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Understanding Somatoform Disorder through Insecure Attachment Developed by Childhood Trauma

Masayo Uji

Department of Clinical Psychology, Hyogo University of Teacher Education, Hyogo, Japan
Email: ujimasayo@hotmail.co.jp

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Abstract

Background: There have been few clinical case studies which explored somatoform disorder patients' mind, in particular, that they are unaware. **Purposes:** By analyzing clinical records of a male patient with a somatoform disorder, this study aimed at 1) To examine how the core personality pathology behind the somatoform disorder developed in his early life, 2) To elucidate how his attitudes and behaviors in his interpersonal relationships relate to the pathology, 3) To understand the reason behind his decision to discontinue therapy, and 4) To propose a role for psychiatry when treating patients with somatoform disorder. **Methods:** The patient's psychotherapeutic process over three years from initiation to termination was described in three periods, based on changes in the nature of the therapeutic relationship. **Results:** Somatic symptoms, the attitudes and behaviors in the therapeutic relationship, and his decision to terminate the therapy were understandable in relation to his adversity since infancy. These relations were discussed by attachment theory and a theory of structural dissociation of personality. **Conclusion:** This study provided a perspective that the core pathology of some somatoform disorder patients has its origin in adversity since infancy.

Keywords

Somatoform Disorder, Personality Pathologies, Termination of Psychotherapy, Personality Dissociation, Schizoid Mechanism

1. Introduction

There are quite a few people who visit a psychiatric clinic complaining of somatic symptoms and are diagnosed with a somatoform disorder (Haller, Cramer, Lauche, & Dobos, 2015; Leutgeb, Berger, Szecsenyi, & Laux, 2018; Lieb, Zim-

mermann, Friis, Höfler, Tholen, & Wittchen, 2002). According to the International Statistical Classification of Diseases and Related Health Problems (ICD-10) (World Health Organization, 2015), Somatoform Disorders are categorized under Neurotic, Stress-Related, and Somatoform Disorders. In the Diagnostic & Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013), somatoform disorder corresponds to Conversion Disorder (Functional Neurological Disorder) under Somatic Symptom and Related Disorders. It has generally been regarded as a neurotic disorder.

Contrary to individuals with psychotic disorders, those with neurotic disorders are regarded as having insight on their disease. Also, unlike psychotic disorders, neurotic disorders do not have deteriorating effects on an individual's life functioning level. Despite having insight, an individual with neurotic disorder generally does not visit a psychiatric clinic immediately after the onset (Nishizono, 1999). It usually takes time for them to visit a psychiatric clinic. Instead, many neurotic patients are willing to visit a variety of clinics other than psychiatric clinics, with chief complaints of somatic symptoms. Furthermore, the rate of dropping out from psychiatric treatment should not be ignored. The reason for low adherence to psychiatric treatment is that their symptoms are the second product of their defense, i.e., the symptoms are a current necessity.

Narita (2012) writes that he does not think about why patients with schizophrenia became that way but does wonder why some patients develop neurotic disorders. This suggests that patients with neurotic disorders choose the disorder in an attempt to resolve their inner conflicts.

Despite being the product of inner conflicts, it is a critical issue that clinical case studies examining inner conflicts of somatoform disorder patients from a psychodynamic perspective by viewing the whole life history from infancy, and also exploring how the somatic symptoms are related with the conflicts, are lacking. Some studies only reported manifestations and development processes of somatoform disorder patients observed by physicians (Smith & Józefowicz, 2012).

An additional issue is that there have been no consensuses concerning the treatment of somatoform disorder, and various approaches have been reported as effective to some extent, e.g. cognitive behavioral therapy (Allen et al. 2006; Goldstein et al., 2010; LaFrance et al., 2009; Sitnikova et al., 2019), psychodynamic psychotherapy (Kallivayalil & Punnoose, 2010; Nickel, Ademmer, & Egle, 2010), and anti-depressants (Luo et al., 2009; O'Malley et al., 1999), among others.

Saswati, Sankar, Saswati, & Arijit (2020) demonstrated negative correlation between the symptom severity of somatoform disorder and perceived social support. However, they did not mention how the perceived social support effects the inner conflicts which patients were unaware of.

A male patient who will be described in this article had a variety of somatic symptoms in accordance with Somatization Disorder categorized under Soma-

toform Disorder (ICD-10). He was provided with psychodynamic psychotherapy for three years. He chose to quit the psychotherapy when his psychiatrist moved to another clinic. This three-year psychotherapy led the author to contemplate deeper ideas on somatoform disorder.

Based on the patient's clinical records, the purposes of this article are:

1) To examine how the core personality pathology behind the somatoform disorder developed in his early life,

2) To elucidate how his attitudes and behaviors in his interpersonal relationships relate to the pathology,

3) To understand the reason behind his decision to discontinue therapy, and

4) To propose a role for psychiatry when treating patients with somatoform disorder.

2. Methods

The clinical records of the man who was in his thirties, diagnosed as having somatoform disorder, were used in order to satisfy the above purposes. This case report was approved by the Institutional Review Board, and informed consent was received from the patient. The psychodynamic psychotherapeutic process was divided into three periods, depending on transitions in the nature of the therapeutic relationship. Details concerning the above mentioned four purposes will be explored in the Discussion section.

3. Results

Clinical case material: Mr. A in his mid-thirties

Life history

Mr. A's parents divorced before his birth. For unknown reasons, his mother left him at her mother's home, where her brother and his wife lived together. Mr. A had always been excluded by his aunt and cousins. Their attitudes got worse when he expressed somatic symptoms of discomfort, which he continues to have in his adult life. Every summer vacation, he visited his mother with his grandmother. Without knowing how to behave, he always became confused especially when his grandmother left him alone with his mother. He didn't know how to express his needs of dependency on his mother. Only when it was time to go home would he express his desire to stay with his mother and that he did not want to go back to the grandmother's house. However, both his grandmother and mother dismissed his needs. In the mother's house was a picture of a man, whom Mr. A assumed to be his mother's partner, making it even more difficult for him to express his need to live with her. During junior and senior high school, he was never given an opportunity to see his mother, who had moved far away to follow her romantic partner.

He got married soon after he graduated from high school and started working in a company. His decision was made by his wife's pregnancy. He was extremely afraid of being criticized by surrounding people if he did not marry her. He said

that if she had not become pregnant, it would have been impossible for him to make the big decision.

Symptoms he had had since infancy had been continuing, fluctuating between worse and better. He once even caused a work-related accident due to a panic attack. As his wife's dedication to childcare increased, particularly towards their youngest son, his symptoms gradually worsened. He became envious of the preschooler receiving his mother's unconditional love. In addition to this, he perceived that his wife was not interested in him anymore, especially after she found out about his infidelity. He always gauged his wife's feelings. His adulterous partner was a substitute for his wife, and looking back to days in the past, for his mother.

Mr. A had visited a variety of clinics other than psychiatric, complaining of somatic symptoms, before visiting the author's psychiatric clinic. Each physician had found no physical problems. This made him dissatisfied. He perceived their evaluations as painful rejection, but was unable to ask for further examination or tell them how he felt.

When he finally visited the author's clinic, this psychiatrist inevitably concluded that he needed leave of absence. While at home, he tried to dominate his wife to make her listen to every distress he ever had during his entire life. When he wanted to talk, he drove his children out of their room so he could be alone with her. However, what he got was the wife's emotional alienation rather than the empathetic reaction he had been looking forward to. From loneliness, he called his mother, who was emotionally distant from him. When he did, his mother responded by crying and blaming herself for being the cause of his loneliness, inadvertently cutting him off. He tried to deal with this situation by taking the blame for eliciting his mother's feeling of guilt. This led him to experience further distress.

From the information obtained from several consultations before starting structured psychotherapy, the following hypotheses were developed:

1) He had not been able to build a basic trust with the first significant other, his mother, which cast a shadow on his current relationship with his wife, and

2) Somatic symptoms were related to his conflicts within interpersonal relationships. Furthermore, it was expected that the transference in the structured psychodynamic psychotherapy would help lead him to self-understanding and, by being watched over by his psychiatrist, changes in his object-relation characteristics.

The following is a sketch of the weekly 50-minute psychodynamic psychotherapy.

3.1. Term One: Patient's Passive Attitudes and Psychiatrist's Intervention

During the first two years of psychodynamic sessions, Mr. A's passive attitudes towards his psychiatrist was astonishing. Under unstructured general treatment for a few months before beginning the psychotherapy, he had been able to re-

spond to the psychiatrist's questions regarding his physical and mental condition. However, under the structured psychotherapy where he was allowed to talk freely about anything he wanted to, he suddenly became unable to initiate a dialogue, resulting in a long period of silence at the beginning.

While he was verbally silent, he engaged in a variety of non-verbal physical movement—hanging his head, casting his eyes downward, and sometimes giving the psychiatrist a glance. When the psychiatrist asked him what he would like to talk about, he complained of somatic symptoms, his wife's indifference towards him, and the psychological pressure he experienced when he was expected by his colleagues or his wife to do something, like preparing a document, or taking his children to and from school. When he was asked about the meaning of his silence, he said that he was unable to talk to anybody if he didn't know whether that person was in a good mood or not.

At the end of every session, contrary to the long period of silence at the beginning, he requested the psychiatrist to prescribe medicine without hesitation, as if it were routine work. By taking advantage of the doctor-patient relationship, he seemed to be able to make this kind of request after convincing himself that the psychiatrist was in a good enough mood to respond to his needs empathetically.

For a long time, he had the idea that he was a nuisance to his surrounding people. When asked if he was dissatisfied for not initiating or creating talk, he said that he had never felt satisfied, but it was easier for him when others asked him questions or talked to him. He further recalled that, from his early life to adult life, he had been dismissed or rejected whenever he complained that he felt physically bad. He continued that he needed warm care. Run-of-the-mill, extra-therapeutic flattering words gave him momentary relief, but there was no gratification.

Sometimes before session, he sat on a chair in the waiting area that was at a dead angle from the psychiatrist's counseling room. One time after session, he left his wallet on his chair when leaving. These seemed to be the non-verbal messages that he needed the psychiatrist's attention. Once when a big disaster hit, he contacted the psychiatrist complaining about his overwhelming anxiety and asked for directions regarding how to take the medicine the psychiatrist had prescribed, to alleviate the anxiety.

After his mother had been diagnosed with a malignant disease, he talked about her more often than before. He recalled that talking about his mother used to invite criticism from his surrounding people, in particular, his aunt. He told his psychiatrist that, because of this, he was ashamed to talk about his mother. He frequently felt envious of his youngest son as well as children in the neighborhood who were allowed to and (more importantly) able to express emotional dependence towards their mothers. He had never been able to see his mother as his real mother, expressing distrust towards her for leaving him with relatives. He confided his complicated feelings regarding his mother, saying that he could never rely on her and at the same time he would be puzzled if she relied on him.

3.2. Term Two: Experience of Relief by Speaking from the Heart

The silence accompanied by a variety of non-verbal messages before starting to talk gradually shortened. At the same time, he came to talk about the difficulties of trusting significant others. He also said that sighing during his silence and mentioning medicine and somatic symptoms were probes to know whether or not his psychiatrist had any interest in him, as well as strategies to manipulate her. He was generally able to start talking only when others paid attention to him after he dropped a hint. He struggled not to be abandoned by using miserableness as a tool. He was puzzled by his psychiatrist's clarification that his accommodating attitudes with significant others, which he had believed as desirable, must have prevented him from developing a trusting relationship with them.

After his mother's death, he found out that she had been taking care of a couple his own age, living in her neighborhood. He expressed sadness that he had not been receiving that kind of care, and that therefore, he had not been able to see her as his real mother. He agreed with the psychiatrist's words that, for the mother, the couple was a substitute for Mr. A, and that Mr. A had always been on her mind. He said he had been loved by his mother, but had not been able to express his attachment honestly. He recalled his mother's lingering fragrance on the blanket. He regretted having kept her away from him. He faced his feelings, sometimes falling silent, about not being confident that his mother would have accepted him if he had expressed attachment towards her, although there were plenty of chances to do so.

His psychiatrist asked him how he felt about the silence, which was absolutely different from the silence when reading faces as described above. He answered that this was a brand new feeling, and felt relieved. The psychiatrist interpreted that this relationship, i.e. the relationship he was able to express honestly, was the one he had been desiring with significant others, in particular with his mother. He responded by saying, "Yes, I feel I am accepted now and feel relief."

One day, he reported about a dream, in which his mother offered him money but he was not able to receive it. He remembered that he experienced this interaction not only during childhood, but also after becoming an adult. The day before the dream, he had had feelings of accomplishment and being needed in his workplace by taking the role of an arbitrator.

3.3. Term Three: Reenactment of Relationship with Mother over Suggestion of Changing Therapy Location

His psychiatrist informed him that they would be moving to a new location for psychotherapy. Behind this was the psychiatrist's expectation that he would continue the psychotherapy. He seemed to have accepted this at first, but gradually started talking about his inability to assimilate to environment changes both in his family as well as in his workplace. The psychiatrist analyzed this as a resistance towards the change in therapy location. His response was that the move made him feel as though his psychiatrist was abandoning him. The psychiatrist's

recommendation to try out the new place a few times caused further confusion in his mind. However, his facial expression was that of absolute relief when he found his psychiatrist at the new location.

In the first session at the new place, he said that coming to psychotherapy, the one and only place where anyone would listen to him, helped him to feel released from his restraints. At the same time, he expressed his inability to trust the psychiatrist's recommendation to continue therapy. He explained that in his mind, there were two different characters, one saying that he should give up the therapy and the other looking forward to receiving further treatment. He actually wanted to trust his psychiatrist but did not know what to do when he perceived the psychiatrist as emotionally coming close to him, which made him put the brakes on. He finally concluded that he would quit the therapy. Even after this decision, he uttered, "I won't have anywhere to go to anymore. I won't have a chance like this to talk to anyone. It's gonna be lonely again…"

4. Discussion

4.1. Examination of Personality Pathologies in Relation to Early Life History

The core issue Mr. A harbored was the dilemma between his excessive need of being loved and inability to become emotionally close to significant others in seeking for that love, i.e. attachment phobia (Van der Hart, Nijenhuis, & Steele, 2006). This derived from emotional neglect and abuse (chronic interpersonal traumatic experiences during early life). For him, becoming close to significant others meant their rejection. His biological mother and other adults, who took the role of the substitute mother, did not take into account his psychological needs.

Bowlby's attachment theory is based on working models of attachment figures and of self (Bowlby, 1973: pp. 203-204). Mr. A's working model of attachment figures was based on the cognition that they were unavailable, in other words, inaccessible or unresponsive to his calls for support and protection. His working model of himself was based on the cognition that he was not worth anyone, in particular, his attachment figures, responding to. This meant that his attachment style was categorized under anxious- or insecure attachment (Bowlby, 1973: p. 213). According to Bowlby's theory, sensitivity concerning changes in expectations regarding the availability of attachment figures persists during the first decade after birth (Bowlby, 1973: pp. 202-203). Mr. A's expectations of his attachment figures being available, as well as his image of himself, never changed during this period, due to repeatedly traumatic experiences with the attachment figures. Through the psychotherapy, his insecure (ambivalent) attachment style became vivid but remained unchanged.

4.2. Understanding His Somatic Symptoms and Attitudes towards Others in Relation to His Personality Pathologies

His somatic symptoms and interpersonal attitudes included various meanings,

e.g., his distrust towards significant others, desire of getting others' attention and care, and resentment and aggression caused by others' rejection of him, which inversely attacked his body because of his inability to express negative feelings towards others. Here, I would like to focus on the first two meanings: his distrust towards significant others, and desire of getting others' attention and care.

It is difficult to explain Mr. A's attitudes in interpersonal relationships as well as his somatic symptoms only by the attachment phobia mentioned above. Reference to the theory of structural dissociation of personality proposed by Van der Hart et al. (2006) is helpful to understand his attitudes and symptoms. Van der Hart et al. (2006) would regard Mr. A's personality as not an integrated entity, but rather constructed by two split parts. One part of his personality claimed excessive needs to be responded to or even loved, whereas the other prohibited the former from expressing the needs straightforwardly, due to inability to trust and fear of rejection. As a result, the former expressed its needs in indirect ways, i.e., manipulating others by pandering, using actions, and manifesting somatic symptoms. Becoming attached to significant others caused extreme fear in Mr. A's mind. This strategy helped him to survive in his adverse early life, but it prevented him from building trusting relationships with his significant others in his adult life.

As mentioned by Bowlby, parental threats to abandon or withdraw love, or actual abandonment (Bowlby, 1973: p. 244) develop anxiety over the accessibility and responsiveness of attachment figures, resulting in insecure attachment. Mr. A had never been provided with an environment where his attachment style could stabilize, due to his repeated experience of separation with the primary attachment figure, the mother, followed by the emotional neglect by the second attachment figures, the aunt and grandmother. The insecure attachment style which had continued up until adult life damaged Mr. A's psychological well-being. In contrast to his fear of attachment to his significant others, when he perceived that others cared about him in some way, he became voracious. This was the result of one of his personality parts—which harbored an excessive need to be loved—being manifested, as can be seen in his infidelity and/or request for medicine.

4.3. Exploration of Mr. A's Cognition and Emotions behind His Decision to Terminate Psychotherapy

Although Mr. A's anxiety or even fear of becoming attached to a significant other, at least to his psychiatrist, seemed to have eased, he decided to terminate the psychotherapy that lasted about three years. It is probable that the paramount reason behind his decision was the mother-transference on his psychiatrist. Of particular importance is that, however, there was a big difference between the external reality of the relationship with his psychiatrist and that of the relationship with his mother. In the relationship with his mother, his prediction that his mother would reject him again when expressing his needs was probably correct. In the past, the mother, despite her feeling of guilt, had repeatedly rejected him.

On the other hand, the psychiatrist was ready to continue providing Mr. A with psychotherapy, which meant she accepted him.

His psychiatrist's moving to another place made him recall a succession of facts from the time his mother moved away during his adolescence—that picture of her partner, that fear of expressing his wish to live with her, not being given a chance to see her for six years, and more. For him, his psychiatrist's recommendation to continue the therapy with her at another place did not mean her acceptance of him. Contrarily, it caused a sense of distrust in his mind. He even perceived it as the psychiatrist's rejection. His relationship with the mother played a big role in this perception. The fact that he had been kept away, or in his perception, rejected by his mother from infancy, and that she died without him recognizing her as his actual mother, brought deep feelings of sadness and loss, as well as a sense of betrayal. He transferred this image of his mother to his psychiatrist. The intensity of his perception of the psychiatrist as the object he sought for as an attachment figure magnified his distrust. His decision of parting from the psychotherapy meant that he was not free from the internalized object, his mother, towards whom he had always been ambivalent. His true self had been restricted from self-expression.

Could his decision to terminate the therapy he needed be regarded as merely a repetition of his past, experienced within the relationship with his mother? Wouldn't it be better to conclude that, this time, he was able to make his own decision, free of imposition or rejection, something decisively different from the past when his mother moved away? If so, he was able to realize that he still was not free from his internal object, even though his external object was neither rejecting nor imposing.

4.4. Proposing Essentials in Treating Somatoform Disorder Patients

Somatoform disorder is generally regarded as a neurotic disorder with the categories, Neurotic, Stress-Related and Somatoform Disorders (ICD-10), and Conversion Disorder under Somatic Symptom and Related Disorders (DSM-5). The defense mechanisms usually applied by neurotic patients in order to deal with instinctual drive such as repression and avoidance come with acceptance, not transformation, of external reality. This is because neurotic disorders are considered autoplastic. However, dissociation, the defense mechanism Mr. A used, was based on his transformation of external reality, as a consequence of his inability to accept it. This is a characteristic of alloplastic disorder. Dissociation is always accompanied by other defense mechanisms, such as denial and projective identification, which are also products of the inability to accept external reality. This means that the ego function of an alloplastic disorder patient is more vulnerable than that of an autoplastic disorder patient. Alloplastic disorders are more likely to be derived from mishaps in the primitive phase during infancy. We know that in Mr. A's case, the mishap led to failure in building a secure attachment within the primitive mother-infant relationship. A psycho-dynamic

view would imply that his pathologies did not remain at a neurotic level.

Of course, this does not apply to every somatoform disorder patient. It is necessary to examine whether or not a somatoform patient personality is dissociated, and also to assess the nature of his/her attachment style. In cases where a somatoform patient's attachment style is insecure, and/or his/her personality is dissociated, it is recommended to provide structured and also stable therapeutic setting in order to integrate his/her personality under a secure therapeutic environment.

5. Limitations

The hypothesis obtained from one clinical case of somatoform disorder cannot be applied to every somatoform disorder patient. However, the hypothesis, that somatoform disorder is a manifestation of insecure attachment and personality dissociation brought about by chronic repetitive traumatic experiences during infancy and childhood, is clinically useful for understanding and treating some somatoform disorder patients.

6. Conclusion

This study demonstrated a perspective that the core pathology of some somatoform disorder patients has its origin in adversity from infancy. A psychodynamic psychotherapy was useful to elucidate the pathology through transference. How attitudes and behaviors within interpersonal relationships were related to the adversity, and how somatic symptoms were associated, were explained by the attachment theory and the theory of structural dissociation of personality.

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Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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