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Somatoform Disorders in Primary Care

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I. Introduction

Somatoform disorders are characterized by bodily symptoms that suggest a physical disorder but for which there are no demonstrable organic causes or known physiologic mechanism. The main feature of somatoform disorders is persistent requests of medical investigations in spite of repeated negative findings and reassurances by doctors that the symptoms have no physical basis. The symptoms are presumed to be associated with psychological factors or conflict.

According to DSM-IV (APA 1994), somatoform disorders are categorized in table 1.

Table 1. Somatoform Disorders

Somatization disorder
Undifferentiated somatoform disorder
Conversion disorder
Pain disorder
Hypochondriasis
Body Dysmorphic disorder
Somatoform disorder not otherwise specified

II. Case Presentation

Mr. X is a 68 year old married Chinese male patient, a retired cook, with no past history of medical or psychiatric illnesses. He reported having sleep disturbance since 6 months ago with irritability and loss of appetite. He also had frequent headache, dizziness and chest tightness sensation. Three weeks before he came to the clinic, he had several episodes of chest pain and was sent to the emergency room of a local medical center. He was admitted for medical work up and was discharged after tests showed no evidence of heart disease. He was referred for psychiatric consultation. During the evaluation, he complained about his sleep disturbance, headache, dizziness and chest tightness. He denied having anxiety or depressed mood. When asked about his family, he reported his wife had worked as a nanny in a distant town for many years and they were used to living apart. Six months ago, she retired and returned to live with him. When talking about his wife, he became animated with agitation and described her as a headstrong women who always did things her way. I pointed out to him possible relationship between his symptoms and his recent life changes as onset of his symptoms coincided with the time when his wife rejoined him.

Mr. X later was able to tell me that his symptoms got worse when his wife aggravated him. They had frequent fights since they had different opinions on everything from how to set up a monthly budget, arrange their furniture, to what gifts to send to their children. He remembered that before he was sent to the emergency room, he was very angry at his wife since "she put wet dishes in the wrong place and messed up the kitchen." I encouraged the patient to ventilate his frustration and anger towards his wife during his visits, and explained to him the relationship between his frustrations and his physical symptoms. I helped him understand that people who do things differently can still work together as long as they know who to cope with each other. I discussed with

him how to effectively communicate his ideas and opinions to his wife and learn to take turn in making decisions. With improved coping skills, he was more able to handle reunion with his wife and reported much less frustration, anger and physical symptoms after 4 visits. Patient terminated with treatment after 4 weeks.

III. Differential diagnoses

- A. Underlying medical illnesses causing the symptoms.
 - B. Comorbid Axis I and Axis II Disorders
Major Depression, anxiety disorders, and alcohol and drug abuse are prevalent among patients with medically unexplained symptoms. Two-thirds of patients with somatization disorder have symptoms of other psychiatric disorders, and one-third meet criteria for at least one other psychiatric diagnosis.
1. **Depression** with somatoform complaints is far more common than somatoform disorders. Patients with major depression present with dysphoric mood or loss of pleasure are usually accompanied by other somatic symptoms (insomnia, fatigue, anorexia, weight loss). When major depression exists, it should be treated first. Usually, both affective and functional somatic symptoms improve with the treatment of depression.
 2. **Anxiety disorders** occur in 86 percent of patients of hypochondriasis, among whom panic disorder is the most prevalent and often goes unrecognized. Panic disorder is characterized by recurrent unexpected panic attacks and patients are persistently concerned about pending attacks. Generalized anxiety disorder, another prevalent anxiety disorder, is characterized by at least 6 months of persistent and excessive anxiety and worry.
 3. **Substance abuse disorders.** Alcohol abuse should always be considered in patients with multiple somatic complaints. Insomnia, morning cough, extremity pains, dysesthesias, palpitations, headache, gastrointestinal symptoms, fatigue, and bruises are common in alcoholics. Frequently, patients are elusive about their drinking problem. Collateral information from their family can be very helpful.
 4. **Psychotic disorders.** The somatic delusions of schizophrenia are generally bizarre and idiosyncratic (e.g., pain on the left half of the abdomen but not on the right half). Patients usually have other coexisting psychotic symptoms like hallucinations and paranoid delusions and their global functioning is generally more impaired.
 5. **Personality Disorder.** Patients with personality disorders have an enduring pattern of behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, is stable over time and leads to distress or impairment. The incidence of personality disorder among patients with somatoform disorders is quite high. Passive-dependent, histrionic traits are common among patients with conversion disorder.

Avoidant and paranoid personality disorders are common among patients with somatization disorder.

6. **Malingering Disorder.** This is one of the two types of voluntary symptom production. The patient lies about symptom's presence or severity and there is an obvious goal or purpose behind the symptom. A high suspicion should be aroused when there is a connection of patient's symptoms and a medicolegal issue, marked discrepancy between patient's subjective distress and objective findings, and when there is presence of antisocial personality disorder.
7. **Factitious Disorder.** This is the other type of voluntary symptom production which shows no apparent self-advantage and often has a self-destructive nature. These patients usually have borderline personality disorder. Psychiatric consultation should be sought to seek help in detecting method of self-induced symptoms and exploration of underlying pathology.

IV. Diagnosis of Somatoform Disorder according to DSM-IV

1. Somatoform Pain Disorder: Pain is the predominant complaint of the patient which causes significant distress or impairment in patient's functioning. Psychological factors are judged to play a significant role in the onset and maintenance of the pain.
2. Conversion disorder: It involves the loss or change in sensory or motor function that is suggestive of a physical disorder but is actually caused by psychological factors.
3. Hypochondriasis: It is the preoccupation and the conviction of having a serious disease despite appropriate medical evaluation and reassurance.
4. Somatization disorder: It is a polysomatic disorder that begins before age 30 years, extends over a periods of years, and is characterized by a combination of pain, gastrointestinal, sexual, and pseudoneurological symptoms.
5. Body dysmorphic disorder: It is the preoccupation with an imagined or exaggerated defect in physical appearance.
7. Undifferentiated somatoform disorder: This is characterized by unexplained physical complaints, lasting at least 6 months, that are below the threshold for a diagnosis of somatization disorder. It is one of the most commonly found somatoform disorders since most patients with somatic symptoms do not satisfy the stringent threshold for somatization disorder. Undifferentiated somatoform disorder is very close to the concept of neurasthenia, a widely held illness belief among Chinese patients.

Diagnosis of somatoform disorders among Asian patients:

1. Diagnosing Asian patients with somatoform disorders is fairly straight forward once other disorders for differential diagnosis have been ruled out.
2. Among Asian patients with medically unexplained symptoms, the most commonly seen symptoms include insomnia, headache, failure to concentrate, anxiety and depression(Lee, 199). They tend to complain a mixture of emotional as well as bodily symptoms and attribute their symptoms to psychosocial reasons. These findings argue against the stereotyped misconception that Asians tend to somatize and manifest few or no emotional symptoms.
3. When Asian patients experience anxiety and depression, they consider them normal response to life stresses and do not consider them as symptoms of distinct disorders. They tend not to report their mood symptoms to their doctors during medical visits. As a result, depressive and anxiety disorders commonly found among patients with somatic symptoms are frequently unrecognized in the Asian populations.
4. When asked about their emotions, most Asian patients are able to describe their mood and are willing to talk about their feelings on things happening in their lives. Frequently, clinicians are hesitant to explore the emotional aspects of patients since Asian cultures are perceived to encourage reservation of personal feelings. When done in a respectful and caring manner, most patients are willing and thankful to have a chance to tell their doctors about their emotions.

In approaching Chinese patients with medically unexplained symptoms, the key is acceptance of their somatic symptoms, actively inquire about patients' mood, explore patients' psychosocial background, and screen for anxiety and depressive disorders, substance abuse, and psychotic symptoms.

V. Treatment of Somatoform Disorders

Treatment of somatoform disorders depends on the specific somatoform the patient has. Some principles hold in the treatment of patients with medically unexplained symptoms. They include:

1. **Rule out concurrent physical disorder** since patients with somatic symptoms are not immune to true medical illnesses.
2. **Treat comorbid psychiatric disorders:** The prevalence of anxiety and depressive disorders is high among somatizing patients. Anxious patients are more self-conscious and tend to catastrophize bodily sensations, misinterpret vague and ambiguous symptoms of unclear origin to serious diseases. Depressed individuals have a negative and pessimistic outlook to their symptoms without the support of

objective evidence. Treatment of anxiety and depressive disorders frequently improve somatic symptoms (Barsky, 1997).

3. **Listen with understanding and acceptance:** Although symptoms may not be fully explained by medical illnesses, listening to the patient's symptoms with patience and understanding, and accepting this is how the patient genuinely feels and suffers can be very therapeutic to the patient.
4. **Catharsis:** Allowing patients to express their sadness, anger and frustration can be very helpful. It may be the main reason why some patients keep returning to the clinic despite their symptoms persist. A frequent misconception is that clinicians do not have time to listen to patients' complaints. In reality, most patients appreciate even a limited time to share their own feelings with their doctors.
5. **Instillation of hope:** It is very important that patients feel their physicians will not give up on them and is trying to provide them the best treatment available. Chronic patients survive on the moral support from their doctors who through perseverance, continue to instill hope to their patients.
6. **Reassurance:** Reassurance is more complicated in these patients. Premature reassurance like "All the tests so far have been negative. There is nothing wrong with you." can be considered by the patients that their physicians are not capable of understanding their problems. Reassurance can be done with an empathetic manner like, "Having done all these tests, I am confident that we are not dealing with a serious physical problem here. I think we need to work together to keep an eye on these symptoms and see what we can do about it." It is necessary to convey the physician's concern as well as optimism about the symptoms.
7. **Treat the patient, not symptoms:** Some patients have chronic patterns of complaining about their somatic symptoms. Dwelling on symptoms sometimes leads to a dead end. It's always helpful to inquire about patients' lives, social background, job, family situation, and recent life events and to show interest in the patient as a person. Remember that relationship is one of the strongest healing factors.

Treatment of specific somatoform disorders:

A. Conversion disorder:

- i) provide support and reassurance that symptoms will improve,
- ii) assist patient ventilate underlying emotional conflicts, and
- iii) use indirect or direct suggestions to prompt symptom relief.

B. Hypochondriasis:

- i) schedule regular, brief appointments,
- ii) inquire about symptoms and about patient's fear and beliefs about his or her illness,
- iii) perform focused physical examinations,
- iv) provide accurate information about objective signs on physical examination, and

- v) explain misconceptions about signs and symptoms the significance of which are frequently being overrated by patients.

Somatization:

- i) one physician to coordinate care for patient's multiple symptoms.
- ii) identify psychosocial precipitants to new symptom complaints,
- iii) plan regularly scheduled appointments of set length,
- iv) do conservative diagnostic workup,
- v) do not treat what the patient does not have.

Treatment of Asian patients with somatoform disorders: Somatic complaints with no organic causes are common among Asian patients. Generally, they do not satisfy the stringent criteria for somatization disorder. Many of them can be categorized as having undifferentiated somatoform disorder. Treatment of Asian patients with medically unexplained somatic symptoms includes:

1. Show genuine interest in the somatic symptoms complained instead of brushing them aside as non-important issues. This includes inquiring onset, characteristics, location, duration, exacerbating and relieving factors of the symptoms. Find out how the symptoms affect the patient, what treatment has been received, and whether they are effective.
2. Be non-judgemental about the symptoms. Listening is more important than attempting to provide a quick fix to the symptoms.
3. Establish a supportive relationship. Be prepared that these symptoms tend to run a chronic course and may fluctuate with psychosocial situations in patient's life.
4. Medications for supportive treatment are welcomed both for symptom relief and as a sign of acceptance of the symptoms. Examples are analgesics for pain and headache, digestants and antacids for abdominal discomfort, β -Blockers for palpitation, and hypnotics for insomnia.
5. Antidepressants may be effective for treating somatoform disorders even when there are no comorbid depressive disorders. Further studies are indicated.
6. Patients have better compliance if they are allowed to participate in making decisions regarding the choice of treatment.
7. Encourage rehabilitational treatment including exercise, physical therapy, Yoga, Taichi and participation in social activities.
8. Inform patients that improvement of their symptoms depends a lot on how much they can alter their life styles and patient is responsible to do it.
9. Work and family are pivotal aspects of Asian patient's' lives. Explore patient's relationship issues in his/her family, at work, and explore whether there have been significant life events. Questions like "What is going on in your family?" or "How is work?" may yield a lot of information about the patient. Listen to the emotional tone when patient responds to the questions.
10. Look for possible relationship between patient's psychosocial events and bodily symptoms and help patient see the connection between them.

11. Refer patients for psychological intervention to address their current life events as well as interpersonal conflicts. Many Asians patients benefit from short-term psychological intervention and from learning communication as well as coping skills.

VI. Traditional Chinese Medicine approaches to Somatoform Disorders

While Western Medicine relies heavily on positive findings in laboratory tests, TCM bases its diagnosis on four techniques; looking (observing), listening and smelling, asking, and pulse feeling. According to TCM theories, all symptoms arise from pathological change of Qi, blood, Yin-Yang or organ inside the body. Using the four techniques, TCM doctors collect information on unbalanced organ, Qi, blood and Yin-Yang to explain patients' symptoms and to provide treatment to alleviate the symptoms. Since it does not rely on laboratory findings for diagnosis, the problem of "medically unexplained symptoms" does not exist in TCM.

Another fundamental difference in the thinking of TCM and western medicine is that Western medicine views mind and body as separate entities while TCM considers mind and body integrated and inseparable. According to TCM, any change of the mind will inevitably affect the body and vice versa, and psychological problems are frequently considered the causes of physical disorders. Emotions (joy, anger, melancholy, worry, grief, fear and fright) are called internal etiologies and life style and circumstances (eating, working and accidents etc) are called external etiologies of diseases. Longstanding and intense emotional stress is thought to upset the homeostasis of the body and disrupt the ability of the body to maintain normal functions of Qi, blood, and organ leading to diseases. Indulgent lifestyle like eating irregular diets, overeating, overworking, and excessive sexual activity are thought to damage organ function.

TCM Diagnosis of medically unexplained symptoms

Medically unexplained symptoms found in western medical practice are usually caused by emotional problems and deviated lifestyle. TCM Diagnosis of patients with medically unexplained symptoms emphasizes on observation of these elements:

- 1) Looking: observe patient's spirit, complexion, response of eyes, posture, state of mind and breathing.
- 2) Listening: note patient's voice, sighing and breathing.
- 3) Asking: inquire possible relationship between emotions or lifestyle with onset, exacerbation and relief of symptoms.
- 4) Pulse feeling: look for wiry or string-taut pulses.

TCM treatment of medically unexplained symptoms

TCM treatment modalities include herbal medicine, acupuncture, Tuina massage and Qigong. The use of one or combined modalities can be used for treatment of patients with medically unexplained symptoms. Patient's preference is generally taken into consideration. Among the four treatment modalities, herbal medicine has the widest application and can be used to treat most commonly found symptoms. Acupuncture is also extensively used and is especially effective for pain relief. For patients who avoid needles, Tuina massage is a good alternative. Qigong is a form of meditation useful for treatment of anxiety and depression. For patients who present with multiple symptoms,

treatment should focus on the main symptom. Treatment of the main symptoms frequently results in relief of other symptoms. The following are examples of TCM treatment to several commonly seen symptoms of somatoform disorder:

1. Headache

- A) Type 1: Headache due to excessive yang: The cause is upsurge of liver yang due to stagnation of Qi or injury of the liver function after a fit of anger which damages the yin. Associated signs and symptoms include blurred vision, severe pain on both sides of the head, irritability, hot temper, flushed face, string-taut and rapid pulse, red tongue with yellow coating.

Treatment:

- a) Acupuncture: Fengchi(G20), Baihui(Du20), Xuanlu(G5), Xiashi(G43), Xingjian(Liv2).
 - b) Herbal medicine: Tian Ma Gou Teng Yin.
 - c) Qigong: Fang Song Gong
- B) Type 2: Headache due to deficiency of Qi and blood: The cause is irregular eating habit, overwork or stress leading to deficiency in Qi and blood and inadequate nourishment of the brain. Associated symptoms include dizziness, blurred vision, lassitude, and lusterless face. Headache is usually aggravated by coldness and relieved by warm temperature. Patient usually has weak and thread like pulses and pale tongue with thin and white coating.

Treatment:

- a) Acupuncture: Baihui(Du20), Qihai(Ren6), Gangshu(B18), Pishu(B20), Shengshu(B23), Zusanli(S36).
- b) Herbal medicine: Jia Wei Si Wu Tang.
- c) Qigong: Nei Yang Qong.

2. Insomnia:

- I. A. Type 1: Insomnia due to deficiency of both heart and spleen: The cause is stress and anxiety resulting in damage in heart and spleen. Blood is exhausted due to damage of the heart and Qi and blood production falls due to deficiency of the spleen. Associated symptoms include dreamful sleep, palpitation, poor memory, lassitude, and pale tongue with a thin white coating. Patient usually has thread like weak pulses.

Treatment:

- a) Acupuncture: Shenmen(H7), Sanyinjiao(Sp6), Pishu(B20), Xinshu(B15), Yinbai(Sp1).
 - b) Herbal medicine: Gui Pi Tang.
 - c) Qigong :Dang Tian Gong.
- B) Type 2: Insomnia with elevated liver fire: The cause is emotional depression leading to prolonged stagnation of Qi in the liver which is transformed into fire and disturbs feelings of well being. Associated symptoms include irritability, fright and fear accompanied with headache, pain in the intercostal region on

distending the body, and bitter taste in the mouth. Patient usually has string-taut pulses.

Treatment:

- a) Acupuncture: Ganshu((B18), Danshu(B19), Wangu(G12), Shenmen(H7), Sanyinjiao(Sp6).
- b) Herbal medicine: Long Dan Xie Gan Tang.
- c) Qigong: Yong Quan Gong.

Suggested readings:

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