

Somatization Disorder: What Clinicians Need to Know

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Somatization disorder represents a substantial burden for both patients and clinicians, particularly in primary care settings. In this paper we will discuss who these patients are, where they are likely to show up, how they present and how they might be treated. According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association [APA], 1994), somatization disorder is characterised by at least four unexplained pain symptoms, two unexplained non-pain gastrointestinal symptoms, one unexplained sexual or menstrual symptom, and one pseudo-neurological symptom. Physical complaints must begin before 30 years of age and generally last over a number of years. The symptoms are not intentionally produced by the patient (as in malingering) and after appropriate investigation cannot be fully explained by a medical condition. Patients with somatization disorder tend to overuse healthcare services and withdraw from productive and pleasurable activities because of discomfort, fatigue or fear of exacerbating their symptoms (Woolfolk & Allen, 2007).

The proposal for DSM-V (APA: DSM-5 Development, 2010) suggests that somatization disorder be subsumed into a new disorder to be called "Complex Somatic Symptom Disorder" (CSSD). CSSD will also include hypochondriasis, pain disorder and undifferentiated somatoform disorder. It will emphasise equally both the physical and the cognitive symptoms. The term "complex" is intended to denote that somatic and cognitive symptoms must be both present and persistent.



Prevalence

In the Epidemiologic Catchment Area (ECA) study (Simon & VonKorff, 1991), the largest study of somatization disorder (carried out in a community sample of 20,000 people across five places in the US), the lifetime prevalence of DSM-III (APA, 1980) somatization disorder was 0.13%.

Other research has reported slightly higher prevalence rates and, not surprisingly, somatization disorder appears to be more common in primary care patients (1.0–1.4%) than in community populations (0.5–0.4%) (Looper & Kirmayer, 2002).

Patients with somatization disorder are likely to have a comorbid condition, with as many as 80% meeting the criteria for another psychiatric disorder. Major depression or generalized anxiety disorder are the most commonly found comorbid diagnoses (Brown, Golding, & Smith, 1990). When comorbid psychiatric disorders are treated, somatization symptoms have been reported to resolve (Dohrenwend & Skillings, 2009).

Background of Patients

Somatization tends to run in families (Asmundson & Taylor, 2005). People with a history of illness can become illness focused, which may then lead to a preoccupation with somatic symptoms. The modelling of a somatic illness focus by parents can then result in their children also becoming illness focused. In a study of recurrent abdominal pain in children, McGrath and Feldman (1986) found an association between functional abdominal pain and poor well-being of family members, major life events and daily stressors. They also found evidence for the influence of modelling and argued that the impact of stress on pain seems to be moderated by the child's perceived competence to manage the pain experience. In line with behavioural



modelling theory, Livingston (1993) found that children of parents with somatization disorder had significantly more psychiatric disorders and suicide attempts than physically ill paediatric controls. They were also found to have experienced more hospitalisations and maltreatment.

Correspondingly, somatization disorder is commonly linked to a history of interpersonal trauma (Reese, 2009) and somatoform disorders are likely to occur more frequently in children and adolescents who have been severely maltreated than in others (Haugaard, 2004). Spitzer, Barnow, Gau, Freyberger and Grabe (2008) argued that sexual abuse is a significant predictor of somatization disorder and found that the odds of having been sexually abused were nine times higher in patients with somatization disorder than those with a diagnosis of major depressive disorder. Additionally, Brown, Schrag and Trimble (2005) suggested that patients with somatization disorder tended to have been raised in emotionally cold and unsupportive families which were characterised by chronic emotional and physical abuse. They qualified their findings by stating that sexual abuse is not necessarily a prerequisite for somatization disorder and that the malign emotional climate of the family sufficed to allow the development of a somatization disorder.

Clinical Presentation

In terms of personality types and cognitive styles, a few have been consistently ascribed to patients with somatization disorder (Woolfolk & Allen, 2007). These patients tend to score higher on scales of neuroticism and negative affect, and express catastrophic and helpless beliefs about their

symptoms. Murray (1999) also demonstrated that high absorption (openness to absorbing and self-altering interpersonal experiences) was a predictor of physical and psychological distress. Those who were more creative and were rated as more socially desirable were less likely to be somatizers. Reese (2009) suggested that somatizing patients presented with significantly higher rates of alexithymia than healthy controls. Alexithymia has been defined as a difficulty in identifying and expressing emotions and having an externally oriented cognitive style that directs focus away from one's inner experience (Woolfolk & Allen, 2007). Changes in alexithymia (also called dyslexithymia) were examined over the course of a 10-session trial of cognitive behavioural therapy (CBT) for somatization disorder. It was found that decreases in alexithymia were significantly correlated with improvement in somatization symptoms. This supported the idea that emotional functioning is a key factor in somatization. Furthermore, Subic-Wrana, Beutal, Knebel and Lane (2009) demonstrated that patients with somatization disorder showed reduced emotional content and reduced Theory of Mind functioning compared with control subjects. This suggested that individuals with decreased emotional awareness may fail to experience affective arousal as feelings and instead experience emotional distress somatically, potentially explaining the phenomenon of somatization.

Treatment

Clients with CSSD are typically over-utilisers of primary care services. The referring general practitioner will often express relief in the psychologist receiving the referral. These clients tend to hold strong beliefs about their illness, think catastrophically about their health, adopt a sick role and often present with anxiety and/or depression (Woolfolk & Allen, 2007). CSSD is commonly encountered in both primary and secondary care but despite its high incidence, the lack of appropriate care leads to increased hospital admissions and investigations. These investigations are often to the patient's detriment and they tend to double the cost to the health services compared to those without CSSD. Currently, psychiatric services tend to concentrate on "serious mental illness" or psychotic disorders, despite the large number of people suffering from somatoform disorders (Jorsh, 2006). Patients with CSSD run the risk of being overlooked by clinicians as they are neither medically "sick" nor do they have a "serious mental illness". Therefore, it is important to identify the issues in dealing with CSSD and create a clear plan for the sake of the patient, clinician, and cost to the health services.

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Relationship Between GP and Patient in Relation to Referral

The management of somatization disorder can be particularly challenging for clinicians. Patients with medically unexplained symptoms are often highly distressed and prompted to make repeated requests for medical care (Looper & Kirmayer, 2002). The physician tends to be initially concerned with ruling out treatable medical conditions and, when none are found, begins to contain "excessive" help-seeking behaviour. This shift often marks deterioration in the doctor-patient relationship, as patients sense that their doctor has lost interest in them or views them as bothersome. Although many GPs are then eager to refer the patient for psychological treatment, patients might see the referral as their doctor's way of questioning the reality of their symptoms. This challenge has encouraged the development of treatment approaches for somatization disorder that meet the different demands of the patient and referring GP (Dohrenwend & Skillings, 2009). Engaging patients in psychological treatment and maintaining a therapeutic alliance is most likely to succeed where there is close collaboration between the psychologist and physician and where the patient's physical distress is validated by ongoing medical management (Looper & Kirmayer, 2002). For this reason, the collaborative nature of CBT has been shown to be particularly effective for somatization. CBT aims to alter the dysfunctional thoughts and behaviours associated with somatization symptoms. Timmer, Bleichhardt and Rief (2004) demonstrated that CBT helped to reduce patients' illness beliefs, symptom severity and doctors' visits. The benefits of treatment were sustained at 12-month follow-up.



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Accordingly, Woolfolk and Allen (2007) highlighted the importance of having a clear plan when dealing with somatization disorder and proposed what they call "Affective Cognitive Behavioural Therapy", which includes the following recommendations for physicians:

- Provide continuity of care
- Avoid unnecessary tests and procedures
- Provide frequent, brief and regular office visits
- Always conduct a physical exam
- Avoid making disparaging comments (e.g., "Your symptoms are all in your head")
- Set reasonable therapeutic goals (e.g., maintaining function despite ongoing pain).

Some other approaches proposed for dealing with somatization disorder include pharmacological intervention, relaxation training and education of primary care physicians (Asmundson & Taylor, 2005).

Whilst no randomly controlled trials have been conducted on the efficacy of medication for somatization disorder (Woolfolk & Allen, 2007), antidepressant treatment for functional somatic syndromes has been shown to improve a patient's physical symptom severity and overall functioning. To date, however, there is no evidence supporting the long-term efficacy of pharmacological intervention (Menza et al., 2001).

Relaxation training and exercise treatments have been shown to give pain relief and improve mood (Woolfolk & Allen, 2007). Kashner, Rost, Cohen and Anderson (1995) demonstrated that group therapy sessions, in addition to the consultation provided by the physician, lead to significant improvement in physical and mental health in patients with somatization disorder compared to a control group who did not attend these sessions. The authors also showed that the more group sessions attended by the patient, the greater the improvement in physical and mental health.

The benefit of sending a psychiatric consultation letter to primary care physicians caring for patients with somatization disorder to inform the physician about somatization disorder and recommend type of treatment has been demonstrated (Looper & Kirmayer, 2002). Kashner et al. (1992) found that this was effective in reducing the cost associated with excessive healthcare use but did not improve the psychological distress of the patient.

Summary

Physical symptoms occur in the absence of any identifiable causal mechanism in clients who present with a somatization disorder. These clients represent a significant proportion of



those seeking help in primary care settings. Due to a lack of appropriate care, patients with somatization disorder often undergo multiple medical procedures which result in an inordinate expense to the health services and leave both the patients and GP feeling frustrated. Somatization disorder calls for a treatment plan that is clearly defined in which the patient feels listened to and understood and where their physical distress is validated by ongoing medical management. Psychologists in close collaboration with a referring GP are ideally placed to help these clients significantly improve their understanding of their emotions, and how cognitions affect their physical symptoms, as well as to apply empirical treatments to comorbid emotional difficulties.

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