

Clinical Practice Guideline: Psychotherapies for Somatoform Disorders

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INTRODUCTION

Somatoform disorders are characterized by the chronic presence of physical symptoms, which are not explained by any physical disease. All somatoform disorder subtypes share one common feature; predominance and persistence of unexplained somatic symptoms associated with significant distress and impairment. The International Classification of Diseases, 10th Revision (ICD-10) describes medically unexplained symptoms, with significant psychological distress as “somatoform disorders” [Table 1].^[1] Patients with somatoform disorders often consult multiple physicians/specialists. Limited understanding of the somatoform disorder and its management among general physicians often results in repeated unnecessary investigations and polypharmacy.

This guideline focuses on the evidence-based psychotherapeutic interventions used for the management of somatoform disorders. It will help clinicians and mental health professionals understand the relevance of psychotherapy in the management of somatoform disorders in adults and in adopting various psychotherapeutic modalities in their clinical practice. The guideline for the management of somatoform disorders in children and adolescents has been published separately.^[2]

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ASSESSMENT

A thorough pretherapy assessment is the cornerstone of any psychotherapy for the somatoform disorder. This includes a detailed description of symptoms, patterns and severity, distress associated, and the effect on functioning [Table 2].

ASSESSMENT OF BIOPSYCHOSOCIAL FACTORS

Multiple factors play a role in the development and persistence of symptoms of the somatoform disorder [Table 3]. Identifying and addressing them during the therapy is important. Certain personality characteristics of an individual increase his/her vulnerability for the somatoform disorder. The presence of stress often acts as a predisposing, precipitating as well as perpetuating factor in the development and maintenance of somatoform disorder. Medical and psychiatric comorbidities may lead to the persistence of features of somatoform disorder.^[3] The assessment should also focus on identifying the strengths of the individual (the presence of psychosocial support, having a job, and nonsubstance user) and strengthening them further during the therapy process.

STRUCTURED ASSESSMENTS FOR SOMATOFORM DISORDER

In addition to clinical assessment, subjective and objective rating tools may be used to assess the severity of somatoform

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Table 1: Somatoform disorders

	Category	Description
1	Somatization disorder	Multiple, recurrent, variable physical symptoms involving several body systems, of 2 years duration (includes Briquet syndrome)
2	Undifferentiated somatoform disorder	Multiple, persistent, variable symptoms of severity and/or duration less than that of somatization disorder
3	Hypochondriacal disorder	Persistent preoccupation with the possibility of having a major disease or presumed bodily disfigurement/deformity (includes body dysmorphic disorder)
4	Somatoform autonomic dysfunction	Multiple unexplained symptoms related to systems under autonomic control (includes psychogenic cardiac, gastrointestinal, respiratory, and genitourinary disorders)
5	Persistent somatoform pain disorder	Unexplained persistent and distressing pain symptoms of possible psychogenic origin
6	Other somatoform disorders	Unexplained symptoms limited to specific body parts/system not mediated by autonomic pathways (includes globus hystericus, psychogenic torticollis, psychogenic pruritus, psychogenic dysmenorrhoea, teeth grinding)
7	Somatoform disorder, unspecified	Unspecified medically unexplained symptoms

disorder at baseline and to monitor the improvement in symptoms with therapy. The commonly used instruments are summarized in Table 4.

FORMULATING A MANAGEMENT PLAN FOR PSYCHOTHERAPY IN SOMATOFORM DISORDERS

Over the last decade or so, the evidence base for psychotherapies in somatoform disorders has grown significantly. This has contributed greatly to our understanding of what works and what does not in this group of patients. A Cochrane review^[10] showed only modest benefits for nonpharmacological interventions, including cognitive-behavior therapy in somatoform disorders. Analyzing these findings, Schroder and colleagues conclude that illness severity, quality and quantity of psychological treatment are important moderators of treatment efficacy. With this in mind, clinicians should note the following general and specific considerations in formulating a treatment plan.

The medications being given for physical as well as psychiatric problems should be continued in liaison with respective physicians. For any new symptoms, the opinion of specialists should be sought.

BASIC STRATEGIES

The basic principles in the management of somatoform disorders can be divided into physician-centered and patient-centered strategies, regardless of their specific diagnosis [Table 5].

SPECIFIC TREATMENTS

Most of the patients benefit from the general measures that have been outlined above. In addition, simple techniques as listed [Table 6] can be used in settings where limited time is available for consultation. If these techniques are not effective, patients may be considered for more specific and

intensive psychotherapy.

Various forms of psychotherapy have been recommended for somatoform disorder. Evidence supports the role of cognitive behavior therapy (CBT), mindfulness-based interventions, acceptance and commitment therapy, and relaxation therapy in the management of individual subtypes of somatoform disorders [Table 7]. There are specific forms of psychotherapy described for specific somatoform autonomic dysfunction, for example, gut-directed psychotherapy for patients with irritable bowel syndrome. Patients, who are considered for psychotherapy, need to be assessed for suitability for psychotherapy. The level of evidence for various psychotherapeutic interventions for somatoform disorder has been mentioned in Table 8.

The assessment of suitability for specific psychotherapy

Suitability assessment aims at evaluating the factors that decide whether a patient with somatoform disorder is suitable for psychotherapy.^[20] Suitability determines the outcome of therapy. The factors can be divided into patient-, illness- and therapist-related factors [Figure 1].

CBT is one of the most evidence-based therapies for patients with somatoform disorder. Patients who are planned for CBT need to be assessed for the cognitive errors (distortions), severity, and nature of distress the individual is experiencing, the maladaptive behavioral patterns (avoidance behavior) along with the sociooccupational and interpersonal impairments.^[21] The assessment of several other psychological factors that might be useful from the psychotherapy point of view are – attribution style, coping skills, and perceived stress.

The assessment for psychotherapy in somatoform disorders is not limited to pretherapy assessment. The clinician/therapist needs to evaluate the progress of therapy by serially assessing the improvement during the course of therapy.^[22] The therapist needs to assess the client's adherence to therapy, factors that hinder the adherence to tasks assigned during

Table 2: Pretherapy assessment in somatoform disorder

	Component	Comments
1	The presence of somatic symptoms	Symptoms without obvious medical cause or in clear excess to medical condition
2	Subjective description of symptoms	Description in local language (e.g., gas-like sensation, churning in bowels)
3	Number of symptoms	Higher number possibly indicates severe illness (monosymptomatic vs. polysymptomatic)
4	Symptom types related to body systems	Symptoms across body systems indicate severe illness (e.g., somatization disorder)
5	Frequency and duration of symptoms	Symptoms may fluctuate (continuous vs. intermittent), chronicity indicates severe illness
6	Severity of symptoms	The intensity of symptoms may vary (e.g., degree of pain as assessed by visual analog scale)
7	Pattern of symptoms	Symptoms are dynamic (symptoms change over time)
8	Beliefs about symptoms	Each patient will have specific beliefs related to the symptoms
9	Attribution	Persistent attribution to medical illness despite medical reassurance
10	Distress related to symptoms	Subjective distress demarcates presence of syndromal disorder
11	Interference with functioning	How the symptoms interfere with the functioning
12	Aggravating and relieving factors	Factors that worsen or improve the symptoms
13	Mood and anxiety symptoms	These symptoms may be present at syndromal or subsyndromal level
14	Medical illness	Comorbid medical illness present (may or may not account for all the somatic symptoms)
15	Psychosocial factors	Factors related to somatic symptoms (though not acknowledged by the patient)

Table 3: Assessment of biopsychosocial factors

	Factors	Comments
1	Genetic	Family history of somatization
2	Early life events	Childhood adversities such as separation from mother, abuse or maltreatment, neglect, insecure attachment
3	Recent life events	Major life events in the past year
4	Chronic daily life stress	This includes feeling pressured at work, feeling “tensed,” frequent arguments with family members
5	Coping	Not able to handle everyday demands of life
6	Unhealthy lifestyle	Lack of exercise, substance use, irregular sleep pattern
7	Personality factors	Presence of alexithymia, Type A behavior, coping styles
8	Support system	Lack of social support (emotional or instrumental), Employment status, Financial condition
9	Comorbid medical or psychiatric disorders	Long-standing medical illnesses, substance use, other psychiatric comorbidities
10	Cultural factors	Higher somatizing tendencies

Table 4: Rating instruments for somatoform disorder

	Scale	Comments
1	PHQ-15	A 15-item questionnaire exploring 15 somatic symptoms. Each symptom is rated from 0 (refers to – not bothered at all) to 2 (refers to – bothered a lot). The cut-off points for low, medium and high symptom severity are 5, 10 and 15 respectively ^[4]
2	SSS-8	An 8-item self-report scale. The symptoms are rated from 0 (not at all) to 4 (very much). The score ranges from 0 to 32. The severity of the symptoms is rated as “no to minimal:” 0–3; “low:” 4–7; “medium:” 8–11; “high:” 12–15; and “very high:” 16–32 ^[5]
3	SASS	This scale consists of four subscales: 1. Pain-related symptoms; 2. Sensory somatic symptoms; 3. Non-specific somatic symptoms; 4. Biological function related symptoms. The symptom severity is rated on a four-point scale ranging from 0 to 3, where “0” refers to absent; “1” refers to mild; “2” refers to moderate and “3” refers to severe. The scale measures symptoms during the past 2 weeks ^[6]
4	SSI	A scale listing 11 symptoms used for screening. The presence of 5 or more symptoms suggest somatoform disorder ^[7]
5	BSI	This is a multi-ethnic inventory of somatic symptoms present with depressive and anxiety symptoms. It contains 46 items ^[8]
6	WI	It has 14 items used to characterize three dimensions, a) disease conviction, b) somatic preoccupation, and c) disease phobia ^[9]

PHQ-15 – Patient health questionnaire 15; SSS-8 – Somatic Symptom Scale 8; SASS – Scale for the Assessment of Somatic Symptoms; SSI – Swartz Somatization Index; BSI – Bradford Somatic Inventory; WI – Whitley Index

the therapy sessions, any ongoing stressor as well as client's attitude toward therapy. The success of psychotherapy depends a lot on individual responsibility; hence, during therapy, it needs to be assessed and reinforced regularly. The competence of the therapist and compliance of the client determine the outcome of the therapy.^[23]

CHOICE OF TREATMENT SETTING

By and large, most patients with somatoform disorders are treated in the outpatient setting using strategies outlined in the previous section. However, there may be exceptional situations in which one may consider

Table 5: Physician and patient centered strategies

A. Physician centered strategies and their respective elements	
Strategy	Elements
1. Establishing a therapeutic alliance	This is the cornerstone of all the successful nonpharmacological approach and forms the base upon which the therapist makes further recommendations including delivery of the diagnosis
2. Validating the nature of and distress caused by symptoms	A thorough clinical assessment, including history and examination is necessary. The findings of the examinations are conveyed to the patient while validating their symptoms
3. Manage general medical conditions	All comorbid general medical conditions are treated appropriately
4. Restrict diagnostic testing and specialist referrals	Limiting diagnostic testing and unnecessary referrals is essential so as to avoid the “next best investigation trap” which is frequently suggested by the patients
5. Communicate with the patient	Includes an open discussion about the formulation of the symptom(s) in biopsychosocial terms (e.g., back pain caused by stress-induced muscle tension and perpetuated by bad sleep habits), the diagnostic tests proposed and outcomes anticipated, the treatment options available, reassurance and setting goals of treatment (whether symptom reduction or cure). The psychogenic basis of the illness and relevance of learning certain therapeutic skills to deal with the psychological distress also need to be communicated to the patient
6. Avoid “dualistic thinking” trap	Patients may try to steer the conversation towards whether the symptoms are purely mental, based on the fact that they have been referred for psychiatric evaluation. Gently move the discussion from “either mental or physical” to “mental as well as physical.” Evidence suggests that patients are often ready to receive both biological as well as psychosocial explanations for their problem
7. Carefully target reassurance	Desist from excessive reassurance and acknowledge uncertainty about the cause of symptoms. Explain that symptoms do not equate with disease and educate about coping with physical symptoms
8. Treat any concurrent anxiety or depression	Early identification and management of these treatable co-morbidities should be focussed upon
9. Shift focus away from symptoms to functioning	Though the patient may focus on the symptom at every visit, the therapist should focus on other areas of life such as work output, activity, and sleep
10. Maintain consistency	This implies that the therapist sticks to the case formulation and management plan in successive consultations and does not get pressurized into changing course in the face of evolving anger or frustration on the part of either the patient or physician
11. Liaise with other specialists involved in care of the patient	Very often, bodily symptoms may require multidisciplinary care for optimum benefits. It also sends across a message to nonpsychiatrists about the necessity and possibility of a collaborative care approach to the management of these cases
12. Be aware of prescription drug dependence (commonly benzodiazepine dependence)	This can affect engagement with and effectiveness of therapy. To avoid this undesirable complication, emphasis should always be given to nonpharmacological strategies as the first line of treatment
13. Look for hints that suggest a psychosocial contributor to the problem	An example of this is symptoms getting exacerbated following an argument with the spouse. The psychosocial factor may/may not have a temporal correlation with the onset of somatoform disorder. These variables need to be explained to the client (as an explanatory model for the illness) during psychoeducation and can be targeted in the therapy too
B. Patient-centered strategies and their respective elements	
Strategy	Elements
1. Explicit resetting of treatment goals	The goals of the treatment are restated with a shift in focus from symptoms to functional improvement
2. Lifestyle changes	Encourage the patient to adopt a healthy lifestyle such as; regular aerobic exercises, balanced diet, sleep hygiene practices, and pursuing hobbies. This will simultaneously activate reward mechanisms in the brain as well as boost the body’s own endogenous opioid systems resulting in attenuation of pain symptoms if any

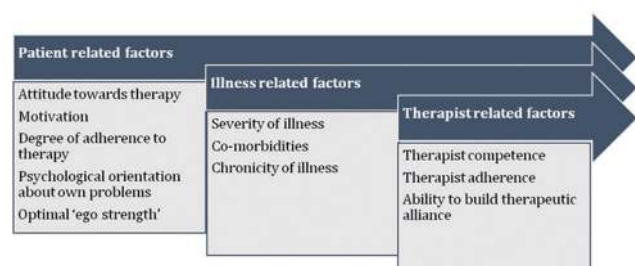
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Table 5: Contd...

B. Patient-centered strategies and their respective elements	
Strategy	Elements
3. Addressing illness beliefs, dysfunctional behaviors (such as avoidance), explanatory models, health-related anxiety and disease conviction	There is a fair amount of evidence showing that these variables are linked to disease outcomes and prognosis in somatoform disorders and therefore, are important for clinicians to address
4. Manage “secondary gain”	Explain caregiver the concept of secondary gains and gradually reduce these gains

Table 6: Simple therapeutic techniques for somatoform disorder

	Technique	Comments
1	Positive suggestion: Somatic symptoms improve with “positive” suggestion about the definite diagnosis, as compared to “negative” suggestion of uncertainty of diagnosis and outcome	This can be incorporated as part of psychiatric consultation
2	Symptoms clinic intervention: Initially provide biomedical explanations for symptoms and initiate psychosocial talk when cued by the patient	Shorter and less psychologically oriented
3	Reattribution therapy: The three parts of this brief intervention includes a) feeling understood – to elicit physical symptoms, psychosocial problems, mood state, beliefs about the problem, relevant examination and tests, b) changing or broadening the agenda – to summarize physical and psychosocial findings and negotiate, and c) making the link – explanation relating the physical symptom to psychosocial problem based on timing or physiology	Has been studied well, but in absence of clear psychosocial problem it is difficult to use
4	Problem-solving approach: Simple steps of problem-solving can be taught to patients in situations when symptoms are related to conflict because of indecision regarding a different course of action	Advantage and disadvantage matrix can be constructed
5	Guided imagery: Construct an image representing a symptom in their mind and then they change it to become “how it should be”	Has been used in gastrointestinal disorders
6	Combined consultation: Simultaneous presence of a physician and a psychiatrist during the process of investigation, announcement of diagnosis and treatment plan	A pragmatic approach. An alternative is a sequential consultation

**Figure 1: Factors related to suitability of therapy**

inpatient care for different subtypes of somatoform disorder [Box 1].

Admission is usually time-limited, and once the necessary evaluation or symptom removal is done, it is advisable to discharge the patient and continue further treatment on outpatient basis as prolonged admission may foster the sick role and contribute to chronicity of symptoms.^[24,25]

AVOIDING DEPENDENCE

During psychotherapy, the therapist needs to evaluate the client for evidence of the development of dependence on therapist. Transference may be a reason for the development of dependence. Box 2 provides an indicative list of situations where dependence on therapist may be suspected.

Early identification of dependence on therapist and timely intervention is essential to achieve the desired outcome of therapy.^[26] Carefully setting the agenda, adhering to the agenda, preparing the client to deal with psychological conflicts, spacing the sessions as the therapy progresses, and periodically evaluating for therapeutic dependence will help prevent it. Identifying the development of dependence, discussing the dependency issues with the client during the therapy sessions, working on the self-esteem of the client as well as the psychodynamics of dependence is an integral part of the therapy process.

TERMINATING TREATMENT

Evidence supports that nearly one-fourth of the patients undergoing psychotherapy report improvement after single session, and nearly half of the patients report improvement by the end of eight sessions.^[27]

There is no general consensus on “when to stop psychotherapy in somatoform disorder?” Conventionally, patients require 10–20 sessions of therapy. However, some patients may need more sessions. The therapy can be stopped, when:

- There is a substantial improvement of the symptoms
- There is serious transference or counter-transference (may be shifted to another therapist)

Table 7: Evidence-based psychotherapies in individual somatoform disorders

Disorder	Therapy	Active components
1. Somatization disorder/Undifferentiated Somatoform Disorder	First line Psychoeducation	Emphasize the mechanism of symptoms than cause/encourage coping. Evidence exists for both individual and group format. Can be combined with consultation letter to physician
	Brief intervention – comprising of psychoeducation, relaxation therapy, and reattribution training	Empathically provide information to patient, progressive muscular relaxation and encourage a biopsychosocial approach to the symptom
	CBT	Targeting catastrophic misinterpretation of symptoms and encourage behavioral activation/functioning. Evidence says that individual CBT may be superior to group CBT
	Supportive psychotherapy	Listen, validate, empathize and targeted reassurance of the patient
	Relaxation therapy	Training on progressive muscular relaxation and diaphragmatic breathing
	Second line Short-term psychodynamic psychotherapy	Aim for insight into various unconscious phenomena, while others seek to address alexithymia, or difficulty identifying and experiencing emotions
	Family therapy	Examine the family's contribution to symptoms and their reactions. Joint discussions with family allow them to be more supportive toward the patient
2. Hypochondriasis	Stress management	Combines elements of relaxation, problem-solving, assertiveness training, and time management
	First line CBT	Cognitive restructuring, Exposure and response prevention to tackle maladaptive behaviors
	Second line MBCT	Combines mindfulness meditation with elements of CBT
	Acceptance and commitment therapy	Mindfulness training, acceptance of feared thoughts and feelings, clarification of values, and commitment to change behavior
	Third line Problem-solving therapy	Six step approach to defining, listing and weighing up solutions and implementing them
	Relaxation therapy	Progressive muscle relaxation, release only muscle relaxation, and diaphragmatic breathing
	Behavior stress management	Combines elements of relaxation, problem-solving, assertiveness training, and time management
3. Persistent somatoform pain disorder	First line CBT	Patient education, behavioral skill training, and cognitive-restructuring. Can be given in individual or group format
	Biofeedback	Psychophysiological demonstration of how mental faculties can influence physiological or biological functions
	Second line Family therapy Relaxation therapy	Focus on communication patterns and appropriate responses Targets muscular tension to relieve pain. Induced self-hypnosis also described. Often combined with CBT approaches

MBCT – Mindfulness-based cognitive therapy; CBT – Cognitive behaviour therapy

- There is no improvement or little improvement despite therapy (with adequate adherence to therapy, and even after evaluating and addressing factors that might contribute to nonresponse)
- The patient is not willing to continue therapy further (as it is a collaborative process).

MAINTENANCE AND FOLLOW-UP IN SOMATOFORM DISORDERS

Follow-up visits should follow a predetermined schedule and should not be symptom contingent. There is no ideal frequency of follow-up that suits or fits all patients. The visit interval differs for individual patients. The goal is to find the

right frequency that avoids the need for emergency visits or out of turn physical or telephonic appointments. Crisis calls must be handled supportively, yet firmly. As far as a possible therapist should try to adhere to the follow-up schedule already agreed on. In most cases, a reasonable schedule for stable patients would be one visit every 1 or 2 months. This schedule can be further tapered for those with good recovery.

The focus during follow-up visits is always to encourage functioning and coping. Early detection and treatment may limit functional impairment and improve prognosis in somatoform disorders.

Table 8: Evidence for psychotherapies in somatoform disorder

Title of the study	Study design/sample	Conclusion
1. The efficacy of cognitive-behavioral therapy in somatoform disorders and medically unexplained physical symptoms: A meta-analysis of randomized controlled trials (2019) ^[11]	Meta-analysis of randomized controlled trials 15 randomized controlled trials; pooled $n=1671$ Psychotherapy: CBT	CBT is effective for the somatic symptoms, anxiety and depressive symptoms in somatoform disorder
2. The effect of positive psychology interventions on well-being and distress in clinical samples with psychiatric or somatic disorders: a systematic review and meta-analysis (2018) ^[12]	Systematic review and meta-analysis 30 studies; pooled $n=1864$ Psychotherapy: Positive psychology interventions	Positive psychology interventions have a beneficial role in somatic disorders by reducing stress and promoting well being Effect size: Small
3. CBT for Health Anxiety: A Systematic Review and Meta-Analysis (2017) ^[13]	Systematic review and meta-analysis of randomized controlled trials 14 randomized controlled trials; pooled $n=1544$ Psychotherapy: CBT	Psychological interventions are superior to usual care, medication, and other psychological treatments Effect size: large
4. CBT for medically unexplained symptoms: A systematic review and meta-analysis of published controlled trials (2017) ^[14]	Meta-analysis of controlled trials 11 controlled trials; pooled $n=1235$ Psychotherapy: Standard CBT and mindfulness-based CBT	CBT is more effective than treatment as usual or enhanced usual care Effect size: Moderate
5. Cognitive-behavioral therapy for body dysmorphic disorder: A systematic review and meta-analysis of randomized controlled trials (2016) ^[15]	Systematic review and meta-analysis of randomized controlled trials 7 randomized controlled trials; pooled $n=299$ Psychotherapy: CBT	CBT is superior to waitlisted controls and psychological placebo in body dysmorphic disorder
6. Nonpharmacological interventions for somatoform disorders and medically unexplained physical symptoms (MUPS) in adults (2014) ^[10]	Cochrane database systematic review 21 randomized controlled trials; pooled $n=2658$ Psychotherapy: CBT, Mindfulness CBT, Behaviour therapies, Psychodynamic therapies, Integrative therapy	Psychological interventions are superior to usual care Effect size: Small Quality of evidence: Low to moderate
7. Effectiveness of psychotherapy for severe somatoform disorder: meta-analysis (2014) ^[16]	Meta-analysis of controlled trials 10 randomized controlled trials and 6 nonrandomized controlled trials; pooled $n=1438$ Psychotherapy: CBT, Psychodynamic interventions, Affective interventions, Interpersonal interventions, Experiential interventions, Body-directed interventions	Psychotherapies are more effective than treatment as usual Effect size: Moderate
8. Mindfulness-Based Therapies in the Treatment of Somatization Disorders: A Systematic Review and Meta-Analysis (2013) ^[17]	Systematic Review and Meta-Analysis 13 randomized controlled trials; pooled $n=1092$ Psychotherapy: Mindfulness-based stress reduction, Mindfulness-based cognitive therapy, Mindfulness-based pain management, Mindfulness meditation, Mindfulness CBT	Mindfulness-based therapies are superior to waitlisted controls in reducing pain, depression, anxiety, symptom severity and improving quality of life Effect size: Small to moderate Effectiveness of Mindfulness-based stress reduction and mindfulness-based cognitive therapy is better than unspecified mindfulness-based therapies
9. Efficacy of short-term psychotherapy for multiple medically unexplained physical symptoms: a meta-analysis (2011) ^[18]	Meta-analysis of controlled trials 27 controlled trials; pooled $n=1781$ Psychotherapy: CBT, behavioral intervention, progressive muscular relaxation	Short-term Psychotherapy is superior to treatment as usual Effect size: Small
10. Short-term psychodynamic psychotherapy for somatic disorders. Systematic review and meta-analysis of clinical trials (2009) ^[19]	Systematic review and meta-analysis of clinical trials 14 trials; pooled $n=1870$ Psychotherapy: Short-term psychodynamic psychotherapy	Short-term psychodynamic psychotherapy has a beneficial role for physical as well as psychological symptoms and sociooccupational functioning

CBT – Cognitive behaviour therapy

ADDITIONAL CONSIDERATIONS DURING FOLLOW-UP

- Ongoing patient and family education about symptoms and their changing nature may be necessary to allay concerns and facilitate return to normal routines and functioning
- The family members must be educated to spend time with and pay attention to the patient even on

symptom-free days so that the secondary gain from the symptoms is reduced

- The patient should be educated that minor variations in symptoms are common and need not be attributed to any “new pathology” in the body. If any stressor is anticipated following return to home or work, plans to address them should be chalked out in advance
- Any fresh symptom in follow-up must be discussed with the primary care provider. The temptation to discuss

Box 1: Situations where in-patient care for somatization disorder can be considered

Persistent somatization (Lipowski's criteria)^[17]

Patients with severe and long-standing physical disabilities (such as wheelchair bound or dependent on walking aids) who require both physical and psychological rehabilitation

When there is a need of multidisciplinary evaluation and psychological testing and when this may be better achieved by admitting the patient

When therapy needs to be planned on a more intensive basis either for the primary disorder or associated co-morbidities (such as depression)

When the family environment carries severe stressors and a brief change of environment is deemed helpful in symptom removal

When the patient resides far-away and may not be able to meet the structure and frequency of outpatient visits at least during the initial phase of treatment

When there is severe caregiver distress; to provide caregivers respite from the burden of care

Box 2: Situations where dependence on the therapist may be suspected

The client insists on frequent sessions

Lack of progress after the initial few sessions

Bringing up too many other issues (which are not part of initially agreed-upon agenda)

The spacing of the sessions resulting in worsening of symptoms

Resisting the change of therapist

Unreasonable demands from the client

Concurrent Personality disorder (especially anxious/dependent personality disorder)

with family and assign "seriousness" labels must be strictly avoided

- Family members can make use of distraction techniques (such as taking the patient out for a walk or a movie) to reduce the focus on bodily symptoms
- The therapist must be particularly vigilant against the possibility of a continued sick role or adoption of a "dependent" lifestyle on the part of the patient. Periodic assessment for psychiatric comorbidities such as depression, anxiety, and suicidal ideation should be carried out.

STEPPED CARE MODEL

A hierarchical symptom intensity-based approach has been described for the management of somatoform disorders.^[28] Essentially, a stepped care model, it advises initial basic care along with watchful waiting and follow-up for mild symptoms while simultaneously recognizing that more intensive, specialist driven psychotherapeutic approaches may be required in addition to basic care for more severe presentations. The distinction between mild, moderate, and severe symptom intensity is essentially based on clinician judgment which takes into account somatic and psychological extent of symptoms, loss of sociooccupational functioning, dysfunctional expectations, and abnormal

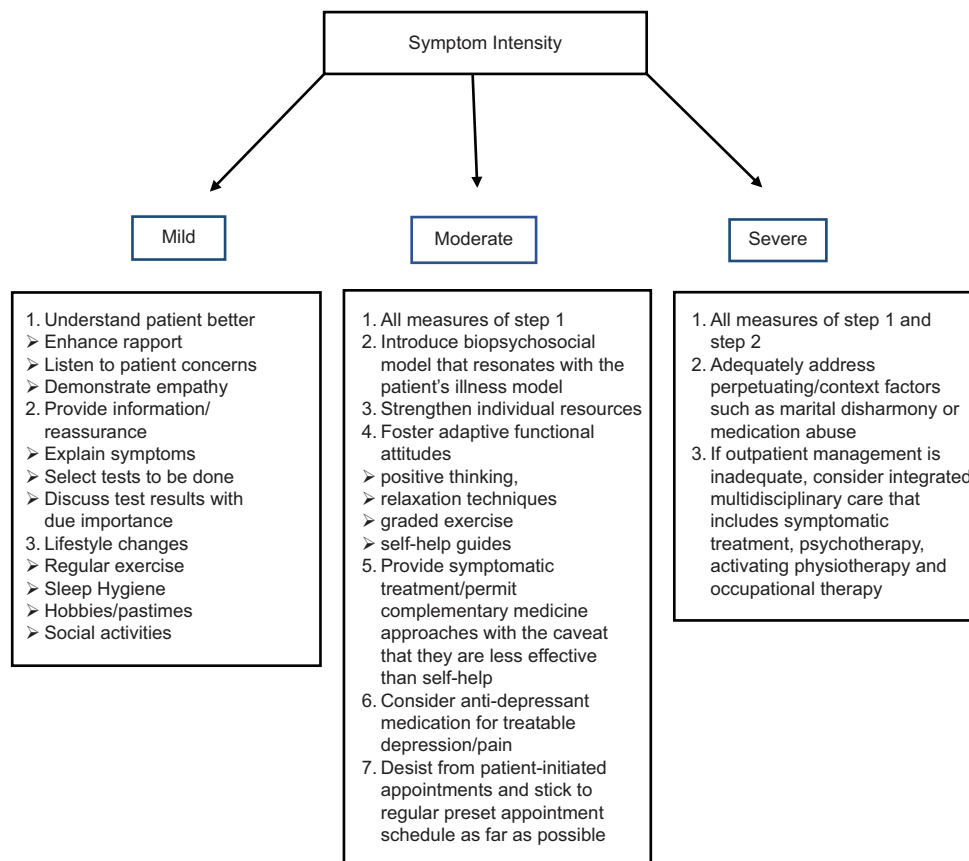


Figure 2: Hierarchical stepped care model for the management of functional somatic syndromes

illness behavior. The salient features of this stepped care model are shown in Figure 2.

CONCLUSIONS

The somatoform disorder includes a range of conditions, spanning from single unexplained symptom to polysymptomatic form, involving one organ system to multiple systems, and of varying severity levels. Approach to somatoform disorder includes a thorough assessment and use of simple psychotherapeutic techniques in most cases. A close liaison with other professionals is important to maintain the continuity of treatment. Few patients will require specific psychotherapy techniques and follow-up for a longer term to achieve adequate control of symptoms.

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Conflicts of interest

There are no conflicts of interest.

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