From Head to Toe:
What to Do About Somatoform Disorders

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While somatoform disorders have a rich descriptive and empirical history in the annals of psychiatry, psychology and general medicine, they continue to perplex and frustrate practitioners. Patients who suffer from these disorders show persistent preoccupation with physical symptoms that cannot be fully linked to an identifiable disease process. The symptoms are very real to the patient, and are not intentionally produced. Psychologic distress is felt to be a primary contributor to patients' physical symptoms.

Excellent and comprehensive reviews of this set of disorders can be found in mental health literature.[1-7] Additional reviews appear in primary care and internal medicine, where somatoform disorders are often described along with other "pseudoneurologic," "medically unexplained," and "functional somatic syndromes."[8-13] While there is no complete agreement on the terminology for this group of disorders, there is clear recognition that the prevalence rate is high, that patients suffer greatly, and that the disorders are associated with high rates of disability and health-care utilization.[13-16] Although these patients are considered difficult to treat, there have been advances in the understanding and management of these complex disorders.

Somatization as a process

The process by which psychologic distress is transformed to physical symptoms is referred to as somatization. The symptoms are typically attributed to physical illness and, as a result, the patient seeks medical help.[17] Three components are inherent in the definition of somatization (Table 1).

What are the somatoform categories?

The latest iteration of the Diagnostic and Statistical Manual of mental disorders (DSM)[18] divides somatoform disorders into several discrete categories.

Somatization disorder

Somatization disorder begins before age 30, and has a chronic course over many years with periods of relative remission. It is characterized by a combination of pain, as well as gastrointestinal, sexual, and pseudoneurologic symptoms. These patients seek treatment repeatedly, and suffer significant impairment in social and occupational areas of functioning, among others.

Undifferentiated somatoform disorder

Patients who suffer from this disorder have unexplained physical symptoms for at least six months that are below the threshold for a diagnosis of somatoform disorder. These patients also suffer significant decline in their overall functioning, and repeatedly seek treatment.

Conversion disorder

In conversion disorder, patients present with unexplained symptoms or deficits affecting voluntary motor or sensory function, which is suggestive of medical ill-

ness. Appropriate assessment leads to the conclusion that psychologic factors are at the root of these symptoms or deficits. Generally, individual symptoms appear acutely after a distressing situation, and remit within two weeks; recurrence is common in such cases. In some situations, patients develop a chronic course leading to impairment in function.

Pain disorder

These patients present with pain as their predominant symptom. Psychogenic factors are judged to play an important role in precipitation, severity, exacerbation, or perpetuation. These patients frequently have a chronic, fluctuating course, and comorbid depression is often present. If a physical cause is found, it is typically insufficient to explain the severity of pain.

Hypochondriasis

Patients who suffer from hypochondriasis are preoccupied with fear of having, or belief that they have, a serious disease. This preoccupation is based on their misinterpretation of bodily symptoms or bodily functions, and often leads to obsessive anxiety.

Body dysmorphic disorder

This disorder is a chronic illness infrequently seen in psychiatric practice, as most patients are reluctant to reveal their symptoms. The characteristic symptom is extreme preoccupation with an imagined or exaggerated defect in physical appearance.

Somatization disorder, not otherwise specified

As is customary in the DSM nosology, patients that do not fully satisfy formal diagnostic criteria, yet present with somatoform symptoms, can be labelled within this category.

There is considerable debate about the reliability, validity, and utility of the formal DSM somatoform disorder categories that is beyond the scope of this brief review. It is anticipated that there will be substantial revision in the next edition of DSM.[14] Until then, and likely thereafter, the debate on the phenomenology and management of somatoform disorders will persist. While this debate continues, caution should be exercised in communicating these diagnoses to patients because of the stigma and self-blame the language of these disorders carry.

How are the disorders managed?

It is well-known that patients suffering from somatoform disorders are very challenging to treat. Clinical research and theoretical integrations enable health-care workers to prescribe rational treatment interventions aimed at various components of the illness.[3] Psychologic interventions (typically labelled behavioural, cognitive-behavioural, stress-management or rehabilitative) have been found to be effective with reasonable effect sizes.[3] Some interventions have been found to be effective in alleviating distress at different levels of the illness process (Table 2).

Other general treatment principles can be applied in a clinical setting. The physician must rule out medical conditions, and then remain on guard as a new or previously missed or coexisting medical illness may emerge.

Table 1
Process of somatization

The process includes:

1. An experiential or subjective component in which the patient experiences bodily symptoms
2. A cognitive or attributional component in which the patient ascribes the symptom to an illness
3. A behavioural component in which the patient expresses the symptom and seeks medical treatment

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Table 2
Interventions for alleviating distress

- Psychopharmacologic management, biofeedback, relaxation training, and general stress management target emotional arousal and physiologic disturbance
- Attention training, distraction, hypnosis and certain kinds of meditation reduce bodily attention
- Re-attribution and behavioural experiments minimize the cognitive bias toward attribution of bodily sensations to illness
- Desensitization, reframing, and psychoeducation reduce illness worry and catastrophization
- Provision of reassurance, response prevention when necessary, and behaviour modification reduce the frequency of the interactional component of help-seeking
- Exposure and graded activity alleviate the behavioural avoidance and deconditioning component
- Support groups, couple and family interventions, consultations to primary health providers, and compensation systems address the social response

Adapted from: Looper KJ, Kirmayer LJ: Behavioural medicine approaches to somatoform disorders. J Consult Clin Psychol 2002; 70(3):812.

Table 3
Management of persistent somatization

The family physician should:

- Arrange regular appointments of a set length, not contingent on physical symptoms
- Negotiate a specific agenda for each visit with the patient
- Limit investigations to objective findings to reduce harm to the patient
- Set limits on interactions outside scheduled appointments
- Provide psychoeducation on the relationship between stress and physical symptoms
- Avoid multiple medications, particularly narcotics and benzodiazepines
- Avoid "it's all in your head" statements and/or implications

Treatment should be centralized at the office of a consistent primary caregiver who can establish a long-term, therapeutic relationship with the patient.

Education about the role of anxiety and stress in somatic symptoms paves the way for psychologic interventions. Unnecessary investigations should be avoided, as they may reinforce the belief that the cause of illness is organic. Regular, scheduled visits that are not contingent upon symptoms help to diffuse crises prior to their occurrence. These visits can also provide the foundation for a therapeutic, interpersonal relationship which can be helpful for those with a history of vulnerable or abusive early childhood attachments.[11,13] As these patients commonly do not accept psychologic factors as a cause of their illness, they should be treated with sensitivity and an in-depth understanding of the psychosocial factors which drive their symptoms. Confrontation typically leads to deterioration, whereas empathic understanding leads to alleviation of their symptoms.

Comorbid anxiety and depression should be treated with the usual standard psychologic and pharmacologic interventions. Key elements of psychotherapeutic approaches include: acceptance of somatic symptoms as real or distressing, emphasis on adaptation to somatic distress, and a gradual diversion of attention from physical symptoms to psychosocial stressors and negative affects which may precipitate or worsen symptoms.[5] While the empirical evidence is biased toward time-limited, cognitive-behavioural therapies, the importance of developing a strong therapeutic alliance in line with general principles of supportive psychotherapy is essential for successful treatment.[3,5] The therapeutic stance should be symptom "management" as opposed to "cure," and this should be communicated to the patient at the earliest possible time following the diagnosis of somatoform disorder.[19]

There is no specific pharmacotherapy available for somatoform disorders. Unfortunately, these patients are often prescribed multiple medications as a result of their

help-seeking behaviour. For this reason, it is important to centralize the patient's treatment with a consistent primary-care physician (Table 3). Psychotropic medication should be prescribed only for comorbid disorders, such as depression and intolerable anxiety. Whereas there is no definitive data, selective serotonin reuptake inhibitors and dual agents, such as venlafaxine, are commonly prescribed for comorbid anxiety and depressive disorders. Older generation antidepressants, which have significant adverse reactions, should be avoided because of these patients' heightened sensitivity to side-effects. Benzodiazepines and narcotics should be minimized because of patient tolerance and propensity for addiction. Occasionally, antipsychotic medications are prescribed when the somatic preoccupation is of delusional proportion. Atypical antipsychotics are preferred as opposed to older generation neuroleptics due to their superior efficacy and improved tolerability.[20] Narcoanalysis, which involves injection of intravenous sodium amytal, is used specifically for conversion disorders to facilitate in-depth exploration and use of suggestion to ameliorate symptoms.[21] Some clinicians prefer to use hypnosis to facilitate the exploration and treatment strategies.[21]

Future directions

Debates about the content of the next version of DSM will provide a momentum for further research in this area. Suggestions for consideration include emphasis on etiologic approach, use of dimensions rather than categories, a fresh look at the definition of the threshold for disorders, and issues of reliability, validity, and utility.[14] If these suggestions are implemented, they will improve our understanding of these perplexing disorders through research, and provide a basis for novel approaches for their management. CME

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Take-home message

- Patients suffering from somatoform disorders are very challenging to treat.
- Treatment should be centralized at the office of a consistent primary caregiver who can establish a long-term, therapeutic relationship with the patient.
- Unnecessary investigations should be avoided, as they may reinforce the belief that the cause of illness is organic.
- Regular, scheduled visits that are not contingent upon symptoms help to diffuse crises prior to their occurrence. These visits can also provide the foundation for a therapeutic interpersonal relationship which can be helpful for those with a history of vulnerable or abusive early childhood attachments.

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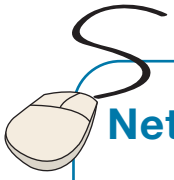

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