

Cognitive-behavioural therapy for patients with multiple somatoform symptoms—a randomised controlled trial in tertiary care

Gaby Bleichhardt*, Barbara Timmer, Winfried Rief

Roseneck-Centre for Behavioural Medicine, Prien am Chiemsee, Germany

Received 29 May 2002; accepted 8 October 2002

Abstract

Objective: (a) To evaluate the effect of a cognitive-behavioural inpatient treatment and (b) to analyse the differential efficacy of an additional (“soma”) group management training of somatisation. **Methods:** The final sample consisted of 191 patients with somatisation syndrome (patients with at least eight DSM-IV somatoform symptoms). Patients were randomly assigned to (I) “standard treatment+soma” or (II) “standard treatment+relaxation training.” A waiting control group consisted of 34 patients. All patients were diagnosed with a structured clinical interview for DSM-IV and received an interview on medical consulting behaviour and questionnaires concerning somatoform symptoms,

general psychopathology, subjective health status, and life satisfaction. **Results:** Results show high impairment of the sample prior to treatment. At the 1-year follow-up, all outcome criteria were significantly reduced. The differential effect of the additional soma treatment was significant only for a reduction of visits to the doctor. Greatest longitudinal effect sizes were found for the reduction of somatoform symptoms. **Conclusion:** Considering the subjects’ high initial impairment, the outcome results are encouraging. The specific effect on health care use highlights the socioeconomic relevance.

© 2004 Elsevier Inc. All rights reserved.

Keywords: Cognitive-behavioural therapy; Group therapy; Randomised controlled trial; Somatoform disorders; Somatisation; Somatisation syndrome; Tertiary care

Introduction

While neglected in earlier literature, treatments for unexplained multiple symptoms and somatoform disorders have received increased attention in the past decade [1]. Consequently, the quality of research studies has improved [2]. In their review of controlled clinical trials on cognitive-behavioural therapy (CBT) for somatisation, Kroenke and Swindle analysed 31 studies [2]. They concluded that CBT can be effective: 20 out of 28 studies reported a reduction in physical symptoms. In another review, Hiller and Rief [3] found positive outcomes for CBT for patients with somatoform disorders within the general medical setting. However, the sample sizes of most studies are only moderate, and most studies are carried out in primary care. If primary care treatments fail, patients are referred to a specialist. If these

treatments are also ineffective in reducing disability and subsequent health care costs, patients can be sent to tertiary care units in some countries. It is presumed that patients referred to tertiary care institutions are more disabled, display more chronic somatic symptoms, and are possibly more difficult to treat. Our randomised clinical trial examined the effect of a multicomponent CBT in a large sample of tertiary care patients.

Due to the frequently reported discrepancy between the high prevalence of somatising patients seen in health care systems [4] and a rather low prevalence of DSM-IV or ICD-10 somatisation disorder [5], alternative concepts of a broader somatisation disorder have been developed and examined since the 1980s [6–9]. Therefore, in this study, the diagnosis of somatisation syndrome was selected as the main inclusion criteria, defined as having at least eight DSM-IV somatoform symptoms [9]. The trial was done in a regular tertiary care hospital for mental and psychosomatic disorders, which is part of the German health care system. The treatment is accessible to patients regardless of social status. Patients usually have a long history of illness, doctor shopping, and sick leave before treatment [10,11].

* Corresponding author. Department of Clinical Psychology and Psychotherapy, University of Mainz, Staudinger Weg 9, 55099 Mainz, Germany. Tel.: +49-6131-3923707; fax: +49-6131-3924623.

E-mail address: bleichha@mail.uni-mainz.de (G. Bleichhardt).

The aim of the study was (a) to evaluate the effect of an inpatient CBT treatment by comparing it with a waiting list control group and (b) to analyse the differential efficacy of an additional group-treatment module for multiple somatoform symptoms by comparing it with a group-relaxation training. A broad improvement in all outcome variables comparing the two treatment groups with waiting list controls was expected. Furthermore, an additional effect was expected of the somatoform group module on specific measures, such as somatoform pathology, health care utilisation, and health status.

Methods

Design and Treatment

The sample included 196 inpatients with somatisation syndrome (patients with ≥ 8 DSM-IV somatoform symptoms) who were consecutively admitted to the Roseneck-Centre for Behavioural Medicine in Prien am Chiemsee, Germany, from January 1999 to July 2001. Mean treatment duration amounted to 51.9 days (S.D.=16.3). Patients in

treatment were compared to patients on a 4-month waiting list prior to admission (mean=128.1 days, S.D.=97.6; $n=34$ waiting controls). Waiting controls were selected during the first year of the study by screening the entry forms for somatoform symptomatology before admission. Therapy outcome was analysed at discharge and at a 1-year follow-up. At discharge, patients received a selection of questionnaires. At follow-up, subjects filled out all questionnaires and were interviewed by the same researcher who conducted the initial interview. All subjects participated voluntarily after informed consent was obtained.

Standard treatment

All patients underwent the standard cognitive-behavioural treatment. It consisted of individual therapy and problem-focused group therapy sessions, assertiveness training and, in some cases, standardised therapy modules focusing on comorbid disorders (e.g., depression, anxiety).

Additional treatments

The subjects were assigned to cohorts consisting of six to eight subjects. Cohorts randomly received one out of two experimental conditions, one being a management

Table 1
Characteristics of the subsamples

	(I) Soma+standard, $n=107$, mean (S.D.) / %	(II) PMR+standard, $n=84$, mean (S.D.) / %	Total I+II $n=191$, mean (S.D.) / %	(III) Waiting controls, ^a $n=34$, mean (S.D.) / %	Significant group differences	
					I vs. II	III vs. Non-III
Age	44.4 (9.6)	43.3 (11.3)	43.9 (10.4)	45.0 (10.0)	n.s.	n.s.
% female	77.6	67.9	73.3	82.4	n.s.	n.s.
Treatment duration (days)	50.8 (15.6)	53.4 (17.2)	51.9 (16.3)	–	n.s.	n.s.
DSM-IV Somatisation Disorder	30.8%	23.8%	27.7%	35.3%	n.s.	n.s.
Comorbid DSM-IV Affective Disorder	70.1%	78.6%	73.8%	82.4%	n.s.	n.s.
Comorbid DSM-IV Anxiety Disorder	44.9%	63.1%	52.9%	67.6%	n.s.	n.s.
Somatoform symptoms in the last 2 years (SOMS)	20.3 (8.0)	21.1 (6.4)	20.6 (7.3)	21.3 (7.8)	n.s.	n.s.
Duration of main mental disorder in years	9.3 (8.1)	9.2 (8.4)	9.2 (8.2)	12.2 (10.0)	n.s.	n.s.
Patients with at least one former psychiatric/ psychosomatic inpatient treatment, %	54.3	43.9	49.7	48.5	n.s.	n.s.
Weeks unable to work in the year before treatment	15.7 (18.0)	12.9 (16.7)	14.4 (17.4)	15.4 (17.9)	n.s.	n.s.
Demand for financial compensation, %	20.6	25.0	22.5	23.5	n.s.	n.s.

n.s., nonsignificant.

^a Four subjects of the waiting control group were excluded for further assessment, 16 subjects participated in standard+soma, and 14 in standard+PMR treatment.

training for somatoform symptoms (soma; $n=107$) and the other a relaxation training (progressive muscle relaxation [PMR]; $n=84$). Both additional group treatments were composed of eight sessions of 100 min each, were manual based (a compendium of the manual is published [15]), and conducted by trained therapists. The overall goals of the soma group treatment were to explain somatoform symptoms considering both biological and psychological aspects and to teach a variety of coping strategies. It consisted of cognitive-behavioural techniques such as behavioural experiments, role play, a short version of relaxation training, one biofeedback session, cognitive restructuring, and reduction of avoidance behaviour. The treatment was based on standardised guidelines for the psychological treatment of somatoform disorders as published elsewhere [12–15]. The PMR treatment was based on modifications of Jacobson's original programme by Bernstein and Borcovec [16].

Instruments

Mental disorders were diagnosed by structured interviews (International Diagnostic Checklists for DSM-IV [IDCL]) [17]. Health care utilisation and occupational disability was assessed through an interview on illness behaviour developed by the authors. Furthermore, a number of evaluated psychometric instruments assessing somatoform symptoms (Screening for Somatoform Symptoms [SOMS]) [18], general psychopathology (SCL-90-R) [19], anxiety and depression (Hospital Anxiety and Depression Scale [HADS]) [20], life satisfaction (Questions

on Life Satisfaction [FLZM]) [21], and health-related quality of life (visual analogue scale of the EuroQoL) [22] were used.

Statistical Methods

Initial group differences were tested with t tests for independent samples, χ^2 for frequencies. Repeated measures ANOVAs were used to test for short- and long-term outcome (time effect) and a time by group interaction effect. "Visits to the doctor" was only normally distributed after logarithmic transformation. Thus, transformed scores were used for ANOVA. Effect sizes were computed as Cohen's d [23] with pooled S.D. as the denominator. As omitting dropouts from further analysis may account for biased treatment effects, an additional intent-to-treat analysis was computed: missing data at discharge/follow-up was replaced with admission data.

Results

Patient Characteristics

The final sample consisted of 191 patients. Four subjects had to be excluded because they were referred to specialised pain- or tinnitus-management groups, which confounded with the soma group. One patient had to be excluded subsequently because his symptoms were diagnosed as Lyme disease at follow-up. Table 1 shows the main characteristics of the subsamples.

Table 2
Treatment effects

	Groups ^a	Admission, mean (S.D.)	Discharge, mean (S.D.)	One-year follow-up, mean (S.D.)	Significance			Effect sizes, admission to 1-year follow-up
					Time	Group	Time by group	
DSM-IV somatoform symptoms	I	10.0 (2.6)	–	6.8 (3.4)	$F=104.1, P<.001$	n.s.	n.s.	1.22
	II	10.3 (2.7)	–	7.5 (3.9)				1.07
Somatisation (SCL-90-R)	I	1.61 (0.74)	1.03 (0.70)	1.10 (0.74)	$F=57.4, P<.001$	n.s.	n.s.	0.69
	II	1.62 (0.74)	1.09 (0.80)	1.19 (0.89)				0.59
Positive Symptom Total (PST, SCL-90-R)	I	55.7 (17.2)	42.9 (20.9)	42.2 (22.4)	$F=64.4, P<.001$	n.s.	n.s.	0.82
	II	59.0 (15.6)	44.2 (21.7)	43.2 (24.5)				0.95
Depression (HADS)	I	10.5 (4.7)	7.7 (4.9)	8.2 (5.3)	$F=41.1, P<.001$	n.s.	n.s.	0.50
	II	10.8 (4.4)	7.7 (5.3)	8.5 (5.1)				0.50
Anxiety (HADS)	I	11.7 (4.2)	8.8 (4.2)	9.9 (4.6)	$F=38.2, P<.001$	n.s.	n.s.	0.43
	II	11.6 (4.1)	8.8 (4.5)	9.7 (4.6)				0.45
Subjective Health Status (EuroQoL)	I	47.7 (19.3)	–	59.6 (24.1)	$F=22.4, P<.001$	n.s.	n.s.	0.63
	II	47.9 (18.8)	–	54.3 (23.0)				0.33
Life Satisfaction (FLZM)	I	13.2 (28.8)	–	26.7 (33.4)	$F=22.6, P<.001$	n.s.	n.s.	0.46
	II	13.8 (30.0)	–	25.6 (33.4)				0.40
Visits to the doctor in the last year ^b	I	41.1 (28.7)	–	25.1 (23.4)	$F=40.7, P<.001$	n.s.	$F=4.3, P<.05^*$	0.48
	II	41.6 (38.4)	–	34.1 (35.9)				0.23

Mean effect sizes over all outcome criteria were $d=0.65$ (S.D.=0.27) for standard+soma and $d=0.57$ (S.D.=0.30) for standard+PMR.

n.s., nonsignificant.

^a I, Somat + standard, $N=89$; II, PMR + standard, $N=68$.

^b Visits to the doctor was logarithmically transformed.

During the treatment period, 9 subjects (4.7%) dropped out of the study; 157 patients (82%) completed the study at 1-year follow-up. No significant differences in sociodemographic, socioeconomic, or psychopathologic variables between the treatment groups were found. There were no differences between the waiting control subjects compared to the remaining sample.

Twenty-eight percent of the total sample fulfilled the strict criteria for DSM-IV somatisation disorder, and comorbidity with affective disorders was 74%. Patients had an average history of 9.2 years of mental disorders (S.D.=8.2; median=6 years) and reported a mean number of 20.6 somatoform symptoms (SOMS) in the last 2 years (S.D.=7.3).

Treatment effects

Significant long-term improvements were found in all selected outcome criteria: number of somatoform symptoms, general psychopathology, anxiety, depression, subjective health status, life satisfaction, and visits to the doctor.

Table 2 displays the treatment effects. Whereas a continuous trend towards greater improvement for the soma group for almost all outcome variables can be seen, a statistical time by group interaction effect was found only for the visits to the doctor. There were no changes in the waiting list control group during the waiting period (Table 3). There was, however, a trend for a reduction in anxiety ($P=.055$).

Largest time effect sizes (Table 2) were found for the reduction of the number of somatoform symptoms: $d=1.22$ for standard+soma, $d=1.07$ for standard+PMR. Effect sizes for the increase of subjective health status were $d=0.63$ for standard+soma, $d=0.33$ for standard+PMR. Responder rates in terms of failing inclusion criteria at follow-up (<8 somatoform symptoms) were 54% for the total sample, 59% for standard+soma, and 48% for standard+PMR. The additional intent-to-treat analysis produced comparable results. All main effects and the interaction effect remained stable.

Table 3
Waiting list control group ($n=34$)

	Registration, mean (S.D.)	Admission, mean (S.D.)	<i>t</i> test
Somatisation (SCL-90-R)	1.50 (0.91)	1.48 (0.91)	n.s.
Positive Symptom Total (PST, SCL-90-R)	52.5 (19.0)	55.0 (18.2)	n.s.
Depression (HADS)	12.2 (4.3)	11.2 (4.8)	n.s.
Anxiety (HADS)	13.7 (4.3)	12.6 (4.5)	$t=1.99$, $P=.055$
Subjective Health Status (EuroQoL)	45.1 (20.3)	45.5 (21.9)	n.s.
Life Satisfaction (FLZM)	13.6 (25.8)	17.7 (31.6)	n.s.

Mean waiting period was 128.1 days (S.D.=97.6).

n.s. nonsignificant.

Discussion

The results indicate the efficacy of the CBT treatment in tertiary care patients. Before patients are referred to German tertiary care units, they have usually been treated unsuccessfully by various approaches. Fifty percent of the patients assessed in our study were treated at least once in a psychiatric or psychosomatic inpatient clinic. The subjects reported an average number of 21 somatoform symptoms, which corresponds to a percentile of 100 (compared to healthy subjects) and 80, respectively (compared to inpatients in a psychosomatic hospital) [18]. There was a high rate of visits to the doctor with a mean number of 40 visits per year. Comorbidity with other mental disorders was also high with a rate of 74% for affective disorders and a rate of 47% for anxiety disorders. These comorbidity rates are usually found in samples with subjects fulfilling the strict criteria for somatisation disorder [24,25]. Escobar et al. [24] found a comorbidity of 63% for major depression in patients with somatisation disorder. On the basis of abridged somatisation criteria, comorbidity rates decreased to 38% for major depression and 8% for dysthymia. The results show that patients with somatoform symptoms treated in tertiary care suffer from severe somatisation and are highly disabled.

Despite the subjects' high impairment, the results demonstrate overall success for the CBT inpatient treatment. Somatoform symptoms, general psychopathology, anxiety, depression, and medical consulting behaviour scores were significantly reduced at discharge and follow-up. Life satisfaction and subjective health status were increased. The stability of the scores of the waiting control group indicate that positive results can be attributed to the inpatient treatment.

There is a systematic trend for larger outcome effects of the standard+soma group condition. Fifty-nine percent of the standard+soma treatment compared to 48% of the standard+PMR treatment had less than eight somatoform symptoms at 1-year follow-up. Although we expected differential effects for somatoform symptomatology, health-related quality of life and medical consulting behaviour, the differential effect of the soma group was significant only for visits to the doctor. The soma group treatment included discussion on medical consulting behaviour and, in line with the work of Warwick and Salkovskis [14], the consequences of reassurance seeking. Possibly, these elements of the module had a specific and behaviour-changing influence on the patients. The reduction of visits to the doctor by 39% for standard+soma and 18% for standard+PMR is especially relevant considering the reduction of health care costs. As has been pointed out previously, patients with somatisation syndromes account for highly elevated health care costs due to excessive visits to the doctor [26,27], surgery and hospital admissions [27,28], occupational disability, and demands for financial compensation [29].

The reason for the lack of other interaction effects may lie in the design of the study. The broad standard treatment

consists of several cognitive-behavioural group and individual therapeutic components. The effects reached by the latter probably exceeded the effects of the single module of soma group therapy. There are two other major limitations of this study, one being the selected sample of tertiary care patients in a psychosomatic inpatient unit possibly limiting generalisation, the other being the impossibility to extract specific treatment effects because of the diversity of treatment modules.

However, the extent of effects on psychopathology, life satisfaction, and subjective health status by far exceeds those found in most studies, even though most effects are only medium in size. In their meta-analysis on CBT for chronic pain, Morley et al. [30] report mean effect sizes of 0.33 for pain experience and 0.38 for depression for treatment versus waiting list controls. In a study on CBT for physical nonspecific symptoms by Ehlert et al., longitudinal effect sizes for short-term reduction of symptoms ranged from 0.56 to 0.91 in the CBT group [31]. In contrast, large effect sizes were found for the reduction of somatoform symptoms ($d=1.22$ for standard+soma; $d=1.07$ for PMR) in our study. In agreement with our results, several studies on somatisation report a larger improvement in somatic symptoms and smaller to no change in psychopathologic measures, such as anxiety, depression, or psychological distress [32–34]. In contrast to older assumptions, the main symptomatology of unexplained physical symptoms can in fact be substantially changed by CBT.

The results of this study suggest that CBT is successful even in chronic and severe somatisation. Stability and extent of the outcomes as well as the cost-saving aspect of reduced medical consulting behaviour are encouraging.

Acknowledgments

This study has been supported by the German Ministry of Research and Technology BMBF. It was part of the Bavarian Network on Rehabilitation Research, project number 01GD9815/3 (project manager, Prof. Rief).

References

- [1] Lidbeck J. Group therapy for somatization disorders in general practice: effectiveness of a short cognitive behavioural treatment model. *Acta Psychiatr Scand* 1997;96:14–24.
- [2] Kroenke K, Swindle R. Cognitive-behavioral therapy for somatization and symptom syndromes: a critical review of controlled clinical trials. *Psychother Psychosom* 2000;69:205–15.
- [3] Hiller W, Rief W. Therapiestudien zur Behandlung von Patienten mit somatoformen Störungen: Ein Literaturüberblick (Therapy studies for the treatment of patients with somatoform disorders: a literature overview). *Verhaltenstherapie* 1998;8:125–36.
- [4] Katon W, Ries RK, Kleinman A. The prevalence of somatizing in primary care. *Compr Psychiatry* 1984;25:208–15.
- [5] Gureje O, Simon GE, Ustun TB, Goldberg DP. Somatization in cross-cultural perspective: a World Health Organization study in primary care. *Am J Psychiatry* 1997;154:989–95.
- [6] Escobar JI, Rubio-Stipec M, Canino G, Karno M. Somatic Symptom Index (SSI): a new and abridged somatization construct. Prevalence and epidemiological correlates in two large community samples. *J Nerv Ment Dis* 1998;177:140–6.
- [7] Kroenke K, Spitzer RL, deGruy FV, Hahn SR, Linzer M, Williams JBW, Brody D, Davies M. Multisomatoform disorder. An alternative to undifferentiated somatoform disorder for the somatizing patient in primary care. *Arch Gen Psychiatry* 1997;54:352–8.
- [8] Hiller W, Rief W, Fichter MM. Further evidence for a broader concept of somatization disorder using the Somatic Symptom Index. *Psychosomatics* 1995;36:285–94.
- [9] Rief W, Hiller W. Towards empirically based criteria for the classification of somatoform disorders. *J Psychosom Res* 1999;46:507–18.
- [10] Rief W, Hiller W, Geissner E, Fichter MM. A two-year follow-up study of patients with somatoform disorders. *Psychosomatics* 1995; 36:376–86.
- [11] Hiller W, Rief W, Fichter MM. How disabled are patients with somatoform disorders? *Gen Hosp Psychiatry* 1997;19:432–8.
- [12] Rief W, Hiller W. The psychological treatment of somatoform disorders. In: Ono Y, Janca A, Asai M, Sartorius N, editors. *Somatoform disorders: a worldwide perspective*. Tokyo: Springer, 1999. pp. 212–7.
- [13] Sharpe M, Peveler V, Mayou R. The psychological treatment of patients with functional somatic symptoms: a practical guide. *J Psychosom Res* 1992;36:515–29.
- [14] Warwick HMC, Salkovskis PM. Hypochondriasis. In: Scott J, Williams JMG, Beck AT, editors. *Cognitive therapy in clinical practice*. London: Routledge, 1989. pp. 78–102.
- [15] Rief W, Bleichhardt G, Timmer B. Gruppentherapie für somatoforme Störungen-Behandlungsleitfaden, Akzeptanz und Prozessqualität (Group therapy for somatoform disorders: treatment guidelines, acceptance, and process quality). *Verhaltenstherapie* 2002;12:183–91.
- [16] Bernstein DA, Borcovet TD. *Progressive relaxation training*. Champaign (IL): Research Press, 1973.
- [17] Hiller W, Zaudig M, Mombour W, Bronisch W. Routine psychiatric examinations guided by ICD-10 Diagnostic Checklists. *Eur Arch Psychiatry Clin Neurosci* 1993;242:218–23.
- [18] Rief W, Hiller W, Heuser J. SOMS Screening für somatoforme Störungen (Screening for somatoform disorders). Goettingen (Germany): Hogrefe-Testzentrale, 1997.
- [19] Derogatis LR. SCL-90-R. Administration, scoring and procedures. Baltimore (MD): John Hopkins University School of Medicine, 1977.
- [20] Zigmond AA, Snaith RP. The Hospital Anxiety and Depression Scale. *Acta Psychiatr Scand* 1983;67:361–70.
- [21] Henrich G, Herschbach P. Questions on Life Satisfaction (FLZM)—a short questionnaire for assessing subjective quality of life. *Eur J Psychol Assess* 2000;16:150–9.
- [22] Kind P. The EuroQoL instrument: an index of health-related quality of life. In: Spilker B, editor. *Quality of life and pharmacoeconomics in clinical trials*. 2nd ed. Philadelphia: Lippincott-Raven, 1996. pp. 191–201.
- [23] Cohen J. *Statistical power analysis for the behavioral sciences*. Hillsdale: Erlbaum, 1988.
- [24] Escobar JI, Gara M, Cohen Silver R, Waitzkin H, Holman A, Compton W. Somatisation disorder in primary care. *Br J Psychiatry* 1998; 173:262–6.
- [25] Rost KM, Kashner TM, Smith GR. Effectiveness of psychiatric intervention with somatization disorder patients: improved outcome at reduced costs. *Gen Hosp Psychiatry* 1994;16:381–7.
- [26] Goldberg DP, Bridges K. Somatic presentations of psychiatric illness in primary care settings. *J Psychosom Res* 1988;32:137–44.
- [27] Barsky AJ, Ettner SL, Horsky J, Bates DW. Resource utilization of patients with hypochondriacal health anxiety and somatization. *Med Care* 2001;39:705–15.

- [28] Fink P. Surgery and medical treatment in persistent somatizing patients. *J Psychosom Res* 1992;36:439–47.
- [29] Zoccolillo MS, Cloninger CR. Somatization disorder: psychologic symptoms, social disability, and diagnosis. *Compr Psychiatry* 1986; 27:65–73.
- [30] Morley S, Eccleston C, Williams A. Systematic review and meta-analysis of randomised controlled trials of cognitive behaviour therapy and behaviour therapy for chronic pain in adults, excluding headache. *Pain* 1999;80:1–13.
- [31] Ehlert U, Wagner D, Lupke U. Consultation-liaison service in the general hospital: effects of cognitive-behavioral therapy in patients with physical nonspecific symptoms. *J Psychosom Res* 1999;47: 411–7.
- [32] Deale A, Chalder T, Marks I, Wessely S. Cognitive behavior therapy for chronic fatigue syndrome: a randomized controlled trial. *Am J Psychiatry* 1997;154:408–14.
- [33] Greene B, Blanchard EB. Cognitive therapy for irritable bowel syndrome. *J Consult Clin Psychol* 1994;62:576–82.
- [34] Speckens AEM, van Hemert AM, Spinhoven P, Hawton KE, Bolk JH, Rooijmans GM. Cognitive behavioural therapy for medically unexplained physical symptoms: a randomized control trial. *Br Med J* 1995;311:1328–32.