Somatising disorders

Untangling the pathology

BACKGROUND
Somatising disorders are a common, complex and disabling cluster of disorders. Research suggests that general practitioners find this group of patients challenging. The disorders are complicated by the fact that doctors play a role in both their aetiology and maintenance. The interaction between the illness worry of the patient and the disease worry of the doctor can lead to escalating disability and the risk of iatrogenic disease.

OBJECTIVE
In this article, common conceptual frameworks for somatising disorders are discussed and a framework for managing these complex disorders is presented.

DISCUSSION
Patients with somatising disorders need to establish a positive therapeutic relationship with their doctor that encourages open and honest discussion of their illness. General practitioners need to strike a balance between empathy for the patient's suffering and collusion in their disease worry. Excessive intervention and investigation should be avoided. This may require considerable professional support for the doctor.

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Janine, 54 years of age, has a history of depression and joint pain. When you see her she is teary and talks a lot about the impact of the pain on her life. She and her husband run a landscaping business and she is finding it increasingly difficult to manage the physical demands of the job. She reveals that her marriage is suffering and she has a tense relationship with her adolescent daughter. Examination is unremarkable, apart from some depressive features that Janine readily acknowledges. She had been taking a low dose selective serotonin reuptake inhibitor (SSRI) for some time, so you suggest a dose increase. She does not admit to suicidal thoughts, but shows some hopelessness and lack of interest in the future. Blood tests and X-rays of her affected joints are normal.

Janine is referred to a rheumatologist who feels she has a chronic pain disorder, with no signs of an inflammatory arthritis. Over the ensuing 10 years, Janine has reduced function, being unable to work most days. She remains with her husband, despite a distant and, in her mind, unsupportive relationship. Janine continues to present to the surgery, seeming to need support in the face of continuing pain, lethargy and disability. Multidisciplinary care through physiotherapists, psychologists and occupational therapists provides temporary periods of improvement. As her doctor, you have vacillated between annoyance, frustration, guilt and compassion. It is easy to understand her sense of helplessness. But why does she make you feel so helpless?

> 'In primary care, most clinicians spend a good portion of each day frustrated in their attempts to turn unexplained symptoms into explained ones'[1]

Somatisation is not a new concept, although its definitions and scope have continued to fluctuate in the medical literature.[2] The essential concept is 'the tendency to experience, conceptualise and communicate mental states and distress as physical symptoms and altered body states'.[3] Key aspects are:

- it is something emotional expressed in the body, and
- it involves perception (experience), conceptualisation (attribution) and communication (illness behaviour).

Somatisation is usually an unconscious process, although malingering is clearly conscious and intentional. It can describe a pattern of overconcern about illness (hypochondriasis) or an extreme response to severe stress (as in a dissociative disorder). It can also range

from acute and transient symptoms to chronic and complex disorders.[4]

Given the different ways somatisation may be described (*Table 1*) it can be difficult to estimate its prevalence. Somatisation disorder occurs in 3–5% of primary care patients[5–7] but lesser forms of somatisation (eg. mutisomatoform disorder, *Table 1*) have a prevalence of 4.4% in the general community and 22% in primary care.[8–10] It is present in many cultures[11] and is well recognised in children and adolescents.[12]

In primary care, there is value in separating four distinct groups of patients:

- those with acute unexplained symptoms
- those with chronic and usually multiple unexplained somatic symptoms
- those with unrecognised physical symptoms of depression or anxiety, and
- those with predominantly an excessive preoccupation or worry about illness[2,3] (*Table 2*).

The diversity between these groups, all called somatoform disorders in DSM-IV, may account for some of the confusion surrounding the management of somatisation in general practice.[4] There is of course a fifth category of somatisation – the psychosomatic or psychophysiologic disorders in which there is a physical disease which has been significantly influenced by psychological factors. The latter might include acute myocardial infarction after a period of stress, or exacerbation of asthma in the child from a family in conflict.

Germ theory or systems theory?

Somatisation can be conceptualised in both reductionistic and holistic ways, and this will fundamentally affect our management approach. Some doctors believe that a chronic somatising disorder will resolve once the emotional cause has been uncovered.[1] Treating the cause will resolve the consequence. This is simplistic and reductionistic and encourages either/or thinking: the belief that the illness is either 'real' or 'not real' and does not match the real life complexity of somatisation.

A biopsychosocial view will be more useful. This acknowledges the dynamic, complex interaction between physical, cognitive, emotional, social and environmental elements rather than just considering the mind and body of the individual.[5] For Janine, it is clear there are a number of psychosocial issues which might contribute to the development or persistence of her symptomatology and illness behaviour. How much of her illness is explained by incompletely treated depression? How much is due to her dysfunctional interpersonal relationships? Does our use of further imaging, or our giving of a medical diagnosis aid or hinder recovery? Does Workcover or litigation aid or hinder recovery? These are all aspects of the 'system' that need to be considered in a holistic view.

Table 1. Definitions of somatisation[29,30]

Somatoform disorder: the presence of physical symptoms that suggest, but which are not fully explained by, a general medical condition, and are not the direct effects of drugs or another mental disorder. In contrast to factitious disorders and malingering, the physical symptoms are not intentional. This DSM-IV term includes conversion disorders, pain disorder, hypochondriasis and somatisation disorder. Psychophysiological disorders are not included in this group

Somatisation disorder: a chronic and severe form of somatoform disorder where the patient over many years seeks medical attention for many physical symptoms with no evidence of organ pathology. DSM-IV requires a minimum of eight symptoms (pain in four sites: two gastrointestinal symptoms, one sexual or reproductive and one neurological) and the pattern beginning before the age of 30 years. Less severe forms are also described (eg. multisomatoform disorder requires three or more symptoms for more than 2 years)

Conversion disorder: an acute loss of sensory or motor function, suggesting a neurological illness though without neurological disease, developed in the context of a psychological stressor or explanation

Psychogenic pain disorder: this is a very unsatisfactory term as it conveys the 'all or nothing' mind-body dualism that is so unhelpful in this field. Nevertheless, it conveys the idea that physical pain can be contributed to by psychological and social factors. DSM-IV now calls this 'pain disorder' and requires a duration of 6 months for diagnosis

Hypochondriasis: a preoccupation with fear of having, or the idea that one has, a serious disease.[29] For diagnosis, the preoccupation must last at least 6 months, persisting despite appropriate medical evaluation and reassurance

Malingering: the intentional feigning of symptoms for a known external purpose such as monetary reward. The mental processes are deliberate and conscious and it is not generally considered a mental illness

Factitious disorder: the intentional production of false or grossly exaggerated symptoms for no obvious (ie. deeply unconscious) reasons. They prefer the sick role to being well and will commonly have other relating problems that suggest personality disorder

Neurasthenia: 'tired nerves' or 'nervous exhaustion' now defined as complaints of increased fatigue after mental effort, or bodily weakness after minimal physical effort, combined with unpleasant physical symptoms (dizziness, headaches), worry, irritability, and sleep disturbance. This diagnosis is used frequently in China and is contained in the ICD classification but not in DSM-IV. The modern Australian neurasthenic will more likely be diagnosed with chronic fatigue syndrome, depression or anxiety

Psychosomatic or psychophysiological disorder: the presence of a physical disease state (eg. the worsening of asthma, myocardial infarction) that has been caused by, or perpetuated by, stress or other psychological factor. This is called 'psychological factors affecting medical condition' in DSM-IV

Symptom perception and illness understanding

'We live in a society where disease seems to be going down and illness seems to be going up'[13]

The cause of somatisation is therefore multifactorial, with contributions from biological and genetic factors, family illness behaviour,[14] personal experience of illness and disease,[13] and comorbidity.[4,15] It is also important to remind ourselves that it is not just multiple factors put into a pot and stirred from which somatisation develops. Time is important. There may be a long cascade of events, each influencing the other, which finally leads to and reinforces somatising behaviour.

One of the key components of somatising disorders involves the interpretations patients make of their symptoms and the attention they give to them (*Figure 1*).[16,17] When people experience a symptom they perceive to be significant or threatening they will make a causal attribution.[18] Barnlund[19] describes this as a search for meaning. 'To aid in coping with a chaos of fleeting sensations... we seek to give events some structure that will render them intelligible. Repeated success in interpreting events contributes to an accumulating set of assumptions on which all future acts depend'.

Table 2. Categories of somatising disorders commonly seen in general practice

- Acute and subacute medically unexplained (functional) symptoms
- Chronicsomatising patients
  - with single or multiple symptoms or clusters of symptoms
  - with a syndromal diagnosis (eg. chronic fatigue syndrome, fibromyalgia)
- Physical symptoms as part of psychiatric disorders (eg. muscle pain, palpitations or pain the chest from anxiety)
- Illness worry and pathological illness behaviour (eg. hypochondriasis, factitious disorder)
- Psychophysiologic disorders (eg. asthma, heart disease)

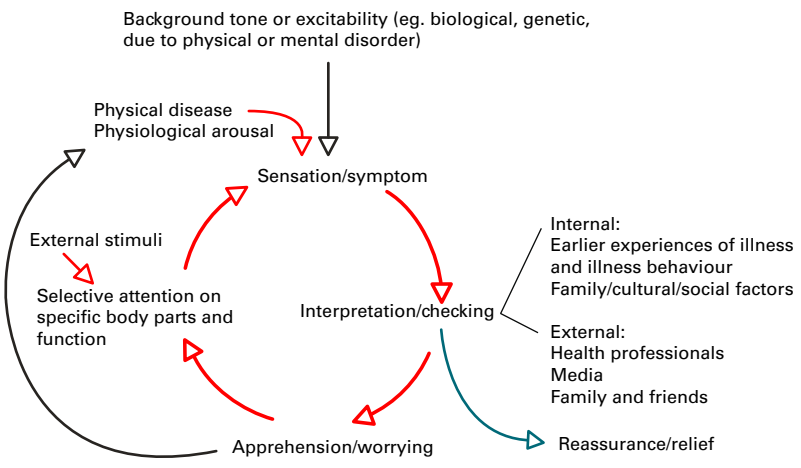

Figure 1. Symptom perception and illness understanding[4]

Patients who somatise interpret their symptoms as arising from a physical cause. These attributions are usually prematurely made and overly simplistic. Significant psychological or social contributors are ignored.[20] Patients may also be overly vigilant, scanning their somatic experiences to detect symptoms they interpret as threatening.[21] *Figure 1* summarises the cumulative effect of these factors. This cycle of apprehension, somatic hypervigilance and unhelpful or catastrophic interpretations of bodily sensations leads to an escalation of concern and illness experience.

Is somatisation iatrogenic?

> 'Chronic somatisers have often embarked on a career of hospital attendances, admissions and investigations to exclude disease that might account for their symptoms. How this process begins and is maintained therefore depends also on doctors'[22]

Chronic somatising patients are not easy to manage, and have been described as 'difficult'[23] and 'hateful'.[24] Patients such as Janine can raise feelings of frustration, guilt and disease worry in the GP and this is mirrored in the patient's frustration, guilt and illness concern. General practitioners may feel frustrated with the patient's abnormal help seeking behaviour and may have difficulty maintaining a healthy relationship with the patient in this situation.[25] The interaction between the patient and the doctor can become pathological and often seems to go around in circles (*Figure 2*).

For GPs, there is a common fear of missing a physical disease and an associated fear of litigation.[26] However, there are other contributing factors. A lack of accessible psychiatric assessment and treatment services makes a positive diagnosis of somatising disorders difficult, for GPs may feel they have insufficient knowledge or skills to make a positive diagnosis themselves.[27] Some GPs feel their role should be limited to biomedicine; others fear opening a 'Pandora's box', and there is a shared concern about encouraging dependency.[4] Lack of time is a perennial problem. Referrals may be made mostly to provide respite for the GP rather than out of any real hope for therapeutic or diagnostic benefit.[4]

A key issue lies in so-called 'patient centredness'. Typically, somatising patients present requesting investigation and the GP may feel it is appropriate to agree to these requests in the interest of patient centredness. It should be recognised that these patients may not make rational choices – part of the 'disorder' of somatisation. By definition, hypochondriacal patients cannot be reassured.

Their degree of illness conviction may be near delusional; their bodily preoccupation obsessional or phobic. Further tests or specialist consultations may serve to reinforce the patient's belief that there is something seriously wrong with them – and the doctor knows it even though he or she is not telling![27]

Treatment options: adopting a chronic course

Somatisation may take an acute or chronic course. Intervention is aimed at minimising the acute becoming chronic; and for persistent somatisation, using a model of 'chronic illness' (*Table 3*). The management of somatising patients can be considered in four phases.

Listen and understand

The main tasks of this phase are to establish rapport and to create a cognitive 'map' of the patient's health beliefs, life situation, coping style and expectations, with the overall aim of engaging the patient and making a diagnosis. Resist coming to a conclusion or offering advice or treatment too soon.

Empathy and rapport are essential. As Fink[4] writes: 'The task lies in coming to understand how the patient thinks, feels and perceives the situation... In general, people are afraid to appear ignorant and to say something that will sound stupid to the expert. Advice offered at the wrong moment may cause the patient to feel stupid and, in the worst case, that he or she is ridiculed or loses face'.[4]

It is important that the patient is examined appropriately. In the past, it has been felt by some that examination should be avoided so as not to reinforce secondary gain. But patients will not be reassured, or indeed consider that their problems have been taken seriously, if they are not examined appropriately. It helps to frame the examination with comments such as: 'nothing in your description makes me think that there is anything wrong with your heart, but I would like to listen to it'.

Following this, it is helpful to summarise the situation to check your own understanding, and to demonstrate to the patient that they are understood. Emotional feedback, 'I do understand that this is difficult for you' is also helpful.

Acknowledge the reality of the symptoms and provide feedback

The patient is the authority on their illness; the doctor is the authority on the disease. It is important that both are emphasised. Whenever the GP states that the symptoms are organically unfounded, they should also reinforce that they understand the symptoms are real and distressing and if possible offer another realistic explanation. Sometimes, of course, no cause is found. More often, especially for acute symptoms, patients are able to see the connection between their symptoms and what is going on in their life once it is pointed out. Feedback should be clear and as specific as possible: 'I can find no indication for further tests and there is no medical or surgical treatment that will help reduce your pain'. Include reference to any treatments suggested by the patient and any disease they fear, and avoid generalised statements such as: 'I could find nothing wrong'. It is easy for the patient to interpret this as the need for more thorough investigation, or more doctor shopping.

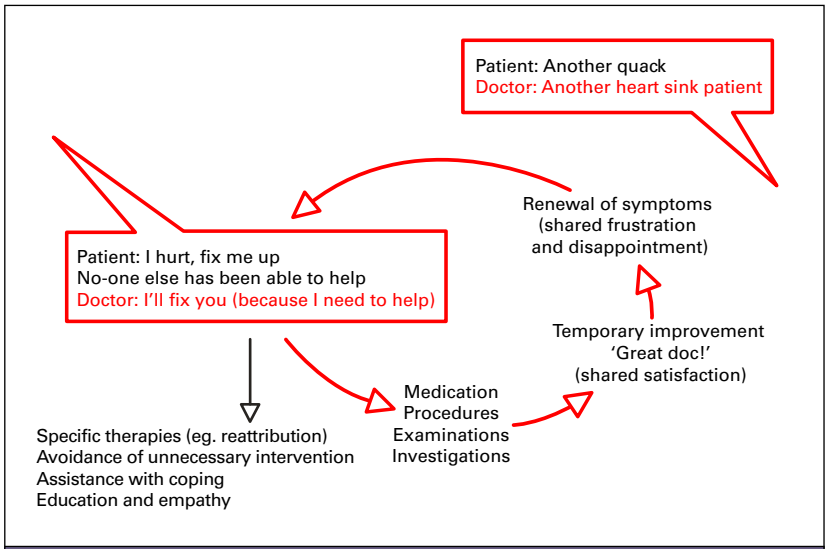

Figure 2. Going around in circles: the pathological interaction between GP and somatising patient[4]

Negotiate a new model of understanding

This stage is known as reframing. It is focused on gradually changing the patient's interpretation of their symptoms without implying that the illness is their own fault. Discussing how stress, anxiety or depression are felt in the body may be helpful. Identifying recent stresses in a patient's life may help them start to make links. Sometimes, no psychosocial cause can be found and working in this area of the 'unknown' is a critical skill for both patient and doctors to learn. Patients may not readily understand what is being said to them and may quite understandably feel rejected and powerless.[28] If it is not possible at this early stage to shift the patient's bodily or physical focus, it remains important to maintain the relationship with the intent to gradually broaden the agenda. Finding common ground and developing treatment strategies consistent with this agreed formulation is the way forward.

Table 3. Principles of management for chronic somatisation[20]

- Reassurance that there is nothing wrong does not help. The patient needs clear information about specific clinical findings
- The patient does not want simple straightforward symptom relief, but understanding. Many patients have a history of abuse or maltreatment in childhood and need empathy and a belief that they are being taken seriously
- The patient wants the doctor to agree that they are sick. Avoid challenging the patient but agree that there is a problem
- A premature explanation that the symptoms are emotional does not help. Patients can see this as rejection
- A positive organic diagnosis will not cure the patient
- Try and be direct and honest with the patient about areas that you agree and disagree on
- Regular scheduled appointments are required so that the patient doesn't have to develop symptoms in order to seek help
- Clear agenda setting in each consultation is helpful
- Diagnostic tests should be limited
- Provide a clear model to the patient that demonstrates it is possible to have both emotional problems and organic pathology. A dualistic view does not help
- Involve the patient's family where possible
- Involve colleagues in the primary care team so that treatment is consistent
- Don't expect a cure. This is a chronic illness

An example may be: 'I know you feel your joint pain is due to a type of arthritis, but I can find no evidence of changes in your joints and that is why medical or surgical treatments are not going to make the pain go away. On the other hand, there are a number of things that you can do to make you feel better, and that would also be the case if you had arthritis. Would it be okay to have a look at these options?'

Key goals are to: reduce apprehension, worrying and hypervigilance, correct somatic interpretations of bodily sensations, and treat conditions that cause hyperarousal such as depression or anxiety (*Figure 1*). This requires a raft of simple explanations, making the link between symptoms and emotional antecedents. Examples may be talking through the link between muscle tension, pain and anxiety, or making the link between a life event and an exacerbation of symptoms. Diaries may help to make this link clearer and encourage the patient to view their illness in a new light.

Strategies for avoiding guilt are also important. It may help to emphasise behavioural aspects, or to mention that it tends to 'run in families', identifying other family members who have been sickly and the role of modelling. Naming the illness, and describing that it is common and the focus of much international research, may help to minimise unhelpful self blame. It is also helpful for patients to understand that the disorder can be chronic and that they can take the key role in controlling the illness and its symptoms. Emphasise the patient's self efficacy: their ability to be able to do something for themselves.

Blackwell[13] has introduced an interesting technique called the 'stress biopsy'. Here the patient is asked to think of a stressful situation and describe their emotional response in one word (eg. fear, worry). They are then asked to note prominent bodily sensations such as muscle tension or abdominal discomfort. This may help a patient recognise their unique pattern of autonomic arousal. This is another way of 'making the link' between emotional and cognitive situations and physical symptoms.

Negotiate further treatment

In acute cases, the ideal situation would be that the patient is reassured and requires no further planned appointments. For the chronic somatiser, it is important to arrange regular scheduled appointments and to try to keep the patient with the same GP wherever possible. Moving to another GP is likely to start the process again. Consider using an antidepressant medication to reduce hyperarousal and institute psychological strategies such as relaxation and structured problem solving. Referral to a psychiatrist may be helpful to help assess and treat comorbid affective disorders, or to clarify the diagnosis and treatment strategy.

Conclusion

Important aspects of chronic management are to maintain a collaborative doctor-patient relationship – this involves finding common ground, agreed goals and mutual respect – and using a rehabilitation model – focusing on improving functioning – while not giving in to the pressure to seek endlessly a physical diagnosis. The disorder is difficult and complex for both patient and doctor, who often share feelings of frustration, guilt and anger.

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