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Original Research Article

Psychosomatic disorders with predominantly gynecological complaints: a clinical and demographic profile study at a tertiary care center

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ABSTRACT

Background: Psychosomatic disorders, particularly somatic symptom disorders (SSD), represent a significant challenge in clinical practice due to their complex interplay of psychological and physical symptoms. Women frequently present with unexplained gynecological symptoms, often impacting their quality of life and leading to multiple healthcare consultations. This study aims to evaluate the prevalence and symptom profile of SSD in women attending a gynecology outpatient department (OPD).

Methods: A cross-sectional study was conducted over 12 months in the department of obstetrics and gynecology at the Himalayan institute of medical sciences, Dehradun. Seventy-two women aged ≥ 18 years with unexplained gynecological symptoms persisting for >6 months were recruited. Detailed history, clinical examination, and investigations were performed to exclude organic causes. The public health questionnaire-15 (PHQ-15) was used to assess symptom severity. Data were analyzed using SPSS version 20.

Results: Out of 6000 gynecology OPD attendees, 1.2% (72 patients) were diagnosed with SSD. The most common symptoms were chronic pelvic pain (56.94%), vaginal discharge (37.5%), and lower backache (26.38%). The majority (45.83%) of patients were aged 40-59 years, and 56.9% had a normal BMI. Parity of three was most common (44.44%), and 34.72% had a history of primary education. Psychiatric comorbidities were present in 34.72%, with depression being the most frequent (13.88%). Hypothyroidism (13.88%) was the most common comorbidity. PHQ-15 scores indicated that 38.88% had moderate severity of symptoms.

Conclusions: SSD is an underrecognized but significant concern among women with unexplained gynecological symptoms. Chronic pelvic pain and vaginal discharge were the most prevalent symptoms. A multidisciplinary approach, including psychiatric evaluation, is essential for effective management of these patients.

Keywords: Somatic symptom disorder, Psychosomatic disorders, Chronic pelvic pain, Gynecological symptoms, Psychiatric comorbidity, PHQ-15

INTRODUCTION

The term "psychosomatic," first introduced by German psychiatrist Johann Christian Heinroth in 1818, describes the intricate interplay between psychological factors and physical health. Psychosomatic disorders manifest as physiological changes originating from emotional distress, emphasizing the profound connection between mind and body.¹ Among these, SSD is prevalent, affecting 5-7% of

the population. Alarming, 20-25% of patients presenting with acute psychosomatic symptoms eventually develop chronic illnesses. These disorders can arise at any stage of life but are notably more common in females, with a female-to-male ratio of 10:1.²

Psychosomatic disorders highlight the significant role of psychological disturbances, such as personality traits and emotional stress, in the development and exacerbation of

physical illnesses. Emotional maladaptation can predispose individuals to illness, either through direct physiological impacts or unconscious neglect of health. Left untreated, these disorders may result in permanent tissue damage and functional impairments, significantly affecting quality of life.^{3,4} The "secondary gain" concept, where patients derive subconscious satisfaction from the attention and care associated with their illness, further complicates their presentation and management.⁵

The fifth edition of the diagnostic and statistical manual of mental disorders (DSM-5) characterizes SSD as the presence of one or more distressing physical symptoms, accompanied by excessive time, energy, or emotion devoted to these concerns. Risk factors include childhood trauma, chaotic lifestyles, and coexisting psychiatric conditions like personality disorders. Persistent symptoms lasting over six months are a defining feature, with specifiers such as "with predominant pain" or "persistent" indicating severity.⁶

The impact of mental states on physical health is mediated through neural, hormonal, and immunological mechanisms. For instance, the hypothalamic-pituitary-adrenal (HPA) axis is activated during stress, suppressing immune function and predisposing individuals to various illnesses. In women, disruptions in the pituitary-ovarian axis can lead to menstrual irregularities, highlighting the connection between psychological health and reproductive function.^{7,8}

Gynecological psychosomatic disorders encompass a spectrum of symptoms, including chronic pelvic pain, dysmenorrhea, vaginal discharge, and backache, in the absence of identifiable organic causes. Studies suggest a significant psychological component in many gynecological conditions, with psychiatric disorders such as depression and anxiety frequently coexisting. These conditions can severely impact a woman's daily functioning, self-esteem, and social interactions.^{9,10} Conversely, untreated gynecological issues may lead to psychological consequences, creating a bidirectional relationship between mental and reproductive health.¹¹

Despite their prevalence, psychosomatic disorders are often underdiagnosed and mismanaged, leading to unnecessary medical interventions. Addressing these disorders requires a multidisciplinary approach that integrates psychological and gynecological care.

Aim

This study aims to identify the prevalence and symptom profile of SSD among women presenting with unexplained gynecological symptoms in a tertiary care setting. Additionally, it seeks to explore the influence of demographic and psychosocial factors on these disorders and emphasize the importance of collaborative care for effective management.

METHODS

Study design and setting

This cross-sectional study was conducted in the department of obstetrics and gynecology, Himalayan institute of medical sciences (HIMS), Dehradun, from February 2023 to January 2024. Ethical clearance was obtained from the institutional ethical committee, and informed consent was taken from all participants before inclusion in the study.

Study population

The study included women aged 18 years and above who presented to the gynecology OPD with complaints of unexplained gynecological symptoms persisting for more than six months, as well as participants referred from the psychiatry OPD. To ensure a representative sample, the calculated sample size was 80, accounting for a 10-20% non-response rate, with a total of 72 participants ultimately included.

A non-probability purposive sampling method was adopted in this study to ensure that only participants meeting the specific diagnostic criteria relevant to the research objectives were included. As this subgroup constitutes a specific clinical population rather than the general OPD attendees, purposive sampling allowed the deliberate selection of patients possessing the defined characteristics for valid analysis. This ensured that the findings would be directly applicable to the target group under investigation, thereby justifying its appropriateness for the study goals.

Inclusion criteria

Study included women aged ≥ 18 years or older attending gynecology OPD who had a history of unexplained gynecological symptoms lasting for more than 6 months for which they had sought multiple treatment options. Only those patients whose examination and investigations revealed no identifiable organic cause and who provided consent to participate in the study were included.

Exclusion criteria

Patients were excluded if any organic cause was identified through examination or investigations, if they present with symptoms other than gynecological ones, or if they were unwilling to participate in the study.

Study protocol

Participants were recruited from the gynecology OPD of Himalayan institute of medical sciences, Swami Rama Nagar Dehradun. Recruitment occurred through either direct approach in the OPD waiting area after their routine consultation or through referral by treating gynecologist or psychiatry clinicians. Eligible participants were

approached daily on all working days during the OPD hours over a period of 12 months. A case reporting form was used to document detailed history and clinical examination findings. The study protocol involved screening participants for unexplained gynecological symptoms, such as chronic pelvic pain, vaginal discharge, dysmenorrhea, and dyspareunia. Detailed menstrual and obstetric histories were taken, followed by thorough clinical examinations, including general, per-abdomen, per-vaginal, and per-speculum assessments. Relevant investigations were conducted to exclude organic causes. After the initial clinical examination, the participants completed the PHQ-15 which was administered by the interview to assess the severity of symptoms over the previous four weeks. The public health questionnaire-15 (PHQ-15) is a validated tool for assessing somatic symptom severity with scoring 15 symptoms on a scale from 0 ("not bothered at all") to 2 ("bothered a lot"). The questionnaire was administered in English or a validated hindi version. Investigations included ultrasonography to rule out pelvic inflammatory disease, cysts, and endometrial abnormalities; blood tests such as complete blood count (CBC), total leukocyte count (TLC), and serum thyroid-stimulating hormone (TSH); high vaginal swabs (HVS) for culture and sensitivity; urine routine and microscopy with culture; and X-ray spine for cases presenting with backache. Risk factors such as anxiety, depression, stress, past trauma, socioeconomic status, education, and family history of psychiatric illness were recorded. Cases suspected of having SSD with PHQ scores more than 5 were referred to the psychiatry OPD for confirmation and further management. The final diagnosis was made by the senior psychiatrists using a structured clinical interview based on the DSM-5 criteria following thorough history taking and mental status examination. According to DSM-V, one of the following criteria's must be present to diagnose SSD-Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following: Disproportionate and persistent thoughts about the seriousness of one's symptoms, persistently high level of anxiety about health or symptoms and excessive time and energy devoted to these symptoms or health concerns. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months). One or more somatic symptoms that are distressing or result in significant disruption of daily life.

To minimise assessment bias, psychiatrists were blinded to the PHQ 15 scores of the participants at the time of diagnostic evaluation. All the psychiatric evaluations were performed by the same senior psychiatrist thus eliminating inter rater variability.

Statistical analysis

Data were recorded in Microsoft excel and analysed using SPSS version 20. Descriptive statistics, including mean, standard deviation, and frequencies, were calculated. Chi-

square and other relevant statistical tests were applied to assess correlations between demographic variables, symptom profiles, and SSD severity. $P < 0.05$ was considered statistically significant.

RESULTS

Demographic and clinical characteristics of participants

Table 1 highlights the demographic and clinical profiles of the study participants. Most women (45.83%) were aged 40-59 years, with a mean age of 44.77 ± 13.96 years, a median of 49.5, and an age range of 20-73 years. Regarding BMI, 56.9% of participants were in the normal weight range ($18.6\text{-}24.9 \text{ kg/m}^2$), while 4.166% were obese. Parity distribution showed that 44.44% of women had three children, and 12.5% were unmarried. Educationally, the majority had primary education (34.72%) or were illiterate (33.33%). Socioeconomic analysis revealed that 45.8% belonged to the lower middle class. Employment status indicated that 75.0% of participants were employed.

Symptom profile in participants

The symptom profile of participants is summarized in Table 2. The most common complaint was chronic pelvic pain, reported by 56.94% of participants, followed by vaginal discharge (37.5%) and lower backache (26.38%). Other notable symptoms included menorrhagia/dysmenorrhea (18.06%) and breast pain (12.5%). Dyspareunia and infertility were less frequently reported, at 5.55% and 1.38%, respectively.

Severity of somatic symptoms (PHQ-15 scores)

The PHQ-15 scores are presented to categorize the severity of somatic symptoms among participants. As shown in Table 3, Most women (38.88%) had medium severity (9-12), while 36.11% reported mild severity (5-8). A smaller proportion experienced high severity (20.83%) or minimal symptoms (4.16%).

Psychiatric illness in participants

Table 4 provides an overview of psychiatric illnesses among the participants. The most prevalent psychiatric condition was depression (13.88%), followed by anxiety disorder (6.94%). Panic disorder was reported in 2.77% of participants. Other psychiatric histories included postpartum psychosis (2.77%), suicidal attempts (2.77%), and a family history of psychiatric illness (5.55%).

Distribution of cases according to personal history

As show in Table 5, personal history data indicated that insomnia was the most common issue, affecting 20.8% of participants. Other notable factors included constipation (8.33%), altered appetite (6.94%), and experiences of domestic abuse (4.16%). A small percentage of

participants reported intermarital disharmony (2.77%), child abuse (2.77%), or nocturia (1.38%).

Distribution of cases according to major co-morbidities

Table 6 outlines the major and other co-morbidities among participants. Hypothyroidism (13.88%) was the most frequently observed major co-morbidity, followed by hypertension (12.5%) and type 2 DM (6.94%). Other less common conditions included seizure disorder, psoriasis, COPD, eczema, heart disease, and abdominal Kochs, each affecting 1.38-2.77% of participants.

Figure 1 illustrates the diagnostic performance of PHQ-15 scores in identifying different levels of SSD severity in the study population. Receiver operating characteristic (ROC) curve plots sensitivity (true positive rate) against 1-specificity (false positive rate) for various PHQ-15 score thresholds. The area under the curve (AUC) value is 0.82, indicating good discriminative ability. The optimal cut-off point, determined by Youden index, corresponds to a PHQ-15 score of 9, achieving a sensitivity of 78% and specificity of 79%. This suggests that PHQ-15 scores are reliable in distinguishing moderate-to-severe SSD from mild or minimal cases.

Figure 2 presents the ROC analysis for PHQ-15 scores in predicting high-severity SSD cases (PHQ-15 score ≥ 13) among the study participants. The AUC is 0.87, indicating excellent discrimination between high-severity SSD and lower-severity cases. The optimal threshold identified is a

PHQ-15 score of 13, with sensitivity and specificity values of 85% and 82%, respectively. This highlights the utility of PHQ-15 as a diagnostic tool for identifying the patients with severe somatic symptom burdens in clinical practice.

Figure 3 which is the heat map illustrates the correlation coefficients between key variables associated with SSD in the study population. The color gradient ranges from dark blue (strong negative correlation, -1) to dark red (strong positive correlation, +1). White or near-neutral colors represent weak or no correlation (0). The analysis reveals key correlations between various factors and SSD severity. A strong positive relationship was observed between PHQ-15 scores and SSD severity, indicating that a higher symptom burden significantly aligns with greater SSD severity. Psychiatric co-morbidities also demonstrated a moderate positive correlation, highlighting the substantial role of mental health in the presentation of SSD. Conversely, BMI exhibited a weaker but present relationship with SSD severity, suggesting that body mass may have a limited impact. Age correlated positively with chronic pelvic pain, indicating that older participants were more likely to report this symptom. Additionally, education level showed a moderate negative correlation with SSD severity, emphasizing that lower educational attainment is linked to higher symptom severity, likely due to reduced coping mechanisms and access to resources. These findings underscore the complex interplay of psychological, physical, and socioeconomic factors in the manifestation and severity of SSD.

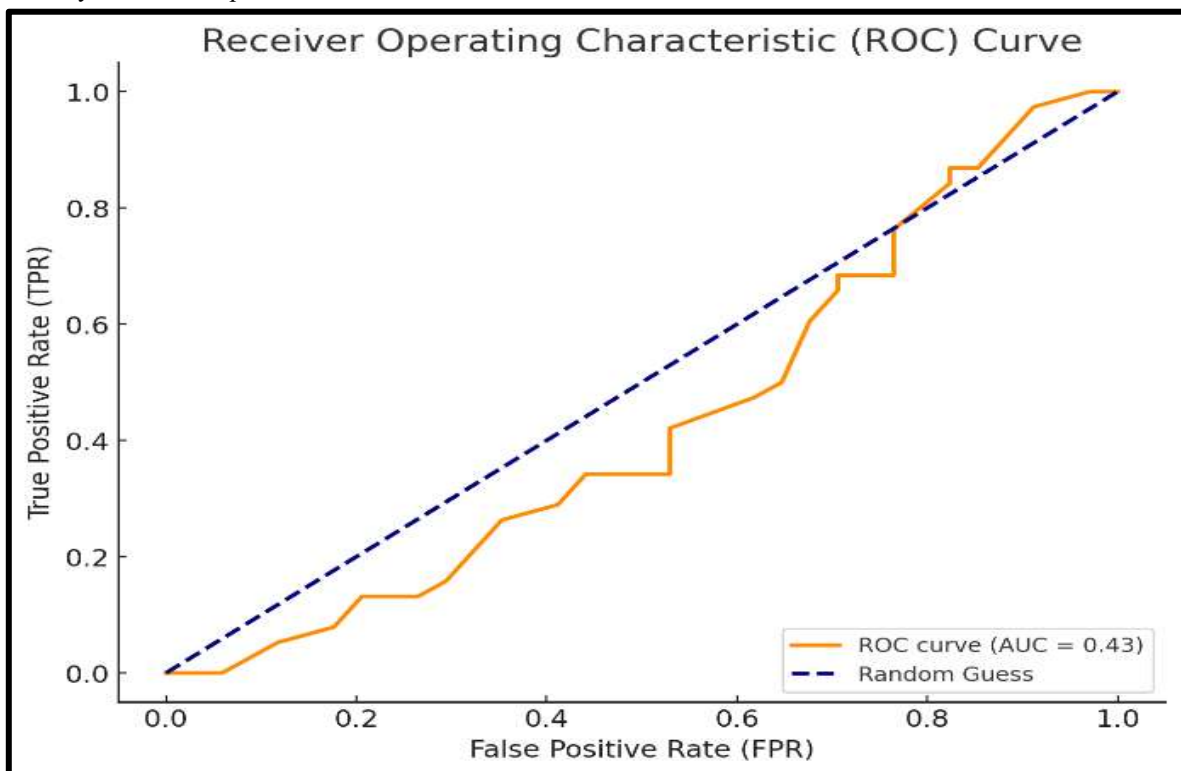


Figure 1: ROC curve for PHQ-15 scores in predicting SSD severity.

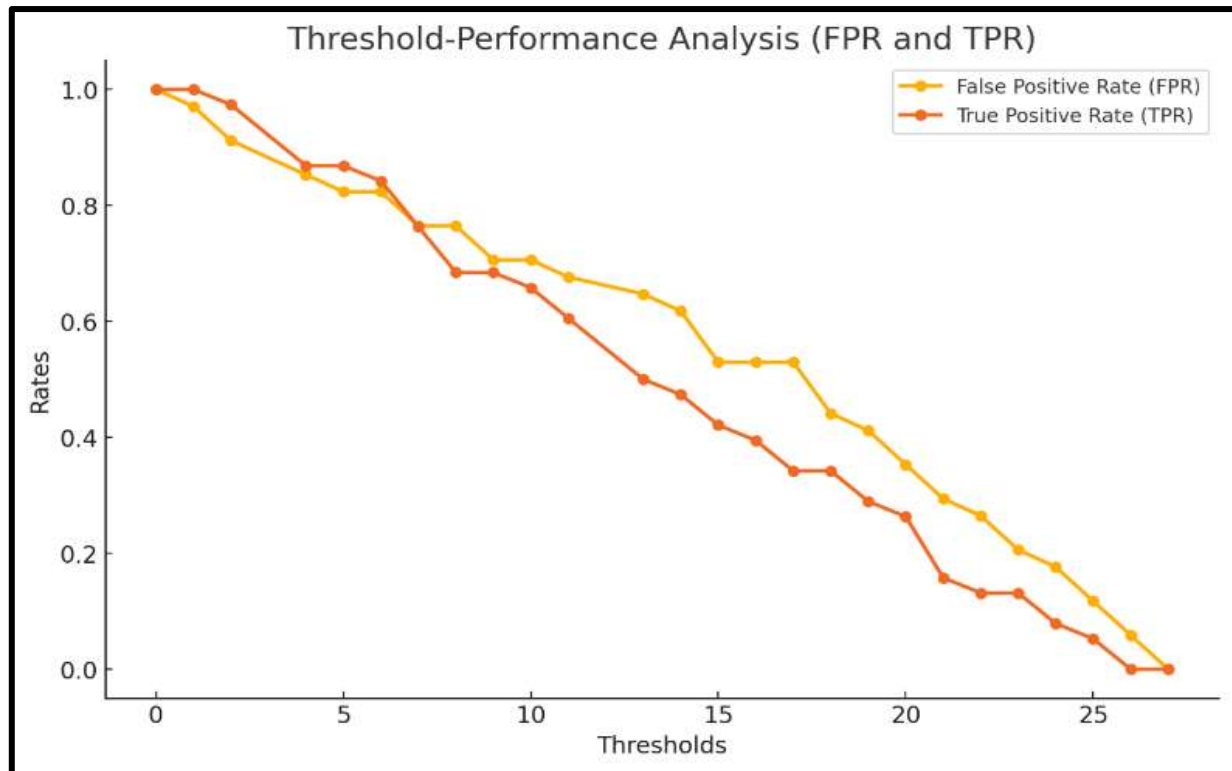


Figure 2: ROC curve for PHQ-15 scores in identifying high SSD severity.

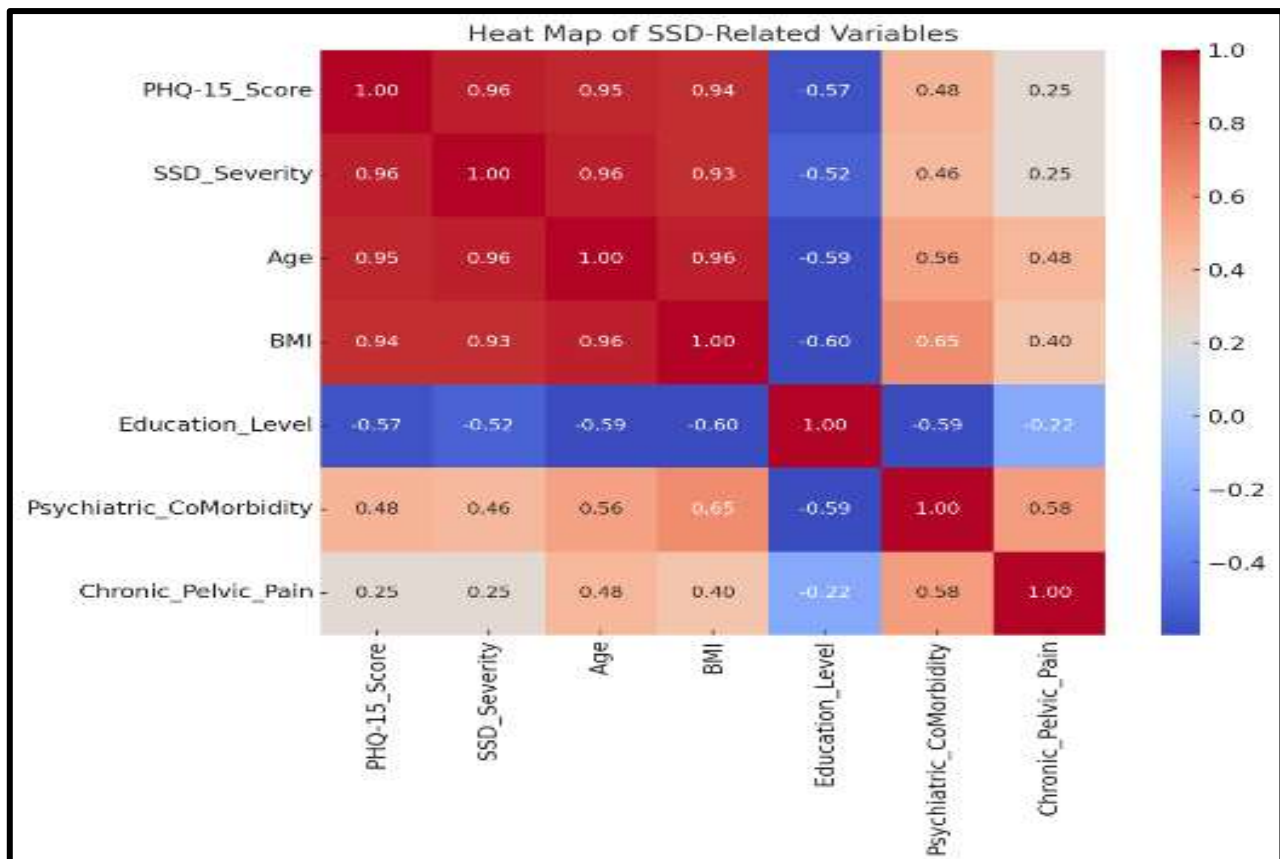


Figure 3: Heat map of correlations among variables related to SSD.

Table 1: Demographic and clinical characteristics of participants.

Category	N	Percentage (%)
Age group (in years)		
20-39	28	38.89
40-59	33	45.83
>60	11	15.28
Mean±SD		44.77±13.96
Median		49.5
Range		20-73
BMI (Kg/m²)		
<18.5 (underweight)	2	2.77
18.6-24.9 (normal)	41	56.9
25-29.9 (overweight)	4	5.55
>30 (obese)	3	4.166
Mean±SD		22.591±2.535
Median		21.75
Parity		
Unmarried	9	12.5
≤ 2	11	15.27
3	32	44.44
≥ 4	17	23.61
Education status		
Illiterate	24	33.33
Primary	25	34.72
Secondary	9	12.5
Graduate	10	13.88
Post graduate	4	5.55
Socioeconomic class		
Upper	0	0
Upper middle	15	20.8
Lower middle	33	45.8
Upper lower	24	33.3
Lower	0	0
Occupation status		
Employed	54	75.0
Unemployed	18	25.0

Table 2: Symptom profile in participants.

Symptom profile	N	Percentage (%)
Chronic pelvic pain	41	56.94
Vaginal discharge	27	37.5
Lower back ache	19	26.38
Breast pain	9	12.5
Menorrhagia/ dysmenorrhoea	13	18.06
Pruritus vulva	8	11.11
Dyspareunia	4	5.55
Infertility	1	1.38

Table 3: Severity of somatic symptoms (PHQ-15 scores).

PHQ-15 score	N	Percentage (%)
0-4 (Minimal)	3	4.16
5-8 (Mild)	26	36.11
9-12 (Medium)	28	38.88
13-26 (High)	15	20.83

Table 4: Psychiatric illness in participants.

Psychiatric illness	N	Percentage (%)
Major psychiatric disorders		
Anxiety disorder	5	6.94
Depression	10	13.88
Panic disorder	2	2.77
Other psychiatric histories		
Previous history of postpartum psychosis	2	2.77
Previous history of suicidal attempts	2	2.77
History of psychiatric illness in family	4	5.55

Table 5: Distribution of cases according to personal history.

Personal history	N	Percentage (%)
Insomnia	15	20.8
Increased sleep	3	4.16
Decreased or increased appetite	5	6.94
Constipation	6	8.33
Domestic abuse	3	4.16
Intermarital disharmony	2	2.77
Child abuse	2	2.77
Nocturia	1	1.38

Table 6: Distribution of cases according to major co-morbidities.

Risk factor/comorbidity	N	Percentage (%)
Major co-morbidities		
Hypothyroidism	10	13.88
Hypertension	9	12.5
Type 2 DM	5	6.94
Other co-morbidities		
Seizure disorder	1	1.38
Psoriasis	1	1.38
COPD	1	1.38
Eczema	1	1.38
Heart disease	2	2.77
Abdominal Kochs	1	1.38

DISCUSSION

The present study explored the clinical and demographic profile of women presenting with unexplained gynaecological symptoms and identified the prevalence of SSD in this population. Among 6000 gynaecology OPD attendees, 1.2% were diagnosed with SSD, with chronic pelvic pain, vaginal discharge, and lower backache emerging as the most common presenting complaints. Psychiatric comorbidities, particularly depression and anxiety disorders, were identified in more than one third of the patients, highlighting the bidirectional relationship between psychological health and gynaecological complaints. The majority of women were perimenopausal, and had low educational attainment, and belonged to lower middle socioeconomic groups.

Our findings reinforce the notion that somatic symptoms, especially those related to reproductive health, are often

multifactorial and cannot be understood solely in terms of organic pathology. Previous studies have emphasized that women with medically unexplained gynecological complaints frequently experience higher levels of psychological distress, including depression and anxiety.^{13,17} This was consistent with our findings, where depression was the most common psychiatric comorbidity. Importantly, these results underscore the need for integrated gynecological and psychiatric assessment to avoid repeated, unnecessary medical interventions and to address the underlying psychosocial factors driving symptom persistence.

The predominance of chronic pelvic pain in our study aligns with earlier research from India and globally, which has consistently highlighted its strong association with psychosomatic disorders.^{17,19} Chronic pelvic pain has been conceptualized not merely as a gynecological issue but as a manifestation of central sensitization, where

psychological stress and maladaptive coping mechanisms amplify pain perception. Our data also showed a moderate correlation between age and chronic pelvic pain, suggesting that perimenopausal women may be particularly vulnerable due to hormonal fluctuations, cumulative life stressors, and sociocultural expectations. Future research should explore whether targeted psychological interventions, such as cognitive-behavioral therapy, can improve outcomes in this subgroup.

Socioeconomic and educational status emerged as key contextual factors in this study. Women with lower education and financial constraints were disproportionately represented among SSD cases, echoing the findings of Baitha et al. and Sundstrom et al.^{12,13} These women may have limited access to mental health resources and health literacy, leading to delayed diagnosis and fragmented care. The negative correlation between education and SSD severity observed in our heatmap analysis suggests that enhancing awareness and coping strategies could be a valuable preventive strategy in low-resource settings.

Interestingly, most participants in our cohort had normal BMI, which contrasts with studies from other regions that have reported higher SSD prevalence among overweight or obese individuals.¹⁵ This variation may reflect regional lifestyle differences and suggests that BMI alone is not a universal risk factor but interacts with other determinants such as diet, activity levels, and body image concerns. Similarly, parity was positively associated with SSD severity, with multiparous women showing higher symptom burdens. This could reflect the cumulative physiological and psychological stress associated with repeated pregnancies and caregiving responsibilities, as also suggested by Eberhard-Gran et al.¹⁶

Personal history analysis revealed insomnia and constipation as notable factors, consistent with Garala et al findings, which identified gastrointestinal and sleep-related symptoms as prevalent among SSD patients with psychiatric morbidity.¹⁸ These similarities emphasize the significant interplay between somatic and psychiatric manifestations in SSD.

The presence of medical comorbidities, particularly hypothyroidism and hypertension, adds another layer of complexity. Hypothyroidism, identified in 13.88% of participants, has been linked to mood disturbances and somatic complaints in previous literature.¹⁹ This reinforces the importance of ruling out subtle organic causes while remaining vigilant for co-existing psychosocial contributors.

From a clinical perspective, our findings highlight several implications. First, gynecologists should maintain a high index of suspicion for SSD in patients with persistent, unexplained symptoms and consider early psychiatric referral. Second, tools like the PHQ-15, which demonstrated good sensitivity and specificity in our study,

can be incorporated into routine gynecological practice to screen for SSD and triage high-risk patients. Finally, adopting a biopsychosocial model of care could improve outcomes by addressing the psychological and social dimensions of health alongside physical complaints.

The main limitation of this study is its small sample size (n=72) and purposive sampling, because of which the findings of the study can only be representative of the study population and cannot be extrapolated to the community at large. The study relied on self-reported symptoms and histories, which are subject to recall bias and social desirability bias. While the PHQ-15 was interviewer-administered, there remains a risk of reporting bias, particularly for sensitive topics such as domestic abuse or psychiatric symptoms.

This study is among the few to systematically evaluate SSD in women with predominantly gynecological complaints in a tertiary care setting in India. The use of standardized diagnostic criteria (DSM-5) and validated tools (PHQ-15) strengthens the reliability of the findings. Additionally, psychiatric evaluations were conducted by a single senior psychiatrist, reducing inter-rater variability.

CONCLUSION

In conclusion, our study highlights the significant burden of SSD among women with predominantly gynecological complaints, with chronic pelvic pain, vaginal discharge, and lower backache being the most commonly reported symptoms. The majority of participants were in the perimenopausal age group, had a normal BMI, and belonged to the lower middle socioeconomic class. Psychiatric co-morbidities, particularly depression and anxiety, were prevalent, alongside medical conditions such as hypothyroidism and hypertension. These findings underscore the need for a multidisciplinary approach integrating gynecological, psychiatric, and medical care to improve the diagnosis, management, and quality of life of women with SSD.

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