

A low-frustration strategy



for treating somatization

Psychotherapy that is educational, supportive, and reassuring can change patients' persistent beliefs that they are physically ill.

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Mrs. M, age 34, was referred for psychiatric evaluation by her primary care physician. She reluctantly agreed to the referral and tells the psychiatrist she “really should be seeing a cardiologist.” Numerous evaluations for chest pain and palpitations—including seven emergency room visits, ECGs and cardiac catheterization—have revealed no medical pathology.

A divorced mother of two children, she says she feels anxious about her “heart condition.” Her father died of a heart attack at age 51. She experiences chest pains at home and at work, particularly when under stress. Sometimes she feels her heart racing and numbness or tingling in her arms.

Although her primary care physician has seen her frequently during the past 6 months, she says the doctor is not taking her complaints seriously. “These chest pains are real,” she says, “so don’t try to tell me they’re all in my head.”

Psychiatrists may be the last doctors patients such as Mrs. M wish to see but the ones best equipped



Box

Illness worry: When does concern become pathology?

Health-related fear—or “illness worry”—is common, occurring in nearly 10% of adults who responded to a recent community survey.² When this fear drives individuals to their physicians for evaluation, frequently no organic cause is discovered. Full evaluations are expensive and lead to increased use of health care resources, including potentially dangerous invasive testing.^{3,4}

Defining somatization has been a source of confusion.^{5,6} Some authors consider somatic complaints to be expressions of suppressed psychosocial stressors. Others label them as medically unexplained complaints, although this definition fails to exclude occult medical problems. Kleinman⁷ defines somatization as “a somatic idiom of psychosocial distress in a setting of medical health-care seeking.” This useful definition links psychosocial problems with somatic complaints and the behavioral drive to obtain a medical evaluation.

In DSM-IV,⁸ the defining characteristics of somatoform disorders are somatic complaints or disease fears that are out of proportion with any identifiable somatic cause. Entities include somatization disorder, undifferentiated somatization disorder, conversion disorder, pain disorder, hypochondriasis, body dysmorphic disorder, and somatoform disorder—not otherwise specified (NOS).

Subthreshold symptoms. Unfortunately, DSM-IV’s categorization of Axis I somatoform disorders does not capture subthreshold presentations, which are common. Patients with less than the required number of somatic complaints are labeled in a wastebasket fashion with “undifferentiated somatoform disorder.”⁹

to relieve their suffering. Our experience in treating somatizing patients and the available evidence suggest that cognitive-behavioral therapy (CBT) combined with psychoeducation, reassurance, and sometimes drug therapy is the most effective approach.

Mrs. M’s persistent chest pain of noncardiac origin is a familiar health anxiety, along with functional GI complaints, headaches, chronic fatigue, and lower back pain. Frustrating to their

doctors and frustrated themselves, patients with medically unexplained complaints consume an inordinate amount of physicians’ time.¹

Without a clear definition of somatization (*Box*)²⁻⁹ or useful clinical guidelines, psychiatrists must rely on the literature for guidance in managing somatization disorders. This article summarizes the evidence and describes how we apply these findings to practice. And when all else fails, we offer last-ditch advice for managing patients who resist your treatment efforts.

IDENTIFYING COMORBIDITIES

Identifying psychiatric comorbidities is the first step in successfully treating patients with somatoform complaints. In an epidemiologic study, 60% of patients with somatoform complaints also had a mood disorder and 48% had an anxiety disorder.¹⁰ In a similar study of patients with hypochondriasis, 88% also had one or more Axis I diagnosis.¹¹

If a patient meets criteria for a comorbid psychiatric disorder and is willing to be treated for it, the somatic complaints may resolve along with the underlying disorder. In fact, the presence of an identifiable Axis I disorder may predict a more positive prognosis.¹²

Personality disorders. Somatization in patients with a personality disorder poses unique challenges.¹³ Granted, when making a diagnosis it is difficult to tease apart somatization from personality disorders because somatization itself may be considered a chronic, maladaptive coping style. However, symptoms such as deception, impulsivity, mood lability, and self-injurious behavior introduce treatment complications that exceed the scope of this article.

Posttraumatic stress disorder (PTSD)—particularly childhood sexual and physical abuse—also predisposes some patients to somatization disorders.^{14,15} Patients with comorbid PTSD and somatization disorder require highly specialized treatment that is beyond the scope of this review.

COGNITIVE-BEHAVIORAL TREATMENT

Cognitive-behavioral therapy (CBT) is the best-studied and most effective treatment for somatoform disorders.¹⁶ CBT for somatization relies on both physiologic and cognitive explanations to account for the patient's experience, without committing to an "either/or" dichotomy. It offers patients an alternate explanation of what is wrong with them—illness anxiety instead of severe physical illness.

By making patients aware of their automatic thoughts, feelings, behaviors, and underlying beliefs, CBT helps them normalize and cope with their illness anxiety. CBT techniques can be applied in a predetermined course of therapy (such as 12 sessions with a mental health clinician), in a group setting, or piecemeal by any health care provider.

Effective strategies. In a review of 30 controlled trials of CBT for somatoform disorders, Loocher¹⁷ showed overall effect ranging from 0.38 to 2.5, where 0.2 was defined as a small effect, 0.5 as medium, and 0.8 as large. Hypochondriasis, somatization disorder, body dysmorphic disorder, chronic pain, chronic fatigue, and noncardiac chest pain were included in this review. The most effective strategies:

- included 6 to 16 treatment sessions
- were symptom-focused as opposed to providing general relaxation training
- included maintenance sessions after the initial series.

Four factors of health anxiety. CBT primarily targets the patient's false beliefs that he or she is physically ill. These beliefs are based on how the patient misinterprets innocuous physical symp-

Table 1

Common dysfunctional beliefs of somatizing patients

- Hurt equals harm
- If I don't worry about my health, then I am likely to become ill
- Any unexplained change in my body is a sign of serious illness
- Every symptom has an identifiable cause
- If you don't go to the doctor as soon as you notice a symptom, then it will be too late
- Heart trouble in the family makes it inevitable that I will have a heart attack
- I've had weak lungs since I was a baby
- Going to a specialist confirms that I have a more-serious illness

toms and responds to them.¹⁸ The cognitive theory of health anxiety holds that health anxiety severity is affected by four factors:

- perceived likelihood of illness
- perceived burden of illness
- perceived ability to cope with illness
- perception of the extent to which external factors will help.¹⁹

The first two factors worsen and the latter two mitigate health anxiety. An individual patient's presenting fears often suggest which factors to address. For example, Mrs. M may describe the burden of illness as the focus of her fears ("If I have a heart attack, who will care for my children?"). This information cues you to shift the focus of therapy to helping her cope with child care needs despite her recurring symptoms.

If she focuses on her likelihood of illness, then uncoupling the symptoms from the diagnosis could be more productive. When she reports palpitations, diaphoresis, and dizziness, have her do breathing exercises that induce those symptoms without producing a heart attack.

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Table 2

**Journaling homework:
5 questions for patients to answer
about one symptom each day**

- In what situation did the symptom occur?
- What seemed to trigger the symptom?
- What thoughts did the symptom produce?
- What feelings did your thoughts produce?
- What action did you take?

She might describe feeling unable to cope when she feels symptoms or when cardiologists tell her nothing is wrong with her heart. In that case, focus on relaxation techniques, global stress reduction, and reducing cardiac risk factors to bolster her ability to cope with her illness.

Journaling is a critical component of CBT in treating somatization disorders. Regular journaling by the patient can reveal dysfunctional beliefs that may be driving his or her health anxieties, such as those listed in *Table 1*. We find it useful to assign patients to answer five questions about one symptom experience each day (*Table 2*). This self-monitoring provides material to work on with the patient during each session.

Cognitive restructuring. During therapy sessions, we ask patients to suggest alternate explanations for the symptoms recorded in their journals. We then ask them to determine which explanations are more feasible.

For example, if Mrs. M develops palpitations during emotionally charged arguments, we would ask her to develop explanations other than, “I was having a heart attack.” Reality testing includes rhetorical questions such as, “Would you be alive today if you were having a heart attack every time you had palpitations?”

We ask patients to suggest alternate explanations for the symptoms recorded in their journals

Automatic thoughts are successively identified and then tested aloud with the patient:

- “Has every unexplained symptom led to the discovery of a serious illness?”
- “Does every instance of hurt equal harm?”

Eventually, patterns of automatic thoughts emerge, and these reveal the underlying dysfunctional beliefs.

Dysfunctional beliefs are maintained when patients selectively attend to and amplify somatic sensations. Behavioral experiments during sessions can demonstrate to the patient in vivo the process by which they misattribute illness to physical symptoms. For example, overbreathing with a patient during a session may elicit lightheadedness, paresthesias, or tachycardia, which can then be linked to overbreathing rather than a chronic or catastrophic illness.

Furthermore, patients can be taught to control the experience. Some patients with headaches or GI pain may be made aware of symptoms by simply asking them to focus their attention on the respective organs. Simply explaining the cycle of misattribution, autonomic activation, and further symptom development with an in vivo demonstration can be illuminating.

Response prevention. Another behavioral technique is to cut back in small increments on actions the patient takes in response to physical symptoms and automatic thoughts. For example, a patient could take medicine and seek reassurance less frequently and avoid rubbing the affected area.

PSYCHOEDUCATION

Two psychoeducation programs for somatization behavior have been formally studied.

The Personal Health Improvement Program²⁰—led by trained facilitators—includes classroom videos, cognitive-behavioral exercises, and home

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Table 3

How to effectively reassure somatizing patients

Action	Benefit
Review records in front of patients	Demonstrates that you take complaints and histories seriously
Acknowledge the severity of patients' distress	Validates subjective suffering
Schedule follow-up visits at regular intervals	Provides access to you and continuity of care; reduces extra phone calls and emergency visits
Use clear and simple language	Improves communication
Explain that they do not have life-threatening structural disease	Opens door to cognitive restructuring
Assign jobs, such as journaling 15 min/day and rounding up medical records	Builds therapeutic alliance, fosters patient responsibility, and restores patients' sense of control
Identify and support the patient's strengths	Builds self-esteem
Use specialty referrals sparingly	Reduces risk of further medical testing and patient anxiety while awaiting results

study assignments. After completing the 6-week course, 171 patients with somatization disorders reported reduced physical and psychological distress and increased function. They also visited their primary care physicians less often.

Coping with Illness Anxiety²¹

relies on mini-lectures, demonstrations, videos, and focused group discussions. After six 2-hour sessions, 33 of 43 study patients (78%) used medical services less often and reported reduced disease conviction, consequences of bodily complaints, health anxiety, and checking and avoidance behaviors. Two psychology graduate students taught the course from a manual, with 6 to 9 patients per group.

Psychoeducation in this context relies on didactic presentations, readings, role playing, and videotaped material. The goal is to teach patients to recognize thoughts, emotions, and behaviors

that lead to and result from somatic preoccupation. Patients can improve when they recognize dysfunctional behavioral patterns and learn alternate coping strategies.

Somatizing patients—with their aversion to the stigma of mental illness—may find psychoeducation particularly attractive. They can be treated as students who are being educated, rather than as patients who are being treated. Classrooms in both studies cited above were located in medical outpatient offices, not in mental health facilities.

Reassurance is most effective when given by a trusted person who is consistent, firm, and empathetic

REASSURANCE

Reassurance is a common therapeutic technique in medicine, although it is poorly understood, poorly taught, and not methodically applied. Reassurance alleviates anxiety, enables patients to endure dysphoria, encourages hope, gives insight, and enhances the doctor-patient relationship.²²



Table 4

How to avoid becoming frustrated with persistent somatization

Situation	Response
Despite patients' urgency	Watch and wait, knowing that psychological distress has been chronic
Despite patients' belief that a single pill or procedure will 'cure' them	Persist in 'rehabilitative' approach
Despite patients' provocations to force you to take a dichotomous approach	Persist in using both physical and psychological explanations
Despite your knowledge that patients are actively maintaining their illness beliefs	Try to be patient as they attribute their misfortune to 'fate,' 'bad luck,' or 'misfortune'
Despite the fact that you have agreed to treat the patient	Realize that his or her family or culture may reinforce the 'sick role' as the only acceptable form of distress
Despite patients' desire to discuss symptoms	Reorient them to sustaining daily function (such as parenting while tolerating fatigue)

Whereas CBT seeks to challenge patients' underlying beliefs and restructure their thought processes,²³ reassurance can help them tolerate their dysfunctional beliefs and dissuade them from believing their health is dangerously impaired. Reassurance offers a substitute explanation of patients' dysfunction, although this explanation is not as central or detailed as it is in CBT.

How to reassure. Patients may consider reassurance offered prematurely or by a stranger to be patronizing or dismissive. Reassurance is most effective when:

- given by a trusted person who is reliable, consistent, firm, and empathic
- the patient's condition has been established as unresponsive to conventional diagnostics or biological therapies.

Patients are most receptive to reassurance when they express distress or frustration with their unexplained symptoms. Affirming that their suffering is legitimate opens the door to further treatment.

Reassurance is least effective when a patient is expressing anger or mistrust, although this is when the physician may feel most pressured to reassure. To successfully reassure a patient, the psychiatrist needs to:

- credibly identify with the patient's distress
- and listen empathically (such as using body language and facial expressions that convey concern and consideration to the patient).²⁴

Starcevic suggests useful techniques for providing reassurance (*Table 3*).²²

DRUG THERAPIES

Psychotropics are considered a first-line treatment for patients with somatization disorders when:

- the patient spontaneously identifies any discrete, vegetative, or psychological complaints that may respond to drug therapy, such as insomnia, weight loss, sadness, or preoccupation

- the patient meets diagnostic criteria for comorbid anxiety or depressive disorders
- the therapeutic alliance is strong enough to weather the inevitable struggle with side effects and incomplete response to treatment. We do not recommend medication in the first encounter, when it may threaten a nascent alliance.

A common obstacle to prescribing psychotropics to somatizing patients is their sensitivity to suggestions that their complaints are “all in their heads.” To sidestep this resistance, describe the medication as treating the stress *caused by*—not *causing*—their chronic physical complaints. Proposing antidepressant therapy after—rather than instead of—physical exams and other diagnostics may elicit a more positive response.

Antidepressants. In clinical trials, somatoform complaints show moderate improvement after antidepressant treatment. In a meta-analysis of 6,595 patients with unexplained symptoms treated only with antidepressants, the number needed to treat was 3 to yield a positive response.²⁵ This report of 94 medication trials included patients with headache, fibromyalgia, functional GI syndromes, idiopathic pain, tinnitus, or chronic fatigue.

In other trials:

- Amitriptyline has reduced somatic symptoms in patients labeled as having “masked depression.”²⁶
- Sertraline has reduced disease fear, disease conviction, and bodily preoccupation in patients with hypochondriasis and panic disorder.²⁷

Consider side effects when choosing medication for patients with somatoform disorders. Selective serotonin reuptake inhibitors (SSRIs) in general—and sertraline, citalopram, and escitalo-

pram specifically—have fewer side effects than tricyclics. The adage of “start low, go slow” is appropriate for somatizing patients; we usually start with one-half the dosages recommended for treating depression.

Antipsychotics. In case reports, patients with “atypical psychosis,” “monosymptomatic hypochondriacal psychosis,” or “delusional disorder, somatic type” have responded to antipsychotics. These patients’ somatic beliefs are of delusional intensity, such as the rare fear of being eaten alive by an intestinal parasite (delusional parasitosis).

Reported behaviors associated with the delusion include starvation, excessive laxative abuse, ingestion of sharp objects, and self-inflicted stab wounds. Treatments described in the literature include the typical agents pimozide and haloperidol and the atypicals olanzapine and risperidone.

TREATMENT-RESISTANT PATIENTS

Some patients with somatoform disorders will not accept CBT, psychotropics, reassurance, or referrals to group psychoeducation. Despite your best efforts, they may persist in focusing on somatic complaints. If you are willing to maintain a

Describe medication as treating the stress caused by—not causing—their physical complaints

Some cognitive-behavioral, psychoeducational, and drug therapies can help reduce chronic somatoform symptoms. In the end, the clinician’s patience, tact, and sensitivity are the most effective therapies for patients who persistently believe they are ill.

BottomLine



Related resources

- ▶ Starcevic V, Lipsitt D (eds). *Hypochondriasis: modern perspectives on an ancient malady*. New York: Oxford University Press, 2001.
- ▶ Information and support Web site for persons with health anxiety or hypochondria. www.healthanxiety.com
- ▶ Anxiety Disorders Association of America. www.adaa.org

DRUG BRAND NAMES

Amitriptyline • Elavil	Olanzapine • Zyprexa
Citalopram • Celexa	Pimozide • Orap
Escitalopram • Lexapro	Risperidone • Risperdal
Haloperidol • Haldol	Sertraline • Zoloft

DISCLOSURE

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therapeutic relationship with them, be prepared to tolerate several ongoing paradoxes (*Table 4*).

Behaviorally, you must “listen more and do less.” Emotionally, you must be willing to enter into a long-term relationship with an inherently frustrating patient whose pathologies make you feel therapeutically hopeless and helpless. Understand that their physical symptoms function as a metaphor for psychological distress. You are not required to explore the source, content, or meaning of the metaphor in detail but simply listen to their somatic complaints through that psychological filter.

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