

## Somatization



- What will you do and how will you feel when you have patients who repeatedly present with unexplained physical complaints that defy your best diagnostic and therapeutic efforts?



### Awesome article series—read!



- <http://www.aafp.org/afp/20000215/1073.html>
  - Somatizing Patients: Part I. Practical Diagnosis
- <http://www.aafp.org/afp/20000301/1423.html>
  - Somatizing Patients: Part II. Practical Management
- <http://www.aafp.org/afp/20000301/1431ph.html>
  - Patient hand-out

### Could the patient be suffering with a psychosomatic illness?



- **Somatization**
  - Physical complaints or impairments:
    - without organic pathology
    - that are grossly in excess of what would be expected from the physical findings

### Somatization



- Somatizing patients:
  - are unable to use emotional language to describe their distress
  - express their psychological illness or social distress with somatic symptoms
- Somatization is an entirely **unconscious** process

### Somatization



- Psychosomatic complaints frequently involve:
  - chronic pain
  - problems with the digestive system, nervous system, and reproductive system
- Typical onset – before age 30
- Higher prevalence for women than men  
(National Library of Medicine, 2006)

## Mechanisms of Somatization



- Somatization may be understood from four theoretical perspectives:
  - Neurobiological
  - Psychodynamic
  - Behavioral
  - Sociocultural

## Mechanisms of Somatization



- **Neurobiological**
  - Somatization results from defective or deficient neurobiological processing of sensory and emotional information
- **Psychodynamic**
  - Somatized physiological sensations occur as expressions of underlying emotional conflict
  - Somatization enables patients to meet latent needs for nurturing and support

## Mechanisms of Somatization



- **Behavioral**
  - Somatization is viewed as behavior that is brought about and reinforced by others in the patient's environment
  - **"Illness-maintenance systems"**

## Mechanisms of Somatization



- **Sociocultural**
  - Social norms concerning emotions
  - When a culture does not allow direct communication of emotional content, one means available to express emotions is through physical symptoms
  - Somatization serves to notify others of emotional or psychological distress in an acceptable or non-stigmatized manner

## Contributing Factors for Somatization



- Childhood abuse
- Acute stress
- Societal roles
- Learned behavior
- Secondary gain
- Cultural factors
- Histrionic, narcissistic, and borderline personality traits

## Significance of Somatization



- Primary care physicians encounter perplexing somatic complaints in up to 40% of their patients  
(McCarron, 2008)
- Many of these patients are suffering from **depression and anxiety**, which are common problems seen in the primary care setting

## Significance of Somatization



- Many patients experiencing depression or anxiety visit their physicians with predominantly physical complaints
  - Fatigue
  - Dizziness
  - Headache
  - Abdominal pain
  - Extremity pain
- That are accompanied by requests for “check-ups”

## Symptoms That Can Occur with Somatization Disorder



- Vomiting and/or nausea
- Abdominal pain
- Bloating
- Diarrhea
- Pain in the legs or arms
- Back pain
- Joint pain
- Pain during urination
- Headaches
- Shortness of breath
- Palpitations
- Chest pain
- Dizziness
- Amnesia
- Difficult swallowing
- Vision changes
- Paralysis or muscle weakness
- Pain during intercourse
- Impotence
- Painful or irregular menstruation

(NLM, 2006)

## Presentation of Somatizers



- Most somatizers are unaware of the psychological disorders (or emotional conflicts) that underlie their symptoms
- Even **when/if** they perceive anxious or depressed feelings, they **rarely** understand or acknowledge a connection between these feelings and their physical symptoms

## Clinical Clues to Somatization



- How can physicians detect this phenomenon and be comfortable with the diagnosis of somatization?

## Clinical Clues to Somatization



- Thick chart syndrome
- Marked change in utilization pattern
- Vague, confusing, or bizarre symptoms
- Resistance to psychological inquiry or explanations
- Specific complaints such as dizziness, fatigue, or insomnia
- Physician’s “heartsink” response

## Differential Diagnosis



- Acute somatization
- Chronic somatization
  - Somatoform disorders
  - Malingering and Factitious disorder

## Differential Diagnosis

### ● Acute Somatization

- Results from transient stress that temporarily overwhelms usual coping mechanisms
- **Most common form of somatization**
- Usually no history of health care-seeking behavior, and fairly readily accept stress as a cause of their symptoms

## Somatization

### ● Chronic Somatization

- Occurs in the context of a specific psychiatric disorder such as depression, anxiety, personality disorders
- Long-lasting process
- Two subcategories of chronic somatization
  - Somatoform disorders
  - Malingering and Factitious disorder

## 7 Categories of Somatoform Disorders

- Somatization Disorder
- Undifferentiated Somatoform Disorder
- Conversion Disorder
- Pain Disorder
- Hypochondriasis
- Body Dysmorphic Disorder
- Somatoform Disorder Not Otherwise Specified

## Factitious Disorders

- Characterized by:
  - Physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role
  - Conscious fabrication of symptoms to gain attention
- Diagnosis is based on direct evidence and by excluding other causes of the symptoms
- The presence of factitious symptoms does not preclude the coexistence of true physical or psychological symptoms

## Malingering

- Intentionally feigning or grossly exaggerating illness or disability to derive benefit or secondary gain (e.g., to escape work, gain compensation, or obtain drugs)

## Factitious Disorder vs. Malingering

- |   |  |
|---|--|
| ● Factitious Disorder   | ● Malingering  |
| ● May agree to unnecessary surgery and interventions          | ● Will not agree to unnecessary surgery/interventions          |
| ● Motivated by psychological needs (attention, security, etc) | ● Motivated by secondary gains (avoid work/stay on disability) |
|   | ● More common in military populations and legal settings       |

## Risk Factors for Malingering



- Risk factors for malingering include:
  - Ongoing litigation
  - Significant discrepancy between subjective disability and objective findings
  - Lack of cooperation with the evaluation and with treatment
  - Antisocial personality disorder

## Evaluation of Patients



- Even when a previously diagnosed psychiatric disorder is present, to what extent should other health complaints be evaluated and excluded as possible causes of unexplained, persistent symptoms?
- Are physicians negligent if they do not perform extensive diagnostic testing?

## Evaluation of Patients



- Each person deserves:
  - Careful and empathic listening
  - Thorough physical exam
  - A review of previous records
  - And, for some, limited diagnostic testing

## Evaluation of Patients



- The laboratory evaluation should be directed with patient-specific symptoms and physical signs

## Management



- Most important aspect of managing somatizing patients?
  - Development of an empathic, trusting **doctor-patient relationship**
  - It is critical to both diagnosis and treatment
- Early detection is important
  - Better response to psychological treatment
  - Fewer iatrogenic effects
  - Stronger doctor-patient relationship

## Management



- **CARE-MD** treatment approach
  - **C**ognitive behavioral therapy (CBT)
  - **A**ssess: rule out medical causes
  - **R**egular visits: Short frequent visits with focused exams
    - Explore stressors, promote healthy coping
    - Set boundaries
  - **E**mpathy
  - **M**ed-psych interface
  - **D**o no harm

(McCarron, 2008)

## Management



- Physician as educator
  - Explain that symptoms are due to a *disorder* of the autonomic nervous system, which can be present despite "normal" diagnostic tests
  - Attempt to identify psychosocial stressors that worsen the patient's pain complaint
  - **Draw a link between these stressors and the autonomic nervous system**
  - Efforts can then be directed by the patient toward reducing or eliminating these stressors

## Management of Chronic Somatizers



- Do not dispute the reality or severity of the patient's physical complaints
- Establish appropriate goals and expectations for both you and the patient

## Empathic Communication Skills



- **Empathy:** "That must have been a very sad event for you"; "I can see how angry you were after you heard the diagnosis"
- **Legitimization of feelings:** "Feeling sad about something like this is perfectly normal"
- **Partnership:** "I want you to know that you and I will be working on this together as a team"
- **Support:** "Whatever else happens, I'll be in your corner"
- **Respect:** "I'm impressed that you've been able to maintain all of your obligations at home and work in spite of your pain. I respect your commitment"

## Management



- Listen to the patient's life stories
- Be aware that somatizing patients are often intellectually challenging to the physician

## Management of Transient Somatizers



- Generally have a good prognosis
- They are often willing to consider psychological or psychophysiological explanations for their symptoms

## Making the Referral



- **Legitimize** the patient's experience
  - Somatizing patient's often feel a **strong need to have their pain validated**; consider their experience...
  - A **real** health problem; it's **not** "all in your head"
- Using **empathy**, make the mental health **referral**
- **Explain** that by addressing their emotional state they will feel better psychologically
- This will help them heal (physically); they will also learn symptom-management techniques

## Making the Referral

- Acute somatizers may accept a referral, but chronic somatizers tend to reject the psychological labeling required to justify the referral
- Even when a referral is accepted, few chronic somatizers respond to insight-oriented therapy and frequently return to primary care settings for chronic management
- **Ask the patient for concerns about referral**

## Psychological Treatment

- Cognitive-behavioral treatment
- Biofeedback
- Relaxation training
- Group therapy
- Family therapy

## Goals of Psychological TX

- Goals of psychological treatment
  - a) Improving their function while managing their pain
  - b) Recognizing their underlying feelings/needs
  - c) Decreasing utilization of health care resources

- Discourage "doctor shopping" and unnecessary tests/procedures and iatrogenic complications
- How can chiropractors contribute to iatrogenic complications?

## Coping

- Resist the temptation to try to "cure" everything
- Acknowledge and accept disturbing feelings
- Discuss feelings with colleagues
- Recognize and understand somatization
- Do not blame the patient
- Have reasonable expectations of the patient
- Schedule these patients at a time that is right for you

## References

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