delusions, and with change in delusions as the primary outcome, that we will make progress towards alleviating the distress at the heart of delusional experience.

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P. A. Garety, Box PO77, Institute of Psychiatry, King's College London, De Crespigny Park, London SE5 8AF, UK. Email: philippa.garety@kcl.ac.uk; **D. Freeman**, Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford, UK

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Psychotherapy for severe somatoform disorder: problems with missing studies

The recent review by Koelen and colleagues[1] of psychotherapy for severe somatoform disorder is welcome in highlighting the need for better evidence in this area. It has unfortunately omitted a number of relevant studies, especially relating to conversion disorder. One major reason for this is that the index date on which studies were searched for, March 2010, was nearly 4 years prior to publication. It is a pity that the authors did not update their analysis at the time of their last revision in June 2013, as they would, at this time, have been able to include a number of relevant studies, including a randomised trial of cognitive–behavioural therapy for non-epileptic seizures ($n = 66$)[2] and a randomised controlled trial of guided self-help for functional neurological symptoms (i.e. conversion disorder) ($n = 127$).[3] These two studies were published before one of the studies included in the analysis, the study by Sattel *et al* published in 2012.[4]

There are further studies of psychotherapy in conversion disorder which were published before March 2010: a study of psychotherapy for non-epileptic seizures ($n = 20$);[5] a study of psychotherapy for conversion disorder ($n = 91$);[6] a study of psychotherapy for psychogenic movement disorders ($n = 10$);[7] and a large controlled and negative trial of psychotherapy for patients with somatoform disorders in a general hospital ($n = 91$).[8] The authors may have excluded them but they did not present a list of the 64 excluded studies as a supplemental file.

Other types of study that could arguably have been included using the authors' own criteria are some randomised trials in functional dysphonia, a form of conversion disorder treated in secondary care with voice therapy and sometimes psychotherapy.[9] There are also treatment studies of children with conversion disorder which have not been included and would not have been excluded by the authors' inclusion criteria.[10,11]

Further studies in conversion disorder have followed in the past 2 years which describe outcomes from multidisciplinary treatment including psychotherapy.[12–15] Journal articles cannot always be up to date, but the number of omissions here make this meta-analysis immediately in need of updating.

Two included studies were of hypnosis for motor conversion disorder.[16,17] Hypnosis is arguably a form of psychotherapy, but also arguably not. In addition, the inclusion of studies which randomised bioenergetic exercise against gym exercise in a setting where all patients received psychotherapy[18] and a study of in-patient multidisciplinary rehabilitation in chronic pain ($n = 298$) graded as 'extremely poor'[19] and then included in a 'treatment as usual arm' is debatable.

The authors could have done more to highlight one of the obvious drawbacks of their review. There is a paradox in reporting on treatment for patients who had been defined as having somatoform disorder (often needing only to have three symptoms e.g. pain, fatigue, dizziness or irritable bowel syndrome) while ignoring studies on psychotherapy for individual functional somatic disorders such as irritable bowel syndrome and fibromyalgia. Most patients with functional somatic disorder also have other symptoms such as fatigue and pain,[20] and probably would, for example, meet criteria for multisomatoform disorder. It is at times highly arbitrary whether authors decide, for example, to use the term somatoform pain disorder or chronic pain disorder. A broader overview of studies in all these fields or at least greater acknowledgement of the overlap would have been helpful for the reader.

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Jon Stone, Consultant Neurologist and Honorary Senior Lecturer, Department of Clinical Neurosciences, University of Edinburgh, Western General Hospital, Crewe Road, Edinburgh EH4 2XU, UK. Email: Jon.Stone@ed.ac.uk

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Authors' reply: Stone commented that more studies should have been included in our meta-analysis.[1] In particular, he suggests that six studies (references 2, 3, 12–15 cited by Stone) that were published after the index date of our literature search (March 2010) and four other studies that were published before 2010 (references 5–8 cited by Stone) could have been included, and that one review that contains randomised trials in functional dysphonia might have met our inclusion criteria (reference 9 cited by Stone). Stone's concern is that these omissions make our meta-analysis out of date.

Apparently, the rationale behind our inclusion criteria requires further clarification. Most importantly, while previous reviews were restricted to psychodynamic psychotherapy only,[2] predominantly involved patients with less severe disorder[3] or included medically unexplained physical symptoms according to divergent criteria,[4] our meta-analysis examined the effectiveness of psychotherapy for severe somatoform disorder. As mentioned in our publication, 'severe' was defined as a diagnosis of somatoform disorder according to established criteria and treatment offered in secondary or tertiary care settings.

We chose to utilise established criteria for somatoform disorder from the psychiatric nomenclature (ICD and DSM in particular). Our main rationale was that psychiatric diagnoses contain explicit criteria about impaired daily functioning in main areas of life (social, interpersonal and occupational), and about psychological factors implicated in the disorder. We opted for these criteria because in our view these would best capture the impairments and the complicated aetiology of these disorders. For this reason, we disregarded medical diagnoses that do not always consider psychological factors implicated in the disorder, and that often use less stringent criteria regarding the duration and severity of the disorder.

The search terms we used simply would not have yielded most of the studies mentioned by Stone, because for the reasons outlined above we did not search for dissociative seizures, pseudo-seizures, psychogenic non-epileptic seizures and psychogenic movement disorders. One study was excluded because Escobar *et al*'s[5] less stringent criteria for somatisation were used (reference 8 cited by Stone). Stone also mentions a review of randomised trials for functional dysphonia (reference 9 cited by Stone), but for the same reason, these studies do not meet our inclusion criteria. Two studies mentioned in Stone's letter meet our inclusion criteria, one of which should probably have been included after revision in June 2013 (reference 12 cited by Stone), while the other was published in October 2013, and could not have been included (reference 13 cited by Stone).

We agree with Stone that there is a paradox in including somatoform disorder while excluding individual somatic syndromes, especially given the arbitrary cut-offs and the high overlap between seemingly distinct somatic syndromes. This is at least in part a reflection of the problematic nomenclature for these disorders,[6,7] which is divided between psychiatry and the remainder of medicine.[8] We concur with Stone that most patients with functional somatic disorders also have other symptoms,[9] and may even meet criteria for somatoform disorder. Yet, we cannot be sure that all patients with individual somatic syndromes do meet criteria for somatoform disorder. For this reason, and for the reasons outlined above, we did not include individual somatic syndromes. At the same time, other reviews have already summarised the effectiveness of psychotherapy for medically unexplained physical symptoms using less stringent criteria, also including some – although not all – conversion disorders.[4]

To conclude, we consider it a strength of the current meta-analysis that it has a narrow and therefore specific focus on a precise diagnostic entity, because this clearly defines the boundaries for generalisation of the findings. We acknowledge that our findings cannot be extrapolated to all fields of medicine and somatic symptom disorders. The results from our meta-analysis specifically apply to patients with somatoform disorder according to established (psychiatric) diagnostic criteria that received psychotherapy in secondary and tertiary care.

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Jurrijn A. Koelen, University of Leuven, Tiensestraat 102, 3000 Leuven, Belgium. Email: jurkoel@gmail.com; **Allan Abbass**, Departments of Psychiatry and Psychology, Dalhousie University, Halifax, Canada; **Jan H. Houtveen**, **Rinie Geenen**, Department of Clinical and Health Psychology, Utrecht University, Utrecht, The Netherlands

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