplained physical symptoms (MUPS) are often referred to psychotherapy, which has been shown to be modestly effective in reducing symptom severity. An investigation of clinical strategies used by experienced psychotherapists in the treatment of clients with MUPS may offer important insights into the treatment process with this challenging group of clients and help further improve the effectiveness of psychotherapy. Individual interviews with 31 psychotherapists experienced in the treatment of adult clients with MUPS were collected. The grounded theory method was used to identify clinical strategies. Clinical strategies were organized into three treatment phases. In the first phase, the psychotherapists' intention was to draw clients who may resist the psychological view of somatic symptoms into psychotherapy. In the second phase, the psychotherapists aimed to influence the impact of the symptoms on clients' lives. In the third phase, the psychotherapists focused on reinforcing the clients' gains from treatment, and they remained open to treatment continuation. The clinical strategies shared by psychotherapists with diverse theoretical orientations point to common mechanisms of change in the treatment of clients with MUPS. Psychotherapists' responsiveness to client preparedness for psychotherapy appears to be important for specifically challenging clients.

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Psychotherapy; medically unexplained physical symptoms; somatoform; somatic symptom disorder; clinical strategy

Some physical symptoms commonly encountered by professionals treating both mental and somatic disorders cannot be fully explained by a diagnosed somatic illness. These symptoms result in a high healthcare burden and a reduced quality of life for the sufferers (Zonneveld, Sprangers, Kooiman, Van'T Spijker, & Busschbach, 2013). The term medically unexplained physical symptoms (MUPS) has often been used for these complaints. In the general population, approximately 6% of people have MUPS that reach the level of a diagnosable somatoform disorder (Kleinstäuber et al., 2014). In primary care, 3–10% of patients consulting GPs have persistent MUPS (Rosendal et al., 2017).

For a small portion of people with MUPS, a somatic cause is eventually found (Skovenborg & Schröder, 2014), and for many people, MUPS resolve without treatment. However, between 10% and 30% of cases become chronic (Olde Hartman, Hassink-Franke, Lucassen, Van Spaendonck, & Van Weel, 2009; van Dessel, Leone, Van der Wouden, Dekker, & Van der Horst, 2014). People with MUPS are often referred to psychotherapy.

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Psychotherapy does not usually cure somatic symptoms, but it has been shown to be helpful in moderately reducing the severity of symptoms and improving the quality of clients' lives (van Dessel et al., 2015). Moreover, although modest, the effects of psychotherapy tend to be maintained in the long term (Kleinstäuber, Witthöft, & Hiller, 2011). The stability of improvements achieved in psychotherapy with MUPS clients and the possible advantage of psychotherapy over other treatments suggest that we should try to identify and enhance the effective clinical strategies that contribute to client improvements.

Many approaches have been adapted for the treatment of MUPS across the main psychotherapy orientations of cognitive-behavioral (CBT), psychodynamic, interpersonal, and humanistic psychotherapies. Specific methods for the management of MUPS have also been developed, such as reattribution (Gask, Dowrick, Salmon, Peters, & Morriss, 2011). To date, reliable evidence has been provided in meta-analyses for the effectiveness of CBT, including its third-wave variants (van Dessel et al., 2015). Likely effectiveness was shown for approaches such as psychodynamic psychotherapy and problem-solving strategies (Kleinstäuber et al., 2011).

The lack of randomized controlled trials that meet quality criteria such as participant blinding, randomization, and the sample size was the main problem in these meta-analyses. Therefore, only several approaches were marked as providing empirical evidence of their effectiveness in the treatment of MUPS (van Dessel et al., 2015). We argue that even if some theoretically sound approaches do not offer high-quality research yet, they may help clients with MUPS when they utilize effective trans-theoretical mechanisms of change that can be identified across a wide range of approaches (Řiháček & Čevelíček, 2019). In fact, there are significant differences in the therapeutic style of therapists espousing the same approach (Roubal, Hytych, Cevelicek, & Rihacek, 2021). Therefore, studying effective mechanisms of change across different approaches may provide better evidence of effectiveness. For instance, mechanisms with empirical support include developing coping strategies, increasing symptom acceptance and emotional regulation, reducing fear of symptoms, or helping clients sense more control over symptoms (Pourová et al., 2020; Řiháček, Čevelíček, Boehnke, Pourová, & Roubal, 2022).

Trans-theoretical mechanisms of change can be connected to the needs of clients with MUPS (Polakovská & Řiháček, 2021), which include the need to feel understood, struggling with isolation, facing uncertainty, being disappointed by healthcare, and the need for active coping. Mechanisms of change within treatment lead to improvements in clients' lives, such as taking better care of their own needs, reducing demands they put on themselves, or better expressing their emotions. While qualitative research that explores how effective mechanisms of change unfold in the treatment from clients' perspective (e.g. Town, Lomax, Abbass, & Hardy, 2019) helps us better understand the needs of clients and the process of change, the examination of clinical strategies used by therapists to invoke effective mechanisms of change helps us understand how these processes can be supported in treatment. Identifying clinical strategies could enhance the effectiveness of psychotherapy for MUPS (Oddli, Nissen-Lie, & Halvorsen, 2016). Goldfried (1980) used the term "clinical strategies" to capture psychotherapists' intentions present in specific interventions across different psychotherapy approaches. Clinical strategies are more abstract than the descriptions of interventions – they transcend interventions by answering the

question "What is the goal of the intervention and the rationale behind that goal?" At the same time, clinical strategies are more specific than grand theories of change.

If we need to identify clinical strategies useful in psychotherapy for MUPS clients, exploring the work of psychotherapists experienced in the treatment of such clients is relevant. However, empirical research on psychotherapists' clinical strategies is rare. In two available Luca (2011, 2012) explored the conceptualizations, interventions, and therapeutic activities of 12 CBT and psychodynamic therapists. The psychotherapists shared the view that clients with MUPS were "concrete" (i.e. unable to reflect on their experiencing; preoccupied with physical symptoms; and unwilling to explore psychological aspects of their distress) and that they were difficult and complaining. The psychotherapists emphasized collaborative work with clients, empathic responding and building trust, flexibility with techniques, keeping an open mind, and multidisciplinary collaboration.

Balabanovic and Hayton (2019) focused on the way therapists engage clients who may resist psychological treatment. They described three stages of client engagement that capture drawing the clients into psychotherapy within the medical system, meeting clients in their current mindset regarding their problems, and nudging them to think about connections between the body and the mind. We argue that studying treatment conceptualizations and the interventions at the level of clinical strategies could be beneficial. Moreover, a study of a wider variety of psychotherapists is warranted. It might also be useful to explore clinical strategies that therapists use when the treatment progresses as planned and strategies they use when obstacles specific to this group of clients emerge (Heijmans et al., 2011).

Other available studies that explored professionals' views of MUPS treatment focused on the management of patients, the conceptualization of MUPS by medical professionals, and the challenges they encounter in the treatment (e.g. Czachowski, Piszczek, Sowińska, & Olde Hartman, 2012; Heijmans et al., 2011). For example, Olde Hartman et al. (2009) found that a clear explanation of symptoms to patients was perceived as important by GPs but that they often felt incapable of providing an explanation. They provided nonspecific reassurance and symptom normalization as the main strategies. When the MUPS patients continued to return, the general practitioners attempted to strengthen the patient-doctor relationship. Since many clients experience chronic problems, different interventions are needed across the pathway of care. Consequently, the clinical strategies of psychotherapists experienced in the treatment of MUPS should be investigated. This view is strengthened by the finding that when compared with general practitioners, mental health professionals tend to provide better outcomes in MUPS treatment (Gerger, Hlavica, Gaab, Munder, & Barth, 2015; Kleinstäuber et al., 2011).

AIM of the study

Studies on clinical strategies that psychotherapists use with people suffering from MUPS are scarce, while the available studies are limited by small sample sizes and the variety of studied theoretical orientations. We chose to expand this research area by exploring the clinical strategies used by experienced psychotherapists in the treatment of MUPS. Consequently, we formulated the following research question: "Which clinical strategies do experienced psychotherapists use with clients suffering from MUPS?"

Method

To answer the research question, we chose the qualitative approach, as it should provide an in-depth understanding of the reasoning that psychotherapists have for the use of specific clinical strategies with clients suffering from MUPS. Because our aim was to capture the range of psychotherapists' clinical strategies in their narratives, we used grounded theory principles as the analytic approach (Strauss & Corbin, 1990) since grounded theory is well suited to capture social and psychological processes in interview data.

Participants

The sample consisted of $N = 31$ psychotherapists (15 females, 16 males; all Caucasian). The participants were aged 32 to 78 ($M = 47.9$; $SD = 10.7$), with the experience of working as psychotherapists ranging from 4.5 to 54 years ($M = 18.7$; $SD = 9.9$) and working specifically with MUPS ranging from 4 to 54 years ($M = 13.7$; $SD = 9.8$). Concerning professional background, 10 were psychiatrists, 17 were psychologists with an MA degree, and four were medical doctors (MDs). They worked with clients suffering from MUPS either at a mental health clinic or in their private practice. All participants were certified psychotherapists with more than 750 hours of postgraduate training in the specific approach they used. Their self-reported psychotherapy orientations included Gestalt (8), psychodynamic (6), systemic and family (6), integrative (4), CBT (4), person-centered (2), and transaction analysis (1). All participants were Czech nationals.

Researchers

MČ (male, aged 35) was a psychologist and researcher focusing on psychotherapy, specializing in qualitative methodology, with a specific interest in psychotherapy integration. JR (male, aged 50) was a psychotherapist and psychiatrist with 20 years of psychotherapeutic practice. He was trained in Gestalt therapy and involved in the psychotherapy integration movement. RH (male, aged 47) was a psychologist and psychotherapist with 18 years of psychotherapeutic practice. He was trained in mindfulness-based therapy. TŘ (male, aged 43) was a psychologist and psychotherapist with 14 years of part-time therapeutic practice. Initially, he was trained in Gestalt therapy and endorsed a humanistic/experiential orientation. However, both his clinical and scholarly activities were considerably influenced by the psychotherapy integration movement.

The analysts did not focus specifically on patients with MUPS in clinical practice, yet they were aware that their background in psychology and psychotherapy might lead them to favor psychological explanations and treatments. Therefore, the option that a somatic cure may ultimately be found or that a psychosocial explanation may not fit clients' MUPS could get suppressed. In consecutive revisions of the manuscript, the authors aimed to avoid this potential bias. The fact that the authors held an integrative view of psychotherapy also led to focus on common factors in psychotherapy in contrast to specifics of different approaches, yet this was an explicit goal of the study. The analysts viewed clients with MUPS as a diverse group. They perceived that some clients with MUPS may be more challenging to treat than other clients in psychotherapy since they prefer medical treatments and may have limited

interest in psychological insights. Yet, the analysts acknowledged that many clients with MUPS do not have these traits. The analysts were aware that putting too much emphasis on either view might represent a bias they strived to avoid.

Data collection

Recruitment procedure

In total, 71 Czech psychotherapists working with clients who had MUPS were asked to participate in the research. We contacted therapists who worked at sites specializing in the treatment of MUPS and who published about MUPS treatment. The identified therapists were asked to recommend additional colleagues with expertise in MUPS treatment to interview. These professionals were sent an e-mail with a summary of the research goals and the interview description, and they were invited to participate in an interview with one of the researchers. The following criteria for participant inclusion were initially set: a) having completed a psychotherapy training; b) having at least 5 years of experience in the psychotherapeutic treatment of clients with MUPS (eventually, we also included those with 4 years of experience due to the lack of available candidates); c) being willing and able to talk about one successful and one unsuccessful recent case of MUPS psychotherapy they could describe in detail. The data collection aimed to include professionals with a broad range of theoretical orientations. Therefore, as the data collection progressed, professionals who adhered to underrepresented orientations in the sample were contacted.

Interview procedure

Two researchers conducted the interviews, each interviewing half of the participants in person from February to September 2018. The duration of each interview ranged from 1.5 to 2 hours. The interviewers followed a written semistructured interview protocol, exploring relevant topics in-depth when needed. Before the interviews started, each researcher used the protocol to interview two psychotherapists who were not included in the study sample. These interviews were supervised by four psychologists and psychotherapists (study authors) who provided feedback to the interviewers.

The interviews aimed to explore two psychotherapy cases with each psychotherapist. With each psychotherapist, the interview aimed to explore two psychotherapy cases, one successful and one unsuccessful, as evaluated by the therapist. The therapists who agreed to participate were asked to select two to three recent cases beforehand that included adult clients with no other serious mental health problems or severe addictions that could overshadow the treatment focus on MUPS. Ideally, the cases should have already been concluded. This interview strategy was designed to reach the following goals: a) eliciting recollections of the MUPS cases the psychotherapists had in recent memory; b) avoiding mere theorizing about MUPS psychotherapy without a clear link to specific cases; c) capturing strategies the psychotherapists used both when the psychotherapy progressed well and when they needed to deal with unfavorable progress; d) exploring the psychotherapists' evaluation of the psychotherapy outcome after the cases concluded.

Interview schedule

For each client the psychotherapists chose to talk about, the same interview protocol was followed. First, descriptive client information was collected: somatic symptoms, somatic

diagnosis, mental health problems, age, sex, education, description of personality traits, and treatment motivation. Second, for each case, the psychotherapists were asked about the client's understanding of their problems and the psychotherapist's understanding of the client's problems. Third, the psychotherapy process was explored for each case. This interview section focused on the following themes: the descriptive information about the case (duration, setting); the psychotherapists' interventions and treatment intentions; treatment phases (if identifiable); the development of the psychotherapy relationship; the evaluation of the treatment outcome (success or failure) and its assumed causes. Additionally, participants had the option to comment on any important aspects of the case and treatment that were not mentioned by the interview schedule. Descriptive data about each psychotherapist were also collected (age, experience, training, profession, theoretical orientation). All interviews were audio-recorded and transcribed verbatim for the analysis.

Client characteristics

The therapists covered $N = 63$ clients (one therapist covered three clients, 30 therapists each covered two clients). The average age of clients reported by the psychotherapists was 38 years (35 clients female, 28 male), and their MUPS lasted for more than 6 months before the treatment started (see Table 1). Most clients attended 50 to 60-minute individual sessions. The number of sessions in successful cases ranged from 10 to more than 100; most clients had between 15 to 40. For the unsuccessful cases, the number of sessions ranged from six to 100; in most cases, the number was either low (less than 10 sessions) or high (up to 100 sessions). Clients sought psychotherapy with the stomach, back and head pain, ingestion and urogenital problems, insomnia, tiredness, and shortness of breath. A diagnosis of mental health problems not associated with MUPS was reported for 10 clients who suffered from affective and anxiety disorders. There were no reported comorbid physical health problems responsible for clients' somatic symptoms, as their absence was a case selection criterion.

Table 1. Client characteristics.

N	63
Female	55.5 %
M age	38
N with other mental health diagnosis	10
MUPS duration	6+ months
MUPS reported	stomach, back and head pain; ingestion and urogenital problems; insomnia; tiredness; shortness of breath
successful cases	
N sessions	10–100
N sessions (most clients)	15–40
unsuccessful cases	
N sessions	6–100
N sessions (most clients)	<10 and >100

The number of sessions that clients received in successful and unsuccessful cases was roughly estimated by the therapists. The therapists' emphasis was that the number of sessions for unsuccessful cases was either low or very high (with limited success).

Research ethics

The participants were informed of their right to withdraw from the research at any point, they received written information about the research goals and process, and they signed a written informed consent form. Before the interview transcription started, participants were assigned codes that were used instead of their names, and any identification information (e.g. names, workplaces) was removed from the transcripts. This research was approved by the Research Ethics Committee of Masaryk University (ref. no. EKV-2017-029-R1).

Data analysis

The analysis focused on two main themes: the psychotherapists' conceptualizations of clients with MUPS and their treatment intentions. Integrating these two aspects, the analysis aimed to capture the middle ground between concrete therapeutic interventions and grand theories of psychotherapy change, as described by the concept of "clinical strategies" (Goldfried, 1980) that served as a sensitizing concept in the analysis. The qualitative analysis of the interview transcripts was conducted according to the grounded theory principles (Strauss & Corbin, 1990). This method was selected because its strength is in capturing patterns and processes present in data. Therefore, it was deemed suitable to identify psychotherapists' subjective reflections of clinical strategies that presume a specific process of change and client-clinician interaction patterns. Grounded theory was also chosen because the authors have extensive experience with this method, and it is widely recognized and offers good reproducibility and trustworthiness.

The analysis had two main steps, summarized as follows. In the first step, $n = 28$ interviews were analyzed. We expected that 20 interviews would suffice to reach theoretical saturation. We aimed to reinforce the support by data by obtaining more interviews with psychotherapists of diverse theoretical orientations and reaching the point of redundancy. Three researchers (MČ, JR, RH) familiar with the concept of clinical strategies gradually coded interview transcripts, and they selectively focused on psychotherapists' client conceptualizations and therapeutic intentions.

At the start of the analysis, the researchers reviewed all 28 interviews. Then, there were three coding cycles. In each cycle, the researchers thoroughly re-read and coded several interviews and condensed each psychotherapist's intentions and client conceptualizations into a narrative summary. A meaning unit was represented by several sentences or paragraphs that captured these two aspects. The interviews in each coding cycle were grouped based on the theoretical orientations of the psychotherapists: 1) gestalt; 2) systemic and psychodynamic; 3) integrative and CBT. After each coding cycle, the analysts discussed the narrative summaries and compared their understanding of the data. Themes that did not fit the emerging categories and the sensitizing concept were discussed and excluded from the analysis. The emerging categories were refined in discussions until the researchers reached a consensus on a final set of categories, which meant that they did not identify any additional relevant categories in the data, and the theoretical saturation was reached. In the last cycle of coding, the models' description was synthesized by the first author, discussed, and adjusted.

In the second step, three remaining interviews were coded and summarized, and the results of this analysis were compared with the formulated model. These interviews included respondents who self-identified as practitioners of approaches underrepresented

Table 2. Treatment phases and clinical strategies psychotherapists use with clients who have medically unexplained physical symptoms.

Phase 1: Establishing the ground for collaboration	**31**
Assessing clients' motivation for psychotherapy	30
Leading clients to accept that they would be the ones "working" in psychotherapy	24
Leading the clients to accept that symptoms are linked to psychosocial aspects	30
Providing a safe space for the exploration of psychosocial factors	28
Showing clients that psychotherapy would help them	24
Phase 2: Changing the impact of symptoms on clients' lives	**31**
Helping clients expand their awareness skills	20
Helping clients develop a nuanced understanding of the psychosocial context	30
Facilitating practical changes in clients' lives	26
Resignation to the original treatment goals	23
Phase 3: Integrating psychotherapeutic gains into clients' lives	**25**
Preparing clients for the return of symptoms	19
Being open to the continuation of treatment	21

Numbers in the last column represent the count of the psychotherapists who reported using the specific strategies and the treatment phases.

initially in the sample (person-centered approach and transaction analysis). This step was taken to ascertain whether the model adequately portrayed the clinical strategies used by most psychotherapists.

After the analysis, there were three categorization levels (i.e. treatment phases, clinical strategies, therapeutic intentions, client conceptualizations, and interventions used within the strategies). The treatment phases and clinical strategies were evaluated with regard to how many of the psychotherapists used them (see Table 2), which was based on the observation of two raters. Interventions are used as examples in the text to show how different therapists implemented the strategies.

We analyzed the cases considered successful and unsuccessful together and did not separate them in the results. The analysis showed that the therapists intended to follow a common pathway with similar goals for both successful and unsuccessful clients. They marked some cases as unsuccessful when they had to diverge from the common pathway, and they needed to try and use alternative strategies. Because various things could go awry for cases marked as unsuccessful, there were no distinct and specific pathways for unsuccessful cases. Instead, we strived to capture the solutions the psychotherapists devised if something did not go as they expected at specific points along the common pathway.

The trustworthiness of study results

The trustworthiness of the results was strengthened in several ways. First, the researchers worked in a group and discussed the emerging results throughout the analysis, using the principle of consensuality (Hill, 2012). Second, the authors' theoretical leanings were described to allow readers an insight into the theoretical preconceptions potentially influencing the results. Third, the verification phase of the analysis was undertaken to check whether the results adequately characterized the data.

Results

Three treatment phases shared across the psychotherapists emerged in the analysis, each of them connected with specific clinical strategies, as presented in Table 2. The first phase seemed to be the most crucial. In this phase, the therapists' task was to draw clients into a psychological treatment by supporting clients' active, trustful, and hopeful attitude to psychotherapy. Only if this task was fulfilled could the therapy be followed by the second phase, in which the therapists intended to work with clients on moderating the impact of the symptoms on clients' lives. Finally, in the third phase, the therapists focused on the continual application of changes achieved in treatment to clients' lives.

Across the treatment phases, we identified specific challenges that psychotherapists encounter with clients suffering from MUPS. These challenges emerged in the process of comparing the psychotherapists' descriptions of successful and unsuccessful cases. The psychotherapists connected unsuccessful cases to a failure in achieving goals across the treatment phases, while clients perceived as successful accepted and made use of the strategies that the therapists offered, and they progressed through the phases.

The clinical strategies used in each of the three treatment phases are introduced here in a specific order. First, the main therapeutic intention within each phase is described in the context of the therapists' client conceptualizations. Then, the therapists' clinical strategies within each phase and the reasoning underpinning their usage are explained. Examples of specific interventions representing the broader clinical strategies are included.

Phase 1: establishing the ground for collaboration

The first phase appeared crucial from the therapists' perspective, as its successful completion was necessary for the treatment continuation. The psychotherapists perceived the clients as often having expectations countering the tasks and goals essential in psychotherapy because their understanding of the treatment and their problems were driven by a predominantly somatic understanding of their symptoms. As a result, some clients expected that they could receive some procedure or advice that would quickly remove their somatic symptoms without any need to explore the psychological context. At the same time, the psychotherapists were wary of arguing with the clients if the clients held the assumption that their symptoms had a primarily somatic cause. Instead, they balanced leading clients to explore the psychosocial context of their symptoms and keeping open the possibility that a somatic explanation of clients' MUPS may ultimately be found or that no sufficient explanation may be possible.

The psychotherapists' main intention in the first phase was to carefully draw clients into a psychological treatment by influencing their expectations, offering them a secure space where they could talk about their concerns, and gradually strengthening their conviction that exploring the psychological perspective could be helpful. This opened the stage for tasks and goals feasible in psychotherapy. The therapists used the following clinical strategies to achieve the intention of drawing clients into psychotherapy.

Assessing clients' motivation for psychotherapy

Clients with MUPS were perceived by their therapists as often not motivated to put their efforts into psychotherapy. For example, they overfocused on a medical explanation of their symptoms, or they did not want to explore the psychosocial basis of their symptoms at all. Thus, at the start of the treatment, the therapists needed to explore the clients' willingness to engage in the therapeutic process. Even though some clients might not have understood the psychosocial aspects of their symptoms or were still unsure about their importance, they were at least expected to try working the way that the psychotherapists offered. An integrative therapist (T14) described how he was able to recognize that the client was willing to work in psychotherapy, even if the client might have lacked some useful skills (i.e. the capacity for insight): "I think that the guy was really motivated, that he wanted the change (. . .). He took some things from the psychotherapy and worked on them by himself, he thought about [the psychotherapy content]."

Some therapists checked clients' willingness to put effort into psychotherapy simply by telling clients how they were going to work with them and expecting them to either accept or reject the offer. When the clients rejected the offer, they would drop out of the treatment. Other therapists started to work in their preferred way and paid attention to whether the clients followed. For example, when a client was talking too much about his symptoms instead of the psychosocial aspects of his life, the therapist used education and discussion of symptoms at first and gradually moved towards an exploration of the client's experience.

Leading clients to accept that they would be the ones "working" in psychotherapy

Clients who viewed their symptoms from the perspective of somatic medicine were perceived by the psychotherapists as often expecting to be "given" a treatment (i.e. surgery, diagnostic procedures) or advice with relief from symptoms. Consequently, the therapists led the clients to recognize that they themselves had the responsibility for doing the "work" in psychotherapy, that the therapist would not have a "cure" for them, and that recovery would be a long-term process. This intention was exemplified by a psychodynamic therapist (T07) who initially felt stuck because a client expected that the therapist would do all the work:

> The client annoyed me in a way (. . .) by her expectation that someone else was going to do something with her. It took some time before she understood that she needed to do the work herself. (. . .) In the beginning, we were kind of stuck because she sat and waited for whatever I would come up with.

In this initial stage, many psychotherapists felt they were more active than with other clients. They considered clients with MUPS to be easily discouraged from continuing the treatment, and they did not want to frustrate the clients who needed more time to become used to their role in therapy. Their plan was to gradually shift the responsibility for doing the "work" to the clients. When using these strategies, therapists were sensitive to the need of clients whom they perceived as seeking an "expert" who could help them. On the other hand, there were therapists who strived to avoid the expert role if they perceived the clients as frustrated with "experts" who were unable to help them.

Leading clients to accept that symptoms are linked to psychosocial aspects

The clients could explicitly or implicitly agree to engage in psychotherapy. However, the therapists noted that the clients differed in the degree to which they believed that it was useful to focus on the psychosocial aspects of their lives in connection with their somatic symptoms instead of seeking a medical explanation. One family therapist (T19) described how she searched for clues that her clients believed it would be useful to explore psychosocial aspects in the following way:

> I think that the first thing I do with these people is that I explore their motivation for looking inside themselves. I am searching for some rudimentary belief in them that (. . .) there is some seed of belief that this [physical symptoms] might have some psychological causes.

The process of accepting the possibility that somatic symptoms could be linked to psychosocial factors was gradual. First, the therapists perceived that the clients were willing to put some faith in the psychosocial explanation of their symptoms, but they were doubtful. The therapists noted that it was useful to strengthen their conviction. It was also important to let the clients experience at least some small change resulting from the treatment or to explain that the treatment results would not arrive immediately. Gradually, the therapists noticed that clients started to believe that it made sense to focus on the psychosocial aspects of their symptoms. However, this process was not straightforward; thus, clients could repeatedly move between a more or less firm belief.

Because psychotherapists expected psychosocial factors to be the main content of psychotherapy, they used several tactics to "get the somatic symptoms out of the way" and make space for psychosocial exploration if the clients overfocused on somatic symptoms. One approach was to ignore the somatic symptoms, as the potential of somatic examinations was exhausted for the clients. This meant gradually developing areas of interest and goals other than the explicit treatment of somatic symptoms. Another approach was to temporally focus on symptoms at the start of the treatment so that the clients were assured that the somatic side of their problems was sufficiently addressed.

Providing a safe space for the exploration of psychosocial factors

An important way of drawing clients into psychotherapy was by developing a supportive and authentic psychotherapeutic relationship. Therapists perceived clients with MUPS as guarded in their interpersonal relationships and especially in contact with health professionals since they viewed many clients as disillusioned by the fact that no professionals had been able to help them thus far. It was important not to suspect clients of malingering and to validate the clients' experience.

The therapists noted several important functions of the therapeutic relationship. First, it served as a corrective experience with regard to the relationships of clients with their family and health professionals, who (according to the clients) often showed mistrust and impatience. Moreover, many clients talked about traumatic experiences that made them cautious in relationships; thus, the therapeutic relationship provided a contrasting experience. Second, the relationship served as a holding environment that should increase the willingness of clients to explore their experience and to make changes in their lives, which could be frustrating. Third, the relationship helped motivate clients to continue with

psychotherapy, even if they sometimes doubted that they could get better with psychological treatment. A gestalt psychotherapist (T18) explained the relationship importance in the following way:

> At the beginning (. . .) there was a pronounced wariness evident [in the client]. (. . .) There was constantly some doubting that what we were doing could actually make the somatic symptoms better. But I think that because a good relationship was established, the client remained there, and it worked.

Showing clients that psychotherapy could help them

The therapists sought to show clients that psychotherapy could help their concerns, which would strengthen clients' resolution to stay in psychotherapy. The strengthening of clients' resolution was important because of recurring doubts regarding psychosocial factors, their exhaustion from failed attempts to find a solution, and the resulting loss of hope.

An important way of demonstrating the usefulness of psychotherapy to clients was to provide them with the experience of improvement at the start of the treatment. The therapists achieved this by interventions such as exercise, relaxation, or practical changes in the client's lives. Other interventions the therapists used to show their clients that psychotherapy could help them were explaining how psychotherapy works and supporting the hope that their symptoms can change. Therapists also gave examples of similar clients who were helped in psychotherapy and explained that many other people have similar issues.

While the therapists strengthened clients' hope and trust in therapy, they warned that high hopes needed to be modulated. Because they could not determine the potential for change and there was the possibility that a somatic cause or no clear psychosocial explanation might be discovered, the psychotherapists warned clients that symptoms might not disappear completely. A family and systemic therapist (T29) explained how the management of expectations failed in a case of unsuccessful psychotherapy:

> She trusted me a lot; she had great hope, maybe a little inadequate, that I would help her get rid of it [the somatic symptoms]. (. . .) I think that our relationship was a bit affected by the fact I had not fulfilled these expectations, and we were not able to arrive at a point where we could talk about this.

Succeeding in drawing clients into the psychotherapeutic way of working seemed to be a specific critical point for clients with MUPS. If the therapists were unable to realize some of the abovementioned goals, the treatment might end before the second phase could start. Either the clients left the therapy themselves, or even the therapists did not want to continue working without successfully going through the first phase. However, even when the clients remained in therapy, it could happen that some goals were partially or completely not met. In such cases, the therapists needed to repeatedly return to some critical points (e.g. the acceptance of psychosocial factors as important) even in the second phase.

Phase 2: changing the impact of symptoms on clients' lives

After the clients were drawn into the treatment, the second psychotherapy phase could start. The therapists' intention in this phase was to help clients understand the psychosocial context of their symptoms and facilitate changes in their lives and experience. The aim was to help reduce the impact of symptoms on clients' lives.

Clients' skills were important in this phase. Because developing an understanding of links among symptoms and psychosocial aspects of clients' lives was the preferred strategy of most therapists, they needed their clients to be able to reflect on their thoughts and bodily and emotional experience. This would enable them to develop insight and change their attitudes and way of relating to other people. If the therapists perceived the clients as not having the skills, the therapists had to find alternative strategies: One option was working with clients to develop the missing skills; the second option was making practical changes in clients' lives that did not require clients to understand the larger picture of their problems; the third option was a resignation in regard to therapeutic work and keeping in basic supportive contact.

Although the content of clients' insights and behavior changes varied as their stories reported by the therapists did, there were some typical themes the therapists noticed: clients often needed to take better care of their needs; improve their relationships with significant others; to change their self-perceptions about demands they put on themselves; to better express their emotions, or to connect to their past and present experience of stressful events. Therapists' focus on experiencing and expressing emotions and their connection to clients' bodily sensations was prominent because clients were often perceived as avoiding their emotional experiences or being disconnected from them.

Helping clients expand their awareness skills

The therapists described clients with MUPS whose awareness of their emotional and bodily experience was low as difficult to work with in psychotherapy. Such clients had trouble using experiential information as guidance when trying to understand and influence the symptoms. Many therapists tried to help clients expand their emotional and bodily awareness.

To help clients expand their emotional and bodily awareness, the therapists used mindfulness exercises, they led clients to keep noticing and name their sensations in the present moment, educated clients about sensations connected to emotional and bodily states, or used their own example to show what people experience in various situations.

While many therapists attempted to gradually expand clients' awareness, sometimes this did not seem to work. Some therapists considered clients' limits to bodily and emotional awareness to be a stable trait, and consequently, they did not attempt to expand it. In these cases, the therapists focused on strategies that did not depend on this awareness (i.e. practical changes in clients' lives or reducing psychotherapy to a basic supportive contact).

Helping clients develop a nuanced understanding of psychosocial context

Most therapists' primary strategy was to help clients develop an understanding of connections between their somatic symptoms and the psychosocial context of their lives.

They noted that although many clients with MUPS suspected that their concerns might be connected to psychosocial factors, they usually did not know how the interaction worked. Understanding this interaction and changing it should alleviate the symptoms. There were two variants of the strategy. The therapists focused on somatic symptoms either directly or indirectly.

Direct focus meant using symptoms as signals of clients' reactions to life events. For instance, a therapist led a client to notice that her fatigue was getting worse when she did not refuse exaggerated demands of others, although she was uncomfortable complying with these demands. As a result of this knowledge, when the client noticed fatigue, she could use it as information about the situation she was in and try to resist others' demands. Thus, symptoms were used as explicit markers: the clients learned to understand these markers as the pattern of their reaction to various events, and this could result in behavior change as the clients developed new responses in symptom-related situations.

Alternatively, therapists did not focus directly on somatic symptoms because they considered this was counterproductive and diverging the attention from the psychosocial aspects of clients' concerns. Thus, the therapists sought to help clients understand the broader picture of their functioning, expecting that the symptomatic change would happen in parallel to this process. Therapists using this strategy variant were more interested in the broader context of their clients' lives rather than their symptoms, although they also explored the context in which the symptoms emerged.

Facilitating practical changes in clients' lives

The degree of insight clients could achieve, according to the therapists, was limited by some clients' introspective abilities and by their ability to connect different aspects (e.g. emotional and bodily experience, social functioning, self-concept) to develop insight. When attempts to develop insight failed, the therapists opted to facilitate practical changes in clients' lives. Practical changes could be accompanied by insight, but it was not considered necessary.

Similar to the previous strategy, the therapists either aimed to directly focus on and influence symptoms or sought to facilitate changes in clients' lives without a direct focus on symptoms. For instance, interventions directly influencing symptoms included medication, systematic exposition, relaxation training, exercise, or changes in clients' home and work environment. Indirect interventions included behavior training (e.g. assertiveness), problem solving, lifestyle changes, developing competencies, seeking new relationships, or bodywork.

There were differences among therapists in the degree to which they deemed practical changes in clients' life as a sufficient outcome of psychotherapy, even though these changes could lead to the disappearance of clients' somatic symptoms. Some therapists considered insight as not always necessary, such as the following CBT therapist (T18):

> I think that insight is a bit overvalued. I am not sure that clients' understanding of why things are happening always means change. (. . .) Some clients indeed (. . .) need to understand and have insight, but for some clients, the process is intuitive; they start to do things differently, and they do not need to know [why the change happens].

On the other hand, there were therapists who said that even though practical changes led to symptomatic changes, somatic symptoms may re-emerge if the clients achieved partial insight or if they retained problematic patterns of behavior in the therapists' view. As a result, some therapists marked clients whose symptoms disappeared as unsuccessful cases because they did not achieve "deeper" changes.

Resignation to the original treatment goals

When the psychotherapists repeatedly attempted to use their clinical strategies across many sessions, but clients did not respond, the psychotherapists resigned to the original goals they considered helpful and agreed on with their clients at the start of the treatment. For example, this happened when they tried to lead clients to explore their experiences in situations connected to the emergence of somatic symptoms. However, clients kept talking about their somatic worries and needed reassurance.

Resignation to the original goals can be seen as a strategy *per se*. Clients with limited progress in therapy were conceptualized as having lower cognitive and introspective abilities, as chronified, lacking motivation, or having limited resources to make the desired practical changes in their lives. A CBT therapist (T22) described his view of a client who made some progress but could not move further in the following way:

> I think that the client did a lot of work with regard to the options he had. My ideas on how he could function better were present there, but I do not think that it is ethical to make this obvious to clients or to push these ideas onto them.

The resignation took different forms and was connected to the psychotherapists' perception of success in psychotherapy. If the therapists felt dissonance between the goals they aimed to reach with all clients suffering from MUPS and goals achieved with specific clients, they considered such cases to be less successful. For some therapists, facilitating practical changes in clients' lives instead of trying to achieve insight already meant a kind of resignation. Most therapists, however, resorted to providing psychological support if their clients appreciated this form of therapy, and they accepted that clients could not be helped more at the time. In other cases, the therapists worked with the clients on accepting the situation or returned to the medical management of their symptoms. Some therapists also ended treatment with clients who did not progress perceiving basic supportive contact as ineffective. In general, resignation meant freeing the therapists from the demands of the best outcome that could be achieved in therapy from their perspective, accepting a limited treatment success, and respecting clients' capacities for change. Whatever the client's gains from psychotherapy were, at a certain point, the therapists started to focus on developing the clients' capacity to maintain their achievements. It was important for them that the gains from psychotherapy were also available to the clients outside the psychotherapy room and hopefully after the psychotherapy. Such a change of focus from reducing the impact of symptoms on clients' life to maintaining the gains from psychotherapy presented a move to the third phase.

Phase 3: integrating psychotherapeutic gains into clients' lives

The therapists noted that somatic symptoms of many clients were reduced in psychotherapy but that they would not disappear completely and that symptoms could sometimes

return even if they disappeared for some time. This was based on the conceptualization of clients as having the tendency to react by developing somatic symptoms to various stressful events in their life and by the notion that some clients did not achieve changes the therapists considered permanent (e.g. stable changes in patterns of functioning or personality changes). As a result, in the third phase, the therapists focused on the integration of progress achieved in psychotherapy into clients' lives. This also worked as a preparation for the potential return of symptoms and as a way of developing potential for further cooperation if needed.

Preparing clients for the return of symptoms

The application of changes in clients' lives both during and after the treatment was emphasized by the therapists. The therapists led clients to be able to continually translate their somatic symptoms into meaningful messages within the context of their lives: they reinforced the competencies clients could use if the symptoms returned, and they also planned with clients the future configuration of their lives and further practical changes. The therapists' intention was to help clients better manage their symptoms without psychotherapy. A psychodynamic therapist (T07) described his client's progress the following way:

> She started to feel competent in the sense that sometimes she could have some issues. It was not like she would leave with "I won't have any problems anymore," which is unattainable, I think. But when she would have some fantasies again, some fears and anxieties, she had some firm ground beneath her, where she could manage them.

The variety of options clients had to manage their symptoms was wide, as was the variety of changes and insights in the previous psychotherapy phase. For example, the therapists mentioned continual exposure to stressful situations, using the sensitivity to emotional and bodily cues as guidance in clients' lives, retaining lifestyle changes, new ways of relating to others, continual usage of relaxation exercises, or emotional expression.

Being open to the continuation of treatment

Because the therapists expected that the clients' symptoms could return and they considered the changes some clients could achieve as limited, they were open to psychotherapy continuation. The openness to continue therapy was also important because the therapists considered clients with MUPS often sensitive to rejection.

The openness to the continuity of treatment had two forms: First, the therapists kept open the possibility that even though some clients had not achieved a significant change, they could later have more resources and be prepared to address important issues more in-depth or to address avoided issues. Second, the therapists were prepared to work with their clients repeatedly when their symptoms returned. An integrative therapist (T05) illustrated his view of therapy continuation in the following way:

> Maybe this is a case of minimalist psychotherapy. When the therapist (. . .) does not expect these people (. . .) to know themselves better and to get rid of all the neurotic mechanisms and be cured. When people do not want that, we should not force them.

Discussion

The present study explored the clinical strategies used by 31 experienced psychotherapists in the treatment of clients with MUPS. The strategies were organized in three treatment phases with specific challenges in each phase.

Changing the clients' passive, guarded, symptom-oriented, and hopeless attitudes to the treatment in the first phase were viewed as the most important for the treatment success. This aim was based on the therapists' response to challenging client characteristics reported previously by diverse professionals across specializations (Balabanovic & Hayton, 2019; Czachowski et al., 2012; Heijmans et al., 2011; Luca, 2012). Engaging clients in treatment by bridging the gap between clients' and therapists' understanding of clients' issues and their expectations from the treatment has been shown as essential for the success of treatment (Balabanovic & Hayton, 2019). The process of drawing clients into psychotherapy resembles strategies of preparing clients for psychotherapy that are useful in increasing session attendance (Oldham, Kellett, Miles, & Sheeran, 2012), which predicts outcomes (Lambert, 2007). The present study enriches the literature by showing in detail what strategies experienced psychotherapists use to prepare clients with MUPS for the treatment and which characteristics they use to identify challenging clients.

The clients reported in successful cases were perceived as not having the challenging characteristics, which aligns with the notion that clients with MUPS are heterogeneous. Many do not have the traits presented as typical for them, such as alexithymia (De Gucht & Heiser, 2003). Clients without these characteristics were perceived as responding to common strategies that the therapists used with various groups of clients. In accord with previous research (Luca, 2012; Řiháček & Čevelíček, 2019), the psychotherapists emphasized strategies tailored specifically to clients with MUPS if they perceived them as typical (i.e. challenging), which helps adapt the treatment to clients' needs (Oddli et al., 2016).

It is important to note that a self-serving bias might be present in the psychotherapists' view of "challenging" clients. When the therapists ascribed a failure of the treatment to some clients' deficiency (e.g. capability, degree of insight), they might miss the option that the failure of the treatment was connected to some aspect of the psychotherapist (i.e. they chose an unsuitable strategy) or that the clients would improve regardless of the treatment (see Cuijpers & Cristea, 2015). Another bias may stem from clients' agreeable attitudes. Some clients act the way psychotherapists expect of them, and they seem to get better, while disagreeable clients seem less successful. The identification of clients' attitudes may guide finding the most suitable strategy for a given client (Norcross & Wampold, 2018).

In the second treatment phase, we discovered a tension between focusing on functional changes in clients' lives and insight-oriented treatment. This tension reflects differences across orientations of therapists, as some therapists who adhered to insight-oriented approaches evaluated clients' progress in other areas less favorably. However, many therapists indicated the need to be accommodating to the clients' momentary needs and resources. This raises an essential point of flexibility in the approach of therapists who treat clients with MUPS (Luca, 2012), which helps them find a helpful focus that does not need to be mainly insight-oriented or pragmatic (Balabanovic & Hayton, 2019). Even though insight is an effective change mechanism (Hoglend &

Hagtvet, 2019), the assumption that insight is necessary to achieve changes may limit therapists' responsiveness to the individual cases and worsen outcomes (Owen & Hilsenroth, 2014). An integrative view of psychotherapy that offers a range of effective change mechanisms in the treatment of MUPS might provide the flexibility that can be more important for clients with MUPS (Řiháček & Čevelíček, 2019). However, such an integrative stance and flexibility can also be achieved by therapists who adhere to a specific psychotherapy approach. The clinical strategy of resignation to original treatment goals, which the therapists used with clients whose progress they perceived as limited, shows how the psychotherapists dealt with frustration encountered by diverse healthcare professionals in the treatment of MUPS (e.g. Czachowski et al., 2012). The unsuccessful cases either encompassed a large number of sessions or very few sessions compared to the successful cases. This shows that the resignation to original treatment goals was usually a reaction to clients' slow progress in the long term, or the psychotherapy ended quickly. Resigning to the original treatment goals may help psychotherapists free themselves from the demands of what should be achieved in the treatment, as they emphasize the respect for clients' capacity for change. This acceptance has been mostly missing in the literature on the treatment of MUPS since, understandably, research mostly aims to find effective strategies for managing MUPS (e.g. Balabanovic & Hayton, 2019; Heijmans et al., 2011) instead of exploring the situations when these strategies fail. However, this exploration appears to be important for the clinicians' management of the most challenging clients.

In the third treatment phase, the therapists focused on developing clients' capacity to maintain their achievements. This responded to the recurrent nature of MUPS (e.g. Rosendal et al., 2017), which shows the importance of developing clients' ability to manage returning symptoms on their own after the psychotherapy ends. In cases when clients are unable to manage their symptoms on their own, or as they become better prepared to make additional progress, the treatment may continue. Keeping the door open for clients with MUPS may be an important strategy, which shows relationally guarded clients that a psychotherapist would not abandon them (Luca, 2011).

Limitations

The present study relies on therapists' retrospective recollections, which are limited by the participants' ability to recall the treatment of individual clients in detail. Even though we attempted to reduce this potential bias by asking the therapists to talk about recent cases, the precision of some descriptions may be limited. The selected research strategy also did not allow us to use standardized outcome and process measures to show that a particular strategy was used with specific clients and that it was related to the therapeutic success, even though this would strengthen the study conclusions.

The psychotherapists were allowed to choose the successful and unsuccessful cases when respecting our selection criteria, but they were not given a definition of success. This was both a strength and a limitation. It enabled us to explore what therapeutic success meant for the participants, but at the same time, we could not control whether the cases noted as successful measurably improved.

This study relies on the assumption that clinical strategies and mechanisms of change are identical across different treatment models. Arguably, the strategies may have different theoretical backgrounds in different approaches. Nevertheless, we believe that the study's strength is that the integrative perspective of clinical strategies allows a generalization of the results (Goldfried, 1980). At the same time, we should note that the study includes therapists who worked with clients in mental health care. For instance, the setting of general practice may require less time-consuming strategies (see Hartman et al., 2009).

The transferability of our results is influenced by the cultural and social context of the Czech Republic, where the study took place. Perceptions of mental health in the Czech Republic gradually change towards higher acceptance of psychological treatments, and psychological distress is perceived as more culturally acceptable. Therefore, the focus on psychosocial explanations in the treatment of MUPS may be more acceptable than in cultures that prefer the perception of (psychological) distress as somatic, such as Asian culture (Kirmayer & Sartorius, 2007).

Future directions

How therapists react when their clients show limited progress in the treatment and the mental concepts and theoretical assumptions leading them to evaluate some cases as unsuccessful could be further explored since these aspects influence the professionals' emotional reactions present in the relationship with clients who have MUPS. Differences between successful and less successful cases and strategies that psychotherapists tailor to clients with specific traits appear to be also a valuable direction for future research because the present article mainly dealt with clinical strategies common across psychotherapists and clients but focused less on nuanced strategies that need to be devised when the treatment does not progress along the expected pathway. The strategies of managing the main challenge of working with clients with MUPS – drawing them into psychotherapy – could be explored in detail and also refined from the perspective of individual therapists. The ways the therapists lead clients with MUPS to integrate gains from psychotherapy in their daily lives could be explored in more detail since symptoms are pervasive in clients with MUPS (van Dessel et al., 2014).

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