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[Intervention Review]

Non-pharmacological interventions for somatoform disorders and medically unexplained physical symptoms (MUPS) in adults

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ABSTRACT

Background

Medically unexplained physical symptoms (MUPS) are physical symptoms for which no adequate medical explanation can be found after proper examination. The presence of MUPS is the key feature of conditions known as 'somatoform disorders'. Various psychological and physical therapies have been developed to treat somatoform disorders and MUPS. Although there are several reviews on non-pharmacological interventions for somatoform disorders and MUPS, a complete overview of the whole spectrum is missing.

Objectives

To assess the effects of non-pharmacological interventions for somatoform disorders (specifically somatisation disorder, undifferentiated somatoform disorder, somatoform disorders unspecified, somatoform autonomic dysfunction, pain disorder, and alternative somatoform diagnoses proposed in the literature) and MUPS in adults, in comparison with treatment as usual, waiting list controls, attention placebo, psychological placebo, enhanced or structured care, and other psychological or physical therapies.

Search methods

We searched the Cochrane Depression, Anxiety and Neurosis Review Group's Specialised Register (CCDANCTR) to November 2013. This register includes relevant randomised controlled trials (RCTs) from *The Cochrane Library*, EMBASE, MEDLINE, and PsycINFO. We ran an additional search on the Cochrane Central Register of Controlled Trials and a cited reference search on the Web of Science. We also searched grey literature, conference proceedings, international trial registers, and relevant systematic reviews.

Selection criteria

We included RCTs and cluster randomised controlled trials which involved adults primarily diagnosed with a somatoform disorder or an alternative diagnostic concept of MUPS, who were assigned to a non-pharmacological intervention compared with usual care, waiting list controls, attention or psychological placebo, enhanced care, or another psychological or physical therapy intervention, alone or in combination.

Data collection and analysis

Four review authors, working in pairs, conducted data extraction and assessment of risk of bias. We resolved disagreements through discussion or consultation with another review author. We pooled data from studies addressing the same comparison using standardised mean differences (SMD) or risk ratios (RR) and a random-effects model. Primary outcomes were severity of somatic symptoms and acceptability of treatment.

Main results

We included 21 studies with 2658 randomised participants. All studies assessed the effectiveness of some form of psychological therapy. We found no studies that included physical therapy.

Fourteen studies evaluated forms of cognitive behavioural therapy (CBT); the remainder evaluated behaviour therapies, third-wave CBT (mindfulness), psychodynamic therapies, and integrative therapy. Fifteen included studies compared the studied psychological therapy with usual care or a waiting list. Five studies compared the intervention to enhanced or structured care. Only one study compared cognitive behavioural therapy with behaviour therapy.

Across the 21 studies, the mean number of sessions ranged from one to 13, over a period of one day to nine months. Duration of follow-up varied between two weeks and 24 months. Participants were recruited from various healthcare settings and the open population. Duration of symptoms, reported by nine studies, was at least several years, suggesting most participants had chronic symptoms at baseline.

Due to the nature of the intervention, lack of blinding of participants, therapists, and outcome assessors resulted in a high risk of bias on these items for most studies. Eleven studies (52% of studies) reported a loss to follow-up of more than 20%. For other items, most studies were at low risk of bias. Adverse events were seldom reported.

For all studies comparing some form of psychological therapy with usual care or a waiting list that could be included in the meta-analysis, the psychological therapy resulted in less severe symptoms at end of treatment (SMD -0.34; 95% confidence interval (CI) -0.53 to -0.16; 10 studies, 1081 analysed participants). This effect was considered small to medium; heterogeneity was moderate and overall quality of the evidence was low. Compared with usual care, psychological therapies resulted in a 7% higher proportion of drop-outs during treatment (RR acceptability 0.93; 95% CI 0.88 to 0.99; 14 studies, 1644 participants; moderate-quality evidence). Removing one outlier study reduced the difference to 5%. Results for the subgroup of studies comparing CBT with usual care were similar to those in the whole group.

Five studies (624 analysed participants) assessed symptom severity comparing some psychological therapy with enhanced care, and found no clear evidence of a difference at end of treatment (pooled SMD -0.19; 95% CI -0.43 to 0.04; considerable heterogeneity; low-quality evidence). Five studies (679 participants) showed that psychological therapies were somewhat less acceptable in terms of drop-outs than enhanced care (RR 0.93; 95% CI 0.87 to 1.00; moderate-quality evidence).

Authors' conclusions

When all psychological therapies included this review were combined they were superior to usual care or waiting list in terms of reduction of symptom severity, but effect sizes were small. As a single treatment, only CBT has been adequately studied to allow tentative conclusions for practice to be drawn. Compared with usual care or waiting list conditions, CBT reduced somatic symptoms, with a small effect and substantial differences in effects between CBT studies. The effects were durable within and after one year of follow-up. Compared with enhanced or structured care, psychological therapies generally were not more effective for most of the outcomes. Compared with enhanced care, CBT was not more effective. The overall quality of evidence contributing to this review was rated low to moderate.

The intervention groups reported no major harms. However, as most studies did not describe adverse events as an explicit outcome measure, this result has to be interpreted with caution.

An important issue was that all studies in this review included participants who were willing to receive psychological treatment. In daily practice, there is also a substantial proportion of participants not willing to accept psychological treatments for somatoform disorders or MUPS. It is unclear how large this group is and how this influences the relevance of CBT in clinical practice.

The number of studies investigating various treatment modalities (other than CBT) needs to be increased; this is especially relevant for studies concerning physical therapies. Future studies should include participants from a variety of age groups; they should also make efforts to blind outcome assessors and to conduct follow-up assessments until at least one year after the end of treatment.

PLAIN LANGUAGE SUMMARY

Talking therapies and physical therapies for medically unexplained physical symptoms: a review of the evidence

Who may be interested in this review?

People with unexplained physical symptoms (somatoform disorders) and their family and friends.

Professionals working with people with somatoform disorders or working in chronic pain services.

General practitioners.

Why is this review important?

Up to one in three people consulting their doctor about physical symptoms have medically unexplained physical symptoms (MUPS) that have no clear cause. MUPS are a key feature of health problems called somatoform disorders. MUPS and somatoform disorders often cause significant distress and cause people spending a lot of time consulting doctors and health professionals to try to find the cause of their symptoms and the correct treatment.

Talking therapies for MUPS are recommended to help with mental health problems that exist alongside the physical symptoms, and to help people change the way they think about their physical symptoms. Physical therapies for MUPS aim to help people improve their physical functioning through various types of exercise. This review aimed to examine the evidence for talking therapies and physical therapies for MUPS and somatoform disorders.

What questions does this review aim to answer?

What is the quality of current research on talking therapies and physical therapies for MUPS?

Are talking therapies an effective treatment for MUPS compared with usual treatment or waiting list?

Which types of talking therapies are most effective?

Are physical therapies an effective treatment for MUPS?

How acceptable are talking therapies and physical therapies to people with MUPS?

Which studies were included in the review?

We used search databases to find all studies of talking therapies and physical therapies for people with somatoform disorders published to November 2013. To be included in the review, studies had to compare talking therapies or physical therapies with either usual treatment, waiting list, enhanced or structured care (where a doctor offered structured appointments to the person but no specific therapy for MUPS), or other talking or physical therapies. We included studies if they had adults aged over 18 years with a clear diagnosis of somatoform disorders or main presenting problem of MUPS.

We included 21 studies in the review with 2658 participants.

What does the evidence from the review tell us?

We rated the quality of current research as low to moderate. Fourteen out of the 21 studies focused on cognitive behavioural therapy, which is a specific form of talking therapy based on the idea that thoughts and thinking can influence emotions and behaviours.

Cognitive behavioural therapy was more effective than usual care in reducing the severity of MUPS. For other types of therapy, we found only one or two studies giving insufficient evidence for conclusions.

Cognitive behavioural therapy was no more effective than enhanced care provided by the person's doctor.

No studies of physical therapy met the criteria to be included in the review.

Talking therapies were acceptable to people and few people dropped out of the trials; however, this may not reflect real clinical practice as the study participants were people with somatoform disorders or MUPS who were willing to try talking therapies. In clinical practice, a high proportion of people may not be willing to accept these treatments.

What should happen next?

The review authors suggest that future high-quality trials should be carried out to find out more about which groups of people benefit most from cognitive behavioural therapy and how it can be most effectively delivered. They also suggest that more studies are needed of other talking therapies, and a particular focus should be on high-quality studies of physical therapies.