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

- 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

- 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

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

- 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 overwhelmed 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
  - May agree to unnecessary surgery and interventions
  - Motivated by psychological needs (attention, security, etc)
- Malingering
  - Will not agree to unnecessary surgery/interventions
  - 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
  - Cognitive behavioral therapy (CBT)
  - Assess: rule out medical causes
  - Regular visits: Short frequent visits with focused exams
  - Explore stressors, promote healthy coping
  - Set boundaries
  - Empathy
  - Med-psych interface
  - Do 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