Making sense of somatoform disorders

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When a patient presents with symptoms that have no apparent physical cause, a diagnosis of somatoform disorder should be considered. Stress, anxiety and depression can all involve physical symptoms.

The word 'somatoform' is a neologism that was created for inclusion in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*-III).[1] The term attempts to describe mental disorders that take the form of physical (or somatic) disease. However, use of the term 'somatoform disorder' is problematic because:

- it demands a categorical distinction between normal and abnormal, while it is likely that most people somatise from time to time
- it labels the bodily complaint a 'mental' disorder, which is generally not acceptable to patients and not useful in the context of developing a helpful therapeutic relationship.

The older term 'somatisation' is defined as 'the expression of personal and social distress in an idiom of bodily complaints with medical help-seeking'.[2] This term describes an internal mind–body process and an external behaviour. The recognition of somatisation involves a judgement by the doctor that the outward bodily complaint is due to inner psychological stress. Although it is clear that stress can cause physical symptoms, and indeed physical disease (e.g. heart disease), it is sometimes a difficult, although necessary, clinical judgement – there are certainly no laboratory tests to confirm it.

A diagnosis of somatoform disorder is often only considered when bodily symptoms have no apparent physical cause after a thorough physical examination and investigation – often called medically unexplained symptoms. Two errors can be made in this diagnosis. First, a physical disease may be present but not fully revealed. Doctors are acutely aware of this possibility and may as a result be tempted to over-investigate. Second, an abnormal test result may be used to explain the symptom although it may just be coincidental and not the cause.

Somatoform disorders draw attention to the distinction between 'illness' and 'disease'. Illness is the experience of the patient. A person is ill if he or she feels or reports being unwell, and it is accompanied by 'illness behaviour' (e.g. going to bed, staying

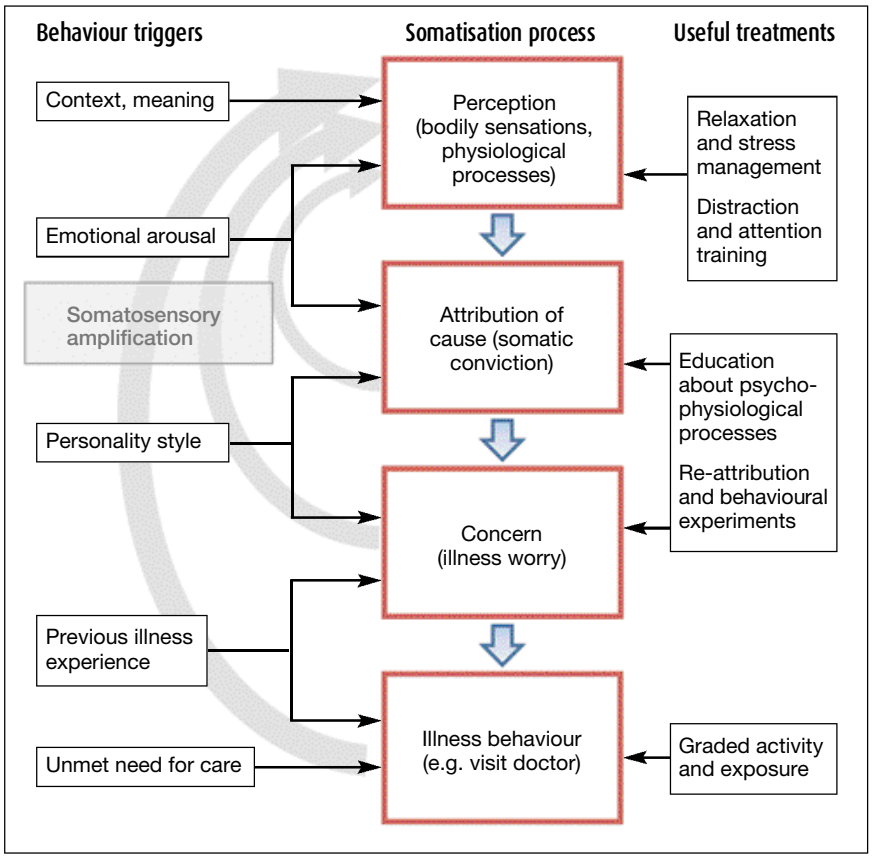

Figure. The process of somatisation. Somatosensory amplification describes the process of feedback; each component influences another component.

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away from work). Disease, on the other hand, is a medical term and refers to a pathological biological process.

The essence of a somatoform disorder is a difference in understanding (of attribution of symptoms and appropriate illness behaviour) between the patient and the doctor. This is when the term 'abnormal illness behaviour' is used. Medically unexplained symptoms and abnormal illness behaviour are the characteristic features of somatoform disorders.

Process of somatisation

Somatoform disorders are underpinned by a process of somatisation, which has a number of components (Figure).

Perception of symptoms

Some people may be or become hypersensitive to symptoms such as pain. In addition, context makes a big difference. Sports people can break bones and play on, while others might have a trivial work injury and experience chronic disabling pain.

Unfortunately, pain is not a symptom that can be objectified – it is always subjective. Cassell points out that suffering associated with pain is related to expectations about its significance (i.e. is it cancer?) and treatment (i.e. will the treatment be effective?).[3] People cope well with severe injury and acute pain if its significance is not dire and there is an expectation that it will be short lived.

Attribution of cause

Commonly with chest pain, people make a quick judgement, based on their knowledge and experience, that it is likely to be cardiac in nature. This may or may not be true – for example, chest pain may be due to chest wall strain or panic. If a person has had a lot of sickness, or grew up with sickness in the family, he or she may be inclined more readily to attribute physical symptoms to a bodily cause.

Concern about illness

In the event of chest pain, it might be reasonable to worry. Those people who are judged to worry more than necessary about the possibility of either having or getting a disease are described as being hypochondriacal. Previously used terms such as 'cardiac neurosis' and 'cancer phobia' are examples of this.

Illness behaviour

The usual and reasonable behaviour when a person has severe chest pain considered to be due to a heart attack would be to call an ambulance and go to hospital. Such action for vague, recurring and chronic symptoms that have been fully investigated previously may be considered excessive and termed abnormal illness behaviour.

Somatosensory amplification

Somatosensory amplification describes the process of feedback whereby each of the components of the process of somatisation influences another component (Figure). For example, consider the person who repeatedly visits their doctor with recurrent medically unexplained symptoms. Medical scrutiny, including physical examination and investigations searching for a physical disease, heightens the individual's anxiety and increases physiological arousal. Increased muscular tension results in more physical symptoms.

Increased anxiety and somatic attribution increase a person's tendency to be attentive to bodily symptoms. This hypervigilance uncovers new symptoms. As the number of perceived symptoms increases, the person seems to worry more and finds further evidence of physical illness. The patient becomes more distressed, caught in a self-perpetuating cycle of somatosensory amplification.[4]

DSM-III categories of somatoform disorders

The *DSM*-III categories of somatoform disorders include:[1]

- conversion disorder – the classic acute presentation of loss of motor or sensory impairment
- (psychogenic) pain disorder – chronic pain in which the relative contribution of psychology and injury cannot be precisely determined
- somatisation disorder – a disabling condition with frequent presentations and a multitude of symptoms occurring over many years
- hypochondriasis – illness worry predominates the presentation.

An important distinction to make is between acute and chronic syndromes. Conversion is generally considered to be an acute illness – often a brief single isolated event caused by some identifiable stressor. Hypochondriasis (illness worry) is more often a general disposition – almost a personality style.

Somatisation disorder and chronic pain are enduring phenomena. Although the prevalence of each of these in the community is not great, chronic conditions contribute a significant burden to the workload of the GP.

Medically unexplained symptoms

Medically unexplained symptoms are very common in general practice. It is estimated that almost 30% of patients presenting to GPs have symptoms that remain unexplained from a medical perspective yet persist over time.[5] A recent Australian study estimated that somatisation, defined as a combination of multiple somatic symptoms and hypochondriacal concern, was present in about 18% of general practice patients.[6]

Physical symptoms frequently present as part of anxiety or depression. Palpitations, sweating, shortness of breath, abdominal upset (even nausea and loss of appetite) and sleep disturbance are common in patients with anxiety and are explained by autonomic activity and mental arousal. Depression and stress are often associated with tiredness. Sometimes medically unexplained symptoms are not due to anxiety or depression, and it remains unclear how they are derived.

Factors that are thought to predispose a patient to somatoform disorders include:

- early neglect or abuse leaving an unmet need for care and sensitivity to guilt feelings
- family modelling of illness
- previous illness, serving as a model for illness and its rewards
- anxious personality
- societal attitudes to physical and mental illness and, in particular, stigmatised views of mental illness.

An episode of somatoform disorder may be triggered by a physical illness, an episode of loss or grief or a stressful event, particularly those that trigger feelings of shame or guilt.

Assessment

Assessment of the patient forms part of the management. Conveying the message to the patient right from the start that psychosocial issues can contribute to physical symptoms is important.

There is a natural tendency for doctors to want to first exclude all possible physical disease. Although understandable, the result is often a long course of investigations before a conclusion is made that there are medically unexplained symptoms, and consideration is given to psychosocial factors. The unfortunate result of this is to reinforce the patient's attitudes that physical diseases are a real concern and physical symptoms need to be investigated to the end.

Clearly the patients' symptoms and concerns cannot be ignored. However, a better way to proceed is to weave psychosocial consideration into the consultations from the start. Enquire at the first interview how the patient is feeling, if there is any stress in his or her life, or if there have been any stressful events in the family ('Is there anything else going on in your life at the moment?').

If a comprehensive history is taken, including the psychosocial context, a more complete understanding of the problem can be achieved. It may be that, after such an enquiry, the doctor can say, 'It may be that these symptoms are stress related, but let's just do this test anyway to make sure everything is alright'. This indicates that the doctor is taking the complaint seriously, but also widens the agenda – opening the door to a more specific focus on the psychosocial to be performed later on without any awkwardness.

Exploring predisposing factors will help understand the patient's vulnerabilities. Identifying a precipitant may help the patient understand the process of somatisation – that is, how their body responds to stress. Perhaps the most important aspect in the assessment, however, is uncovering and clarifying the nature of any health anxieties (e.g. fear of death), any distorted cognitions associated with them and the patient's level of need for reassurance and care.

It is essential to ask patients how they understand the problem – for example, what they think is causing the problem and what the significance of this is to them (e.g. do they expect to die?). This will gauge the level of illness anxiety and the strength of somatic conviction.

Management

The common form of somatisation in general practice is the presentation of physical symptoms associated with stress, anxiety or depression. The aim of management here is to educate the patient about the process of somatisation. This is called re-attribution.[7] It involves:

- conducting a thorough history and examination, conveying to the patient that you understand his or her concerns and are taking them seriously, and, at the same time, interweaving the psychosocial aspects into the consultation – indicating that you consider these are also important
- after the physical examination, broadening the agenda by suggesting that the symptoms may be due to the stress, anxiety or depression of which the patient has spoken
- making the link more definite by helping the patient understand how symptoms may be caused by stress, anxiety or depression. This is achieved, for example, by referring to the temporal relationship in the history; providing a description of how stress causes muscle tension, which may cause headaches; and demonstrating how hyperventilation causes peripheral tingling or muscle spasm.

Specific psychological strategies that are useful in treating patients with somatisation include:

- relaxation, stress management and attention training to reduce physiological and emotional arousal
- education and training to improve understanding about psychophysiological responses
- re-attribution and behavioural experiments to further increase understanding of the bodily responses
- graded activity to gradually increase functioning
- exposure to treat accompanying phobic avoidance.

The principles of the management of patients with chronic somatisation are the following:

- although symptoms cannot be relieved (because they are by definition 'chronic'), some medication is often useful to partially control symptoms. However, the use of narcotic analgesics in chronic noncancer pain is not a particularly good idea – it usually does not fully control pain and yet complicates management
- developing and maintaining a positive therapeutic relationship over a long period of time is the most important thing. This, however, can be difficult because, eventually, there is likely to be disagreement between the doctor and patient about the nature of the problem. It therefore requires some effort to maintain a positive relationship. Agreeing on goals and providing support and advocacy is

the basis for this relationship
- it is important to have modest aims and not to promise a cure, because a cure of symptoms is unrealistic. However, increasing functioning through a structured rehabilitation program, is realistic, and this should be the focus of mutual goal setting
- directing patient attention away from the physical symptoms (about which you cannot do much) and encouraging patients to look after their mental health, relationships and general wellbeing is an important aim. It is useful to be able to recognise patient's helplessness, often experienced just as strongly by the doctor, and to work with the patient to bring areas of control and mastery into their life.

Issues of compensation or litigation add another layer of complication to unexplained medical symptoms. When this happens, hope for substantial improvement is reduced even further.

Chronic somatisation needs to be seen like any chronic physical condition. The aims of management are best symptom control and maximising physical function and psychological and interpersonal wellbeing. Unfortunately, unlike physical disease, it carries significant stigmatisation and is associated with low self-esteem. MT

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