Somatization in the Primary Care Setting

May 01, 2006 | Somatoform Disorder [1], Munchausen Syndrome [2], Histrionic Personality Disorder [3], Hypochondriasis [4]
By Robert M. Mccarron, DO [5]

Somatoform disorders (disorders that are not fully explained by a medical condition or mental disorder) may require psychiatrists to consult with physicians.

Primary care physicians encounter perplexing complaints in up to 40% of their patients.\(^1\,^2\) Patients are often frustrated with troublesome symptoms that are inexplicable and refractory to multiple treatment regimens. Because there is variability in how patients present and no apparent cause for their symptoms, this clinical situation has historically been difficult to conceptualize, categorize, and treat effectively. A review of somatization in the primary care setting is germane to psychiatrists who function as consultants to primary care practitioners, since they are often asked to evaluate patients with somatoform disorders.

**DIAGNOSTIC CONSIDERATIONS**

Ancient Egyptian healers noticed that women were affected with perplexing somatic complaints more often than men and concluded that a "floating uterus" was the culprit. In the 17th century, Thomas Sydenham believed a multifactorial process that included "antecedent sorrows" should be considered for both men and women.\(^3\) Charcot and then Freud used the word "hysteria" to describe a condition they thought was largely based on unconscious emotional conflict with a related maladaptive somatic response. This term was commonly used until 1980, when the *DSM-III* changed the diagnosis to Briquet syndrome, in honor of the work done in this area by the 19th century French physician Paul Briquet. Currently, in primary care settings, the informal diagnosis of somatization is broadly used to describe patients with physical complaints that cannot be totally explained by physical examination and a corresponding diagnostic workup.

With a focus on the need to "exclude occult general medical conditions or substance-induced etiologies for the bodily symptoms," *DSM IV* includes 7 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 (Table 1). It is important to note that the grouping of these disorders does not necessarily imply shared pathogenesis. The somatoform disorders are not fully explained by a general medical condition or other mental disorder and, in order to meet diagnostic criteria, must cause significant impairment or distress. Also, unlike a diagnosis of malingering or factitious disorder, patients with a somatoform disorder do not intentionally produce their symptoms.

Alternatives to the *DSM-IV* nomenclature have been suggested because of the perceived rigid diagnostic criteria, frequent overlap between the somatoform disorders, and the resultant impractical application to clinical practice. For example, in order to establish a *DSM-IV* diagnosis of somatization disorder, one must have 4 pain symptoms, 2 GI symptoms, 1 sexual symptom, and 1 pseudoneurologic symptom during the course of the illness. This somewhat arbitrary combination of symptoms is not always relevant to commonly encountered somatization in the primary care setting. Also, a person with a diagnosis of somatization disorder must have had multiple somatic complaints before the age of 30. However, studies have shown that patients are often unable to reliably recall their medical history with sufficient detail.\(^5\)

The wide clinical spectrum of somatization has prompted some medical specialties to develop their own system to identify unexplained somatic symptoms. Some common examples include irritable bowel syndrome, chronic fatigue syndrome, and fibromyalgia. Because many patients do not meet full diagnostic criteria for somatization disorder, Escobar and colleagues\(^6\) introduced the abridged somatization disorder as a less restrictive alternative. This syndrome is based on lifetime symptoms and the presence of 4 somatic complaints in men and 6 in women. Several reports, including the World Health Organization Psychological Problems in General Health Care multicenter study, indicate high instability of recall when it comes to lifetime symptoms.\(^5\) In this study, 61% of unexplained somatic symptoms reported at baseline were not reported 1 year later. Multisomatoform disorder (MSD) is another diagnostic option for primary care patients with somatization that addresses this issue.\(^7\) Multisomatoform disorder is defined as the presence of 3 or more acutely distressful,
medically unexplained symptoms from a checklist of 15 common symptoms found in the primary care setting (developed using the Primary Care Evaluation of Mental Disorders [PRIME-MD] scale that measures psychopathology\(^7\)). Patients with MSD must have active symptoms with at least a 2-year history of somatization.

The differential diagnosis for somatization seen in the primary care setting is extensive. It is important to keep in mind that inexplicable illness can refer to a general medical condition, confirmation of which cannot be found, after a complete assessment, or it can explain a general medical condition that exists but medical evidence for which has not been discovered after a comprehensive workup. Lyme disease is an example of the latter. Before Lyme disease was discovered in 1982, children and adults were presenting with arthritis, myalgias, and fatigue with no known precipitant or cause. It is beyond the scope of this paper to discuss a full differential diagnosis for somatization, but it is important to do a complete diagnostic workup while considering somatization disorder a diagnosis of exclusion.

Before establishing a diagnosis of somatization disorder, one must attempt to rule out the intentional production of false physical or psychological symptoms. A patient in whom malingering is diagnosed is focused on feigning illness in an attempt to gain external incentives such as financial compensation, shelter, or escape from military duty or criminal prosecution. Factitious disorder also involves the purposeful and sometimes elaborate self-report of somatic complaints with the objective of assuming the “sick role.” People with this disorder have no obvious external secondary gain beyond the sick role. When evaluating either condition, the physician should obtain collateral history (particularly from other area hospitals), complete a focused examination and, as with somatization disorder, consider both of them as diagnoses of exclusion.

**Clinical Significance**

People with somatoform disorders experience high levels of physical discomfort and tend to be unsatisfied with life.\(^8\) A retrospective review of more than 13,000 psychiatric consultations found that somatization disorder resulted in more disability and unemployment than any other psychiatric illness.\(^9\) It is difficult to accurately establish the prevalence of somatization because of wide-ranging definitions and patients’ limited ability to accurately recall symptoms from the distant past. Medical explanations for common somatic complaints, such as malaise, fatigue, abdominal discomfort, and dizziness, are found only 15% to 20% of the time.\(^10\) Somatization disorder has an estimated prevalence of 0.2% to 1.0% in primary care settings and is 5 times more common in women.\(^6\) The abridged somatization disorder has a higher prevalence in the primary care setting of about 20%.\(^6\) Multisomatoform disorder is uniquely based on current symptoms and is found in primary care patients 13% to 20% of the time.\(^11,12\)

Patients with somatization in the primary care setting have more than twice the outpatient utilization and overall medical care cost when compared with patients without somatization.\(^13\) This often translates into increased frustration and low levels of professional satisfaction for physicians who manage these patients.\(^14\) Part of the problem may be a lack of psychiatric supervision and instruction during residency training. Sullivan and associates\(^15\) surveyed 348 primary care program directors and found that two thirds of them believed more psychiatric education (particularly in the area of somatoform disorders) was needed for residents. Smith and coauthors\(^16\) showed that health care utilization and cost decreased by more than 50% when primary care physicians effectively treated their patients who had unexplained medical symptoms. An increase in training of primary care physicians in this area could result in improved job satisfaction and decreased patient morbidity.

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>Definition</th>
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<tr>
<td>Somatization disorder</td>
<td>• Many unexplained physical complaints before age 30</td>
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### Table 1

Brief definitions of commonly used somatoform disorders\(^4,6,7\)
<table>
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<tr>
<th>Disorder</th>
<th>Criteria</th>
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<tr>
<td>Undifferentiated somatoform disorder</td>
<td>• ≥1 unexplained physical complaint</td>
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<td>• Duration ≥ 6 months</td>
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<tr>
<td>Conversion disorder</td>
<td>• ≥1 unexplainable, voluntary motor or sensory symptom or deficit</td>
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<td></td>
<td>• Directly preceded by a psychological stress</td>
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<td>Pain disorder</td>
<td>• Pain in ≥ 1 site that is largely caused by psychological factors</td>
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<tr>
<td>Hypochondriasis</td>
<td>• Preoccupation with a nonexistent disease despite a thorough medical workup</td>
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<td></td>
<td>• Does not meet criteria for a delusion</td>
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<tr>
<td>Body dysmorphic disorder</td>
<td>• Preoccupation with an imagined defect in physical appearance</td>
</tr>
<tr>
<td>Somatoform disorder Not otherwise specified</td>
<td>• Somatoform symptoms that do not meet criteria for any specific somatoform</td>
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disorder

Non-DSM-IV

Abridged somatization disorder

- Presence of 4 unexplained somatic complaints in men and 6 in women
- Long history of physical complaints

Multisomatoform disorder

- ≥ 3 unexplained somatic complaints from the PRIME-MD scale
- ≥ 2 years of active symptoms

PRIME-MD, Primary Care Evaluation of Mental Disorders.

All above disorders: (1) cause significant social/occupational dysfunction, (2) are not caused by other general medical or psychiatric conditions, and (3) are not intentionally produced or related to secondary gain.

TREATMENT

The treatment of somatoform disorders exemplifies the "art" of medicine. Because this condition is on a wide-ranging continuum with an unknown cause, it is impossible to apply a strict evidence-based approach to treatment. The acronym CARE MD represents a set of guidelines that can help primary care physicians work with patients who have somatoform disorders (Table 2). Consultation psychiatry/Cognitive-behavioral therapy

Consultation with a psychiatrist and use of cognitive-behavioral therapy (CBT) has been shown to decrease the intensity and frequency of somatization. Kroenke and Swindle reviewed 31 controlled studies and concluded that CBT is an effective treatment for patients with somatization type disorders. Group therapy using CBT has also been found to be beneficial. CBT is generally a short-term psychotherapy (8 to 20 weeks) with the goal that patients will develop skills that last indefinitely. This type of psychotherapy is based on the premise that inaccurate or dysfunctional thoughts are predominant in patients with somatoform disorders. Examples of such thoughts are: "I will always be sick," "No one understands my pain," or "Everyone thinks it's all in my head." Through a variety of mechanisms, patients learn to recognize and reconstruct the dysfunctional thought patterns with resultant decreased somatic complaints. In collaboration with the therapist, primary care physicians can learn to use brief cognitive behavioral techniques during office visits.

Assessment

Assessing patients on each visit for general medical problems that might explain troublesome physical complaints is important. This is particularly essential for patients who have a long history of somatic preoccupation and present with a new complaint or worsening of existing symptoms. About 25% to 50% of patients with a diagnosis of conversion disorder eventually have an identifiable,
nonpsychiatric disease that explains the symptoms. It is also important to screen for other common psychiatric conditions. Concurrent mood or anxiety disorders affect 25% to 50% of patients with somatoform disorders. The number of unexplained somatic symptoms is highly predictive of comorbid mood and anxiety disorders as well as functional disability. Physicians can use the PRIME-MD scale, which uses a combination of self-reporting and clinician interview, to reliably screen for psychiatric disorders in the primary care setting. **Regular visits**

Regular visits with one physician are critical to the management of somatoform disorders. Short, frequent counseling appointments have been shown to decrease outpatient medical costs while maintaining patient satisfaction. These encounters should include a brief but focused examination followed by open-ended questions such as: "How are things at home?" "What is the biggest stress for you now?" or if the patient is exposed to CBT, "Tell me about your most frequent dysfunctional thoughts since your last visit." The patient should use this interaction in lieu of inappropriate emergency room visits or frequent calls to the physician's office. Longer, less frequent "noncounseling" visits are reserved for assessment and treatment of all other medical disorders. In sum, spending more than 80% of each "counseling" visit on worrisome psychosocial stressors will provide an outlet for the patient to cope, with less somatic preoccupation as a result. **Empathy**

Empathy, or experiencing the emotional state of the patient, is a key ingredient to forming a healthy therapeutic alliance and optimizing treatment for patients with somatoform disorders. The use of empathic remarks such as, "This must be difficult for you" or "I might feel the same way if I were in your situation" are often beneficial, particularly when frustrated family or friends are in the examination room with the patient. **Medical-psychiatric interface**

Medicine and psychiatry should interface in the treatment of every patient with somatoform disorders. It is important for patients with somatization to know that emotions and stressors can have a direct effect on the entire body. Many patients are reluctant to accept an explanation such as, "It's all in your head" or "A psychiatrist will have to deal with your symptoms" for their diagnosis. Instead, primary care physicians should provide a diagnosis and, if necessary, arrange for a psychiatric consultation while remaining the primary caregiver. During the short but frequent "counseling" visits, patients should be asked if the unexplained symptoms get worse as the primary stressor worsens or if the symptoms improve as the primary stressor improves. If the answer is yes to both questions, allow the patient to slowly make the connection by asking an openended question like, "Do you have any thoughts on why that is?" **Do no harm**

Doing no harm by unneeded consultations or procedures is the most important part of treating patients with chronic somatoform disorders. Primary care physicians should not deviate from normal practice style to appease a patient or minimize frustration. After taking reasonable steps to rule out a general medical condition, the appropriate somatoform diagnosis should be made and treatment should follow accordingly.

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<th>Table 2</th>
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<tr>
<td>CARE MD--treatment guidelines for somatoform disorders*</td>
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<tr>
<th>Consultation psychiatry/Cognitive-behavioral therapy</th>
<th>• Follow the CBT treatment plan developed by the therapist and patient</th>
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<tr>
<td>Assess</td>
<td>• Rule out potential general medical causes for the</td>
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somatic complaints
• Treat comorbid psychiatric disorders

Regular visits
• Schedule short, frequent visits with focused examinations
• Discuss recent stressors and healthy coping strategies
• Obtain patient agreement to stop overuse of medical care (eg, inappropriate emergency department visits or excessive calls and pages to the primary care physician)

Empathy
• "Become the patient" for a brief time
• During "counseling" sessions, spend most of the time listening to the patient
• Acknowledge patient-reported discomfort

Medical-psychiatric interface
• Help the patient self-discover the connection between physical complaints and emotional
stressors
• Avoid comments such as, "Your symptoms are all psychological" or "There is nothing wrong with you medically"

Do no harm
• No unnecessary diagnostic procedures
• Minimize referrals to medical specialists
• Once a reasonable diagnostic workup is negative, feel comfortable with a somatoform-type diagnosis and initiate treatment

CBT, cognitive-behavioral therapy.


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References: References


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