

Overview of Somatization-Diagnosis and Management

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Abstract

Background: Neurologists and general practitioners frequently encounter patients with inexplicable, unintentionally produced somatic complaints otherwise known as somatoform disorders.

Methods: A literature search was performed including MEDLINE, as well as local and international journals using the following keywords/ phrases and cross-referencing: somatoform disorder, somatization, medically unexplained physical symptoms.

Results: Illness with excessive somatic preoccupation is difficult to diagnose or categorize reliably due to rigid diagnostic criteria that often overlap with several psychiatric disorders.

Conclusion: Management of patients with dysfunctional somatoform disorders is complex and challenging, particularly when initiated in a neurology outpatient or inpatient setting. The acronym CARE-MD represents a comprehensive treatment regimen that can be used to decrease physician and patient frustration, dramatically minimise health care over utilization, and improve overall well-being for patients with somatoform disorders.

Keywords: Somatoform disorders, somatization, hypochondriasis, medically unexplained physical symptoms

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Introduction

Better understanding of psychiatry is critically important for practising neurologists, as neurology and psychiatry share a long and honourable common history. An inordinate number of patients presenting to neurologists have complaints that defy a neuroanatomical or neurophysiological explanation and fall under the broad rubric of somatoform disorders. Somatoform disorders represent a group of disorder characterized by physical symptoms suggesting a medical disorder. However, somatization disorder (also Briquet's disorder or, in antiquity, hysteria) is a psychiatric condition because the physical symptoms present in the disorder cannot be fully explained by a medical disorder, substance use, or another mental disorder. Half of the patients seen by

neurologists have co morbid psychiatric illness, most commonly somatoform disorders.¹ Patients are often frustrated with troublesome symptoms that are inexplicable and refractory to multiple treatment regimens. Neurologists encounter unexplained and perplexing complaints in up to 60% of their patients.² Because there is variability with how patients present and no apparent physical cause for their illness, this clinical situation has historically been difficult to conceptualize, categorize, and treat effectively.

Diagnostic Considerations

The pathophysiology of somatization and somatization disorder is unknown. The 17th century physician Thomas Sydenham believed a multifactorial process including "antecedent sorrows" for both men and women should be considered when treating patients with unexplained somatic complaints.³ Sigmund Freud used the word *hysteria* to describe a condition he thought was largely based on unconscious emotional conflict with a related maladaptive somatic response. This term was commonly used until 1980 when the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* changed the diagnosis to Briquet's syndrome in honour of the work done in this area by the 19th century French physician Paul Briquet. Currently in neurological settings, the informal diagnosis of "somatization" is broadly used to describe patients with physical complaints that cannot be totally explained by physical examination and a corresponding diagnostic workup. With a focus on the need to "exclude occult general medical conditions or substance-induced aetiologies for the bodily symptoms", the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*⁴ includes seven diagnoses under the category of somatoform disorders: somatization disorder, undifferentiated somatoform disorder, conversion disorder, pain disorder, hypochondriasis, body dysmorphic disorder, and somatoform disorder not otherwise specified (Table I). It is important to note that the grouping of these disorders does not necessarily imply shared pathogenesis. The somatoform disorders are not fully explained by a general medical condition or another mental disorder

and, in order to meet diagnostic criteria, must cause significant impairment or distress. In addition, unlike a diagnosis of malingering or factitious disorder, patients with somatoform disorder do not intentionally produce their symptoms. Some because of the perceived rigid diagnostic criteria have suggested alternatives to the DSM-IV-TR nomenclature, frequent overlap in clinical presentation among the somatoform disorders, and the resultant impractical application to clinical practice. For example, in order to establish a *DSM-IV-TR* diagnosis of somatization disorder, one must have four pain symptoms, two gastrointestinal symptoms, one sexual symptom, and one pseudo neurological symptom during the course of the illness. In addition, people with a diagnosis of somatization disorder must have had multiple somatic complaints before the age of 30. The wide clinical spectrum of somatization has prompted some medical specialists to develop their own system to identify unexplained somatic symptoms. Some common examples include irritable bowel syndrome, chronic fatigue syndrome, and fibromyalgia. Because many patients do not meet full diagnostic criteria for somatization, the abridged somatization disorder was introduced as a less restrictive alternative.⁵ This syndrome is based on lifetime symptoms and the presence of four somatic complaints in males and six in females. Several reports, including the multi-centered World Health Organization Psychological Problems in General Health Care study, indicate high instability of recall when it comes to lifetime symptoms.⁶ In this study, 61% of unexplained somatic symptoms reported at baseline were not reported 1 year later. Multi somatoform disorder is another diagnostic option for primary care patients with somatization that addresses this issue.⁷ Multisomatoform disorder is defined as the presence of three or more acutely distressful, medically unexplained symptoms from a checklist of 15 common symptoms found in the primary care setting (developed from the Primary Care Evaluation of Mental Disorders or PRIME-MD). In order to meet full diagnostic criteria, patients with multisomatoform disorder must have active symptoms with at least a 2-year history of somatization.

Conversion disorder, one of the somatoform disorders encountered most frequently by neurologists, is a condition in which patients present with complaints involving the voluntary motor or sensory nervous system e.g. inability to walk or sudden blindness. There is no evidence that the symptoms are feigned or intentionally produced, cause significant distress and are not found to be secondary to general medical or neurological

pathology. Unlike many of the other somatoform disorders, patients with conversion disorder often have a psychosocial stressor that precedes and is directly associated with and symbolized by somatic complaints. Fortunately, the majority of patients have at least partial resolution of symptoms within a few weeks of onset.

The differential diagnosis for somatization is extensive. It is important to keep in mind that "inexplicable" illness can refer to a general medical condition that does not exist after assessment or a general medical condition that exists and has not been discovered after a comprehensive workup. When considering a differential diagnosis for a medically unexplained illness, it is important to do a complete evaluation and consider the somatoform disorders, malingering and factitious disorder as diagnoses of exclusion. Patients diagnosed with malingering fabricate illness in an attempt to gain external incentives such as monetary compensation or shelter. Factitious disorder also involves the purposeful and sometimes elaborate self-report of somatic complaints with the objective of assuming the "sick role." People with disorder have no obvious external secondary gain but consciously seek out medical care and attention from health care practitioners.

Clinical Significance

People with somatoform disorders experience high levels of physical discomfort and tend to be dissatisfied with life.⁸ A retrospective review of more than 13,000 psychiatric consultations found that somatization disorder resulted in more disability and unemployment than any other psychiatric diagnosis.⁹ It is difficult to establish accurately the prevalence of somatization because of the wide-ranging definitions and the patient's limited ability to accurately recall symptoms from the distant past. Neurological explanations for common somatic complaints like malaise, sensory deficits, and dizziness were found only in 15% to 20% of the time.¹⁰ Somatization disorder has an estimated primary care setting prevalence of 0.2% to 0.7% and is 5 times more common in females.^{5, 11, 12, 13, 14} Fink and co workers¹ reviewed 198 consecutive patients referred for the first time to a neurologist and found that 61% had at least one medically unexplained symptom and 33% met criteria for one of the somatoform disorders. Gureje and Obikoya¹⁵ surveyed 214 patients and found that 1.1% fulfilled the DSM-III-R criteria for somatization disorder, but 4.7% and 10.8% met the criteria for somatoform pain disorder and undifferentiated somatoform disorder, respectively.

Patients with somatization have more than twice the outpatient utilization and overall medical care costs when compared with nonsomatizing patients.¹⁶ This often translates into increased frustration and low levels of professional satisfaction for treating physicians.¹⁷ Part of the problem is likely a lack of psychiatric supervision and instruction during medical school, residency training, and thereafter. Sullivan and co workers¹⁸ surveyed 348 primary care program directors and found that two thirds of them believed more psychiatric education (particularly in the area of somatoform disorders) was needed for trainees. Numerous studies have shown that up to 70% of neurologists do not recognize common psychiatric conditions such as somatoform disorders.^{2, 19} Smith and co workers²⁰ showed that health care utilization and cost decreased by more than 50% when physicians effectively treated their patients with unexplained medical symptoms. Increased training for primary care physicians in this area will likely result in improved job satisfaction and decreased patient morbidity.

Treatment

The treatment of somatoform disorders exemplifies the "art of medicine." No one treatment has been found to cure somatization disorder. Because this condition is on a wide-ranging continuum with an unknown aetiology, it is difficult to apply a strict evidence-based approach to treatment.²¹ Physicians who are trained to use information from the medical history and physical examination to guide treatment are often confronted with apparent therapeutic failure. Neurologists are frequently put in this situation because they are often called upon to evaluate and treat patients with medically unexplained symptoms. Two studies have shown that up to one third of new patients referred to neurologists fulfil criteria for somatoform disorder.^{2, 22} Therefore, it is imperative that neurologists be aware of effective management strategies that can be utilized in consultations to general practitioners as well as their own practices.

The management of somatoform disorders consists of psychosocial measures that all general practitioners and, in many cases, neurologists can provide. The acronym CARE-MD, integrates the art and science of medicine to help health care providers effectively work with patients who have somatoform disorders (Table II). For many patients with somatization disorder, medication approaches rarely are successful. Physicians should search for evidence of psychiatric co morbidity, such as depression or anxiety disorder. If present, medication interventions specific to the diagnosis can be attempted.

Successful treatment of a major depression or an anxiety disorder, such as panic disorder, also may produce significant reduction in somatization disorder.

Consult Psychiatry/Cognitive Behavioural Therapy

Consultation with a psychiatrist is indicated for patients with recurring symptoms or progressively worsening overall function. Some patients may actively resist psychiatric consultation. Many patients see referral to a psychiatrist as an accusation that they are imaging or fabricating their symptoms or as the first step in the referring physician's withdrawal of involvement in care. It is advisable to schedule a routine follow-up visit soon after the consultation.

The use of Cognitive Behavioural Therapy (CBT) has been shown to decrease the intensity and frequency of somatic preoccupation.^{23, 24} Kroenke and Swindle²⁵ reviewed 31 controlled studies and concluded that CBT is an effective treatment for patients with somatization-type disorders. Group therapy using CBT with an emphasis on education has also been found to be beneficial.²⁶ CBT is generally short-term psychotherapy (8 to 20 weeks) with the goal that patients will develop skills that last indefinitely. This type of psychotherapy is based on the premise that inaccurate or dysfunctional thoughts are pervasive in patients with somatoform disorders. Through a variety of mechanisms, patients learn to recognize and reconstruct the dysfunctional thought patterns with resultant decreased somatic complaints. In collaboration with the psychotherapist, physicians can learn to use brief cognitive behavioural techniques during office visits.

Assess

Assessing patients on each visit for general medical or neurological problems that might explain troublesome physical complaints is important. This is particularly essential for patients who have a long history of somatic preoccupation and present with a new complaint or worsening of existing symptoms. About 30% of patients diagnosed with conversion disorder eventually have an identifiable, non-psychiatric disease that explains the symptoms.²⁷ Twenty-five percent to 50% of patients with somatoform disorders have concurrent depression or anxiety-related disorders.^{28, 29} Physicians can use the PRIME-MD, a screening tool that is a combination of self-report and clinician interview, to reliably screen for psychiatric disorders in the primary care setting.

Regular visits

Indeed, appointments should be regular, brief, instead of follow-up visits on an as-needed basis, and not

contingent on the presence of symptoms. This allows patients to receive the attention they desire without having to develop new symptoms to obtain it. It is essential always to complete a focused examination and screen for frequently co morbid psychiatric illness. The goal of these sessions is to provide an outlet for patients to cope, with less somatic preoccupation, and in some cases to link their symptoms to a particular psychosocial stressor.

Empathy

Empathy or “becoming the patient” is a key ingredient to forming a healthy therapeutic alliance and optimizing treatment for patients with somatoform disorders. Explicit acknowledgment of any emotional or physical suffering on the part of the patient is critical since patients may believe their physician questions the legitimacy of medically unexplained symptoms. The use of empathy can also minimize negative feelings or counter transference for the treating physician.

Medicine-Psychiatry Interface

Medicine and psychiatry should interface in the treatment of every patient with somatoform disorders. One way to accomplish this, while building a collaborative relationship with the patient, is to develop an easily understandable and mutually acceptable language to discuss symptoms. This approach helps the patient safely explore emotions and develop effective coping strategies that will minimize the use of somatization as a defence against stressful situations. It emphasizes the collaborative management of the illness symptoms between the physician and the patient.

Do not harm

Doing no harm by unneeded consultations or procedures is the most important part of treating patients with chronic somatoform disorders. After taking reasonable steps to rule out a general medical or neurological condition, the physician is able to make the appropriate somatoform diagnosis and treatment accordingly.

Conclusion

Disorders relating to somatization in the neurological setting are extremely common and often frustrating for both physicians and patients as they are frequently challenging to manage. Disorders can range from mild and transient to severe and chronic. Fortunately, effective CARE-MD management strategies are available for patients who are functionally impaired by somatization. Early treatment improves prognosis and limits social and occupational impairment.

Table II: CARE-MD- Treatment Guidelines for Somatoform Disorders

CARE-MD	Brief Treatment Plan
Consult psychiatry/ cognitive behavioural therapy	Consult psychiatry with recurring symptoms or worsening overall function. Follow the cognitive behavioural therapy treatment plan developed by the therapist and patient
Assess	Rule out potential general medical causes for the somatic complaints
Regular visits	Schedule short frequent visits with focused examinations Discuss recent stressors and healthy coping strategies. Patients should agree to stop over utilization of medical care (e.g., frequent emergency department visits, or excessive calls and pages to the primary care physicians).
Empathy	Become the patient for a brief time During brief visits, spend most of the time listening to the patient.
Medicine-psychiatry interface	Acknowledge patient-reported discomfort. Help the patient self-discover the connection between physical complaints and emotional stressors Avoid comments such as Your symptoms are purely psychological or There is nothing wrong with you medically.
Do not harm	Order no unnecessary diagnostic procedures Minimize consultations to medical specialties. Attempt to obtain collateral history from area medical centres with complex cases. Once a reasonable diagnostic workup is negative, feel comfortable with a somatoform-type diagnosis and initiate treatment.

Table I: Brief definition of commonly used somatoform disorders

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision

Disorder*	Definition
Somatization	Many unexplained physical complaints with an onset before age 30 Four pain, two gastrointestinal, one sexual and one pseudo neurological symptom(s). Rarely encountered in clinical settings.
Undifferentiated somatoform	One or more unexplained physical complaints. Duration of at least 6 months.
Conversion	One or more unexplained, voluntary motor or sensory neurological symptoms. Directly preceded by a psychological stress. Relatively good prognosis. More commonly seen by neurologists.
Pain	Pain in one or more sites that is largely due to psychological factors. Can coexist with other pain disorders.
Hypochondriasis	Preoccupation with a nonexistent disease despite a thorough medical workup. Does not meet criteria for a delusion.
Body dysmorphic	Preoccupation with an imagined defect in physical appearance.
Somatoform	Somatoform symptoms that do not meet criteria for any specific somatoform disorder.
Not otherwise specified	

Non-Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision

Abridged somatization	Presence of four unexplained somatic complaints in men and six in females.
Multisomatoform	Three or more unexplained somatic complaints from the PRIME -MD scale. Two or more years of active symptoms.

*All disorders shown (1) cause significant social/occupational dysfunction; (2) are not due to other medical, neurological, or psychiatric conditions; and (3) are not intentionally produced or related to secondary gain.

PRIME-MD = Primary Care Evaluation of Mental Disorders

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