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CLINICAL PEARL
Managing Somatization Disorder
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Patients and primary care physicians (PCPs) both become frustrated when troublesome physical complaints cannot be explained after repeated assessments and persist after multiple treatment attempts. PCPs encounter these perplexing somatic complaints in up to 40 percent of their patients [1,2]. Medical explanations for common physical complaints like malaise, fatigue, abdominal discomfort, and dizziness are found 15-20 percent of the time [3]. The remaining somatic complaints—up to 20 percent in primary care settings—are called unexplained physical symptoms (UPS). It is difficult to determine the prevalence of unexplained physical complaints reliably, due to wide-ranging definitions [4]. Although somatization may ultimately have general medical and psychiatric etiologies, the goal of this article is to help psychiatrists provide practical information and advice to PCPs who treat patients with unexplained physical symptoms that are due to psychiatric pathology.

Diagnosis
The *Diagnostic and Statistical Manual of Mental Disorders* 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. In order to meet the criteria for any of the somatoform disorders, one must have significant social or occupational dysfunction that is directly related to psychopathology and not due to an occult general medical condition or substance abuse [5]. Patients with somatoform disorders somatize unconsciously as a dysfunctional and maladaptive coping mechanism; they do not produce their symptoms intentionally as do those with malingering or factitious disorder.

Table 1. Somatoform disorders—diagnostic criteria [5]

Disorder	Diagnostic Criteria
Somatization Disorder	Many unexplained physical complaints before age 30 Four pain, two gastrointestinal, one sexual and one pseudo-neurological symptom(s)

Undifferentiated Somatoform Disorder	One or more unexplained physical complaints Duration of at least 6 months
Conversion Disorder	One or more unexplainable, voluntary motor or sensory neurological deficits Onset directly preceded by a psychological stress
Pain Disorder	Pain in one or more sites that is largely due to psychological factors
Hypochondriasis	Preoccupation with a nonexistent disease despite a thorough medical workup Does not meet criteria for a delusion
Body Dysmorphic Disorder	Preoccupation with an imagined defect in physical appearance
Somatoform Disorder Not otherwise specified (NOS)	Somatoform symptoms that do not meet criteria for any specific somatoform disorder

All above disorders must: (1) cause significant social/occupational dysfunction (2) not be due to other general medical or psychiatric conditions and (3) not be produced intentionally or related to secondary gain [5].

The CARE MD Approach

Somatoform disorders occur on a wide-ranging diagnostic continuum, have elusive etiologies and can be difficult to treat or manage. The CARE MD treatment approach encourages patients to be active participants in their care and serves as a guide to help PCPs work effectively with people who have somatoform disorders [6].

Table 2. CARE MD—treatment guidelines for somatoform disorders [6]

*C*ognitive Behavioral Therapy/Consultation	Follow the cognitive behavioral therapy treatment plan developed by the therapist and patient
*A*ssess	Rule out potential general medical causes for the somatic complaints Treat co-morbid psychiatric disorders

*R*egular visits	Short frequent visits with focused exams
	Discuss recent stressors and healthy coping strategies
	Patient should agree to stop overutilization of medical care (e.g. frequent emergency room visits or excessive calls and pages to the primary care provider, etc.)
*E*mpathy	"Become the patient" for a brief time
	During visits, spend more time listening to the patient rather jumping to a diagnostic test
	Acknowledge patient's reported discomfort
*M*ed-psych interface	Help the patient self-discover the connection between physical complaints and emotional stressors ("the mind-body" connection)
	Avoid comments like, "your symptoms are all psychological" or "there is nothing wrong with you medically"
*D*o no harm	Avoid unnecessary diagnostic procedures
	Minimize consults to medical specialties
	Once a reasonable diagnostic workup is negative, feel comfortable with a somatoform-type diagnosis and initiate treatment

Cognitive behavioral therapy/Consultation. Consultation with mental health professionals and the use of cognitive behavioral therapy have been shown to decrease the severity and frequency of somatic preoccupations [7, 8]. Psychiatric consultants should encourage patients to learn and actively engage in this type of therapy style [9]. Patients should also be instructed to use a daily dysfunctional thought record (DTR) to monitor their depressive or anxious emotions and associated negative thoughts. In collaboration with the therapist, PCPs can learn to use basic cognitive behavioral techniques and quickly review the DTR during office visits (much like they would review daily blood glucose records).

Assess medical and psychiatric comorbidities. On each visit PCPs should assess patients thoroughly for medical problems that might explain troublesome physical complaints. This is particularly important for those who have histories of psychiatric illness and present with a new complaint or a worsening of existing symptoms. Up to 25-50 percent of patients with conversion disorder (one of the seven types of

somatization disorder) are diagnosed eventually with a nonpsychiatric disease that explains the symptoms [10]. Physicians should also screen for other common psychiatric diagnoses. Twenty-five to 50 percent of patients with somatoform disorders have comorbid anxiety or depressive disorders [11, 12]. PCPs can assess and better address frequently co-occurring depression and suicidal ideation by using the Physician Health Questionnaire (PHQ-9), a patient self-report tool that reliably screens for depression in the primary care setting. All patients with a score greater than five should be assessed for a possible major depressive disorder.

Regular visits. Psychiatrists who are working with patients diagnosed with somatoform disorder should stress the importance of regular visits with one primary care physician. Short, frequent appointments or telephone calls have been shown to decrease outpatient medical costs while maintaining patient satisfaction [13]. These clinical encounters should include a brief but focused history and physical exam followed by open-ended questions like, "How are things at home?" or "What is your biggest problem?" If the patient is undergoing cognitive behavioral therapy, say "Tell me about your most frequent negative or inaccurate thoughts since your last visit." Over time, patients can use these scheduled, supportive, caring interactions in place of excessive phone calls and visits to the emergency room or clinic.

Empathy. Empathy or briefly "becoming the patient" is a key component to developing a strong therapeutic relationship with the patient. The use of empathy can also minimize physicians' negative feelings or countertransference. Truly empathic remarks such as "Having so much pain and discomfort must be difficult for you," or "The discomfort you have would probably be a challenge for anyone" are often helpful. Although there are clear benefits associated with the use of empathy, it can also be emotionally taxing to the physician [14].

Medical-psychiatric interface. General medicine and psychiatry frequently overlap in the treatment of patients with somatoform disorders. Patients with this diagnosis should be educated about the direct effects that emotions and stressors have on their pain or discomfort. Understandably, many patients do not accept purely psychiatric explanations for their symptoms. Physician statements such as "Your physical problems are really caused by psychological or emotional problems," or "There is nothing medically wrong with you," or "A psychiatrist will have to treat this problem" tend to be poorly received by patients. Instead, primary care practitioners should provide a diagnosis and remain the primary medical caregiver.

During the short, regularly scheduled office visits, patients should be asked if their symptoms worsen as the identified stressor intensifies or if the symptoms improve as the primary stressor lessens. Patients who answer in the affirmative to both questions should be allowed time and opportunity to make the connection. Physicians can promote this by asking an open-ended question like, "Any idea why this might be?" Essentially, it is best to help the patient discover the connection between the unresolved stressor and the symptoms for himself.

Do no harm. Doing no harm when treating patients with chronic somatization disorder means, first and foremost, avoiding unnecessary procedures or consultations. Psychiatric consultants should encourage treating physicians not to deviate from normal practice style simply to appease a patient or to minimize the patient's or the physician's frustration. While unnecessary invasive procedures should be avoided, routine health care maintenance tests and workup should be offered and their importance emphasized.

Bottom Line

While psychiatrists are not normally on the "front lines" when dealing with patients with somatization disorders, they frequently are called upon to advise primary caregivers. Unexplained physical symptoms due to a somatoform disorder usually cause great frustration and anxiety to both the treating physician and the patient. As consultants, psychiatrists can help treating physicians recognize and properly use their countertransference and encourage the use of the CARE MD management plan.

Notes and References

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14. The best way to deal with emotional exhaustion is to anticipate and recognize it early on. Clinicians who have difficulty handling intense negative countertransference may benefit from Baliant Groups (seminars that focus on the patient-physician relationship) or regularly scheduled and confidential discussions about challenging patient encounters, with colleagues who experience similar clinical situations.

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