**Somatoform Disorders**

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Somatoform disorders are multiple somatic complaints in which physical symptoms cause significant and often long-term distress and often have no medical explanation. Somatization is a process in which mental or emotional problems result in physical symptoms. For example, many people experience occasional headaches, abdominal distress, chest pains, tiredness, fatigue, dizziness, back pain, and other aches and pains as a result of emotional stress. **Somatoform disorders** can be diagnosed if somatization leads to multiple somatic complaints in which physical symptoms cause significant and often long-term distress. Although many of these physical symptoms have no medical explanation, individuals with somatoform disorders are usually convinced that their symptoms have a physical cause.

Persistent complaints of fatigue and exhaustion after minor physical effort are classified as **Neurasthenia**. This condition is best resolved by establishing a strict sixteen hours out of bed and eight hours in bed regime coupled with a thorough review of activities to be carried out and goals to be attained when awake. If unexplained somatic complaints are numerous, severe, and long-standing, the individual may qualify for a diagnosis of **Somatization Disorder**, whichis a rare type of somatoform disorder characterized by many physical complaints from different parts of the body, in which the individual experiences multiple, recurrent, and frequently changing physical symptoms for several years. Management of these individuals is more difficult than dealing with specific isolated somatic symptoms and warrant referral to specialist services. **Hypochondriacal disorder** is another type of somatoform disorder and is characterized by the individual’s preoccupation with the belief that he or she has a serious illness. For example, an individual may believe that a minor headache is caused by a brain tumor or that a mild rash is the start of skin cancer. This preoccupation occurs without adequate organic pathology to account for the degree of concern and persists in spite of medical reassurance. The course of hypochondriacal disorder is thought to be chronic and fluctuating and has been shown to affect about 3% of patients in primary care settings. The preoccupation with illness may cause distress, anxiety, and reassurance-seeking behavior, yet some individuals will otherwise function normally. Some individuals may dominate or manipulate family and social networks as a result of their symptoms.

**Differential Diagnosis**

In unexplained somatic complaints or in somatisation disorder, the focus is on the presence of the symptoms, whereas in hypochondriacal disorder, the focus is on the presence of an underlying disorder and its future consequences. Individuals with hypochondriacal disorder may accept that their symptoms are minor (unlike in somatisation disorder) but believe or fear that they are caused by some serious disease.

Individuals who have a depressive disorder are often very aware of everyday physical aches and pains or may become morbidly preoccupied with the belief that they have a serious illness. Depression may be secondary to a primary somatoform disorder, and establishing which problem started first is important. In addition, in schizophrenia, delusional disorder, or depression, individuals may have strange somatic beliefs, such as the belief that an organ or a part of the body is decaying. However, the beliefs associated with somatoform disorders are not as fixed as disorders that are accompanied by somatic delusions. Furthermore, individuals with long-standing hypochondriacal concerns may have been labeled as personality disordered since they often become dissatisfied or even hostile when faced with the perceived failure of health professionals to deal with their problems.

While anxiety about health can occur transiently in any individual, somatisation and hypochondriacal concerns may feature in a number of anxiety disorders. One of the domains of worry in generalized anxiety disorder (GAD) may be concern about physical illness in either oneself or one’s family. However, in GAD, the illness anxiety is just one of many concerns rather than being the sole cause of distress. During panic attacks, avoidance and preoccupation with thoughts of physical or mental disease are prominent (i.e., fear of dying, going mad, or losing control). However, individuals with panic disorder tend to misinterpret their acute anxiety responses (which then tend to escalate as anxiety increases), while in somatoform disorders, the symptoms that are misinterpreted are more likely to be those not related to anxiety (e.g., lumps and blemishes). The panic misinterpretations also tend to be acute, occurring while the individual experiences anxiety symptoms (e.g., heart attack), while hypochondriacal fears (i.e., cancer) and unexplained somatic complaints tend to be longer term. Many people with hypochondriasis experience intrusive thoughts followed by compulsive checking, which is similar to symptoms of obsessive-compulsive disorder. However, while people with hypochondriasis are afraid of having an illness, people with OCD may fear that they or their family will develop a serious illness such as AIDS or cancer.

**Management of Somatoform Disorders**

The management of somatisation and hypochondriacal disorders have much in common, although the clinician needs to adapt the management plan below depending on the specific symptom profile. The main principle of management for individuals with somatisation and hypochondriacal disorders is to help them cope with their physical symptoms. This principle is equally applicable to individuals who have more isolated somatic complaints. The goal of management is not the acute relief of symptoms but rather assistance with rehabilitation in the face of chronic disability. Treatment would ideally include the following components:

**1. Ongoing Assessment**

*Medical assessment*: Typically, individuals with these complaints will have previously undergone a routine medical examination with their general medical practitioner so as to rule out underlying physical disease. Following a complete medical assessment, the clinician can discuss the symptoms with the individual, and the main points of education in this context would include:

* An explanation of the results of the medical tests or physical examinations.
* An emphasis on the finding that there are no life-threatening symptoms present or underlying illnesses.
* If appropriate, the provision of a physiological explanation for the symptoms, particularly for individuals with somatisation disorder (e.g., “Muscle tension can often cause pain—think of how your arms have felt after carrying heavy shopping bags for a long period of time”). Relaxation methods may help relieve symptoms related to tension
* The general practitioner should limit further medical investigations and access to prescription drugs, provide time-limited, regularly-scheduled appointments, and deal sensibly with all new signs and symptoms that are presented.

*Psychological assessment:* The clinician should also establish whether the individual has co-occurring mental disorders and determine which problem is primary or secondary. Anxiety or depressive disorders are common in this population, and the underlying or accompanying disorders will require treatment.

**2. Establish a Strong Therapeutic Relationship**

This step is important as many individuals will be reluctant to view their problems as being caused by anything other than a medical condition and will therefore be resistant to engaging in treatment or to discussing any other possibilities related to the cause of symptoms. Since individuals will be unlikely to link their experience of illness to psychological factors, the communication of a psychiatric diagnosis is not helpful. In addition, since the individual will be unlikely to present for specialist mental health treatment, the general practitioner is central to the management of these disorders. Presenting the treatment approach as one in which various hypotheses about the origins of the symptoms can be tested may be useful, and such an approach will be more readily accepted if a trusting therapeutic relationship has been established.

Acknowledging that the individual’s experience of the physical symptoms is real and that the symptoms are not lies, inventions, or figments of the individual’s imagination, as well as acknowledging the distress caused by the individual’s concerns, will also help establish rapport and engage the individual in treatment. The clinician may also want to discuss the individual’s previous experience of how medical professionals have responded to the symptoms, which will enable the individual to “feel heard.”

**3. Cognitive Behavioral Therapy**

CBT is the best-established treatment for somatoform disorders and targets the thoughts, feelings, and behaviors that perpetuate the disorder. For example, thinking of one’s physical aliment as catastrophic may lead to a decrease in activities for fear that participating in activities will make the symptoms worse. A decrease in activities may then lead to more time thinking about one’s ailments and consequently result in greater stress. Furthermore, increased stress and anxiety may actually worsen the physical symptoms and disability.

* *Cognitive interventions*: Therapy targets the individual’s negative thoughts and overemphasized fears related to his or her physical ailments. For individuals with hypochondriasis in particular, the clinician should present alternative rational explanations and explain why the individual’s ideas may be mistaken. For example, consider the case in which an individual presented to his clinician with the belief that a lump on his forehead was proof that he had a brain tumor. Every time he looked in the mirror he thought the lump was growing bigger. Three previous CAT scans had not provided reassurance. However, when presented with the testable alternative hypothesis that the lump was not growing, he conceded that if the lump really was growing, it would have been the size of a golf ball by now. He agreed that it was possible that the lump had always been there and that it was therefore less likely to be a brain tumor, and his anxiety was considerably lessened.
* *Behavioral interventions*: The goal is to help individuals reintroduce activities and develop other interests despite continued physical symptoms. Use graded exposure concepts and activity planning to encourage activities and structured problem solving to facilitate planning. Behavioral interventions focused on modifying inappropriate reassurance seeking or checking behavior and avoidance is particularly important, and the clinician should review the figure below with the individual.

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For inappropriate reassurance-seeking or checking behavior:

* Point out the role of this behavior in perpetuating somatic concerns (see diagram). Checking and reassurance seeking, while decreasing anxiety in the short-term, focuses the individual’s attention on the symptoms. This heightened awareness often results in greater anxiety and overinterpretation of symptoms. Furthermore, constant checking and prodding can actually cause tenderness and other injury.
* Once you have provided appropriate information, advise the individual to stop checking or seeking reassurance so that he or she may break the cycle. Explain that this will lead to a temporary increase in anxiety but that this will in time decrease.
* Come to an agreement with the individual that he or she will seek no further tests or medical opinions. This agreement may require the involvement and agreement of any partner or spouse. Treatment, like that for OCD, involves exposure to the cues for hypochondriasis and prevention or inhibition of the reassurance-seeking responses.

For avoidance:

* Individuals can overcome avoidance using the principles of graded exposure. For example, individuals who gradually begin a program of exercise can test whether physical exertion leads to a worsening of their symptoms (and in doing so will probably learn that they feel better with exercise).

**4. Increasing Emotional Awareness and Identifying Perpetuating Factors**

For individuals with somatisation disorder, this step is particularly important in facilitating an understanding of the link between emotions and physical symptoms.

* Individuals with somatisation disorder often have difficulty identifying and expressing their own emotions, and they may need skills such as mindfulness and emotion regulation as central components of treatment.
* The clinician should also encourage individuals to systematically identify and list all the principal factors that perpetuate the symptoms. Factors may include low mood, stress, poor sleep, misinterpretation of bodily sensations, and unhelpful coping behaviour (e.g., lying in bed all day). The clinician should encourage discussion of emotional stressors that were present when symptoms arose or that seem to exacerbate symptoms. Keeping a diary of symptoms and events on a daily basis may help clarify these connections.

**5. Further Management**

For individuals with somatisation disorder, the clinician should avoid referrals to medical specialists unless new symptoms or signs arise, as somatic concerns are best managed by regular planned contact with general medical practitioners. When hypochondriacal concerns are severe and are a major feature of an individual’s difficulties, expert consultation may be required to develop and enhance the treatment strategies outlined above. Consultation with clinicians who have expertise in cognitive behavioral strategies may be useful.

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