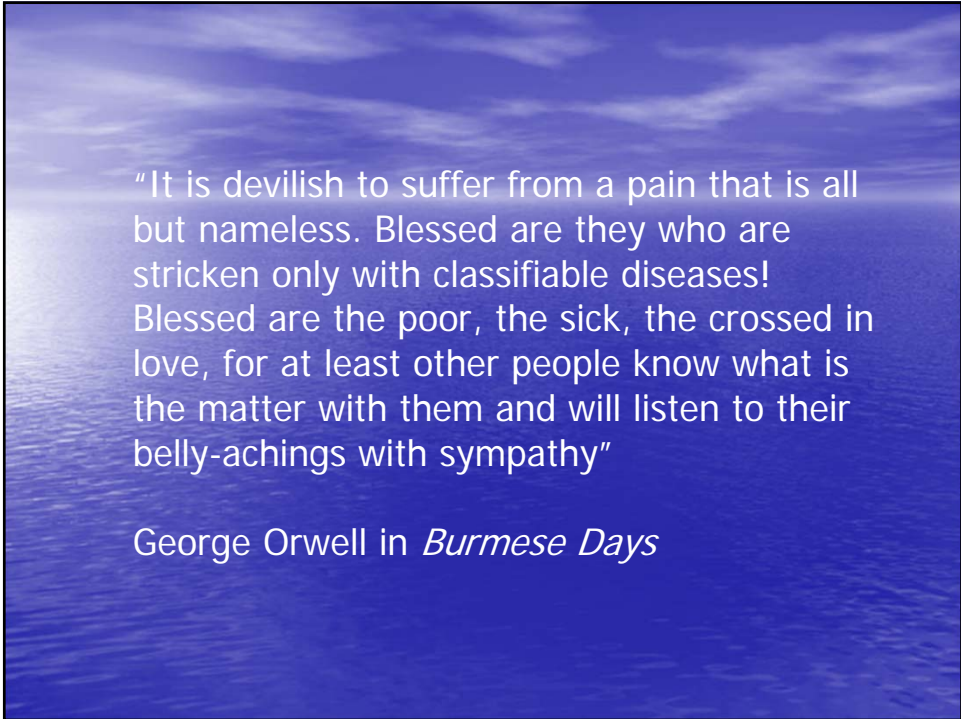




Somatization in Primary Care

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"It is devilish to suffer from a pain that is all but nameless. Blessed are they who are stricken only with classifiable diseases! Blessed are the poor, the sick, the crossed in love, for at least other people know what is the matter with them and will listen to their belly-achings with sympathy"

George Orwell in *Burmese Days*

Objectives

1. Learn about extent and impact of somatization in primary care
2. Understand how somatization is classified
3. Learn about a rating tool which can assist with the diagnosis of somatization, anxiety and depression
4. Learn how to manage somatization in the primary care setting

Case #1

- 30 year female with multiple anxiety disorders (GAD, PTSD and SAD), and endometriosis
- Frequent presentations to her family physician with various physical symptoms, especially during periods of stress
- At times presentation appear related to a flare-up of her endometriosis but this was not always clear

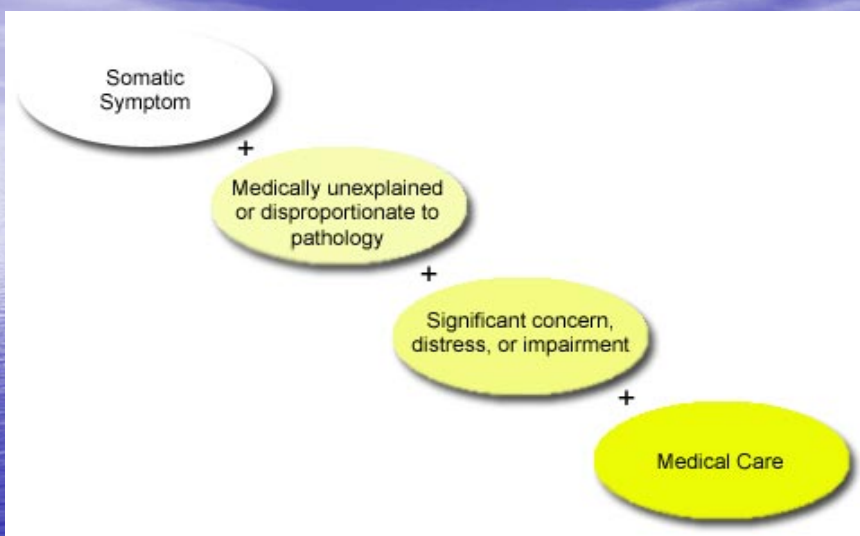
Case #2

- 55 year old woman with a history of abdominal pain and migraines dating back to her childhood
- As an adult developed fibromyalgia and later depression leading to her having to go on disability

Some definitions

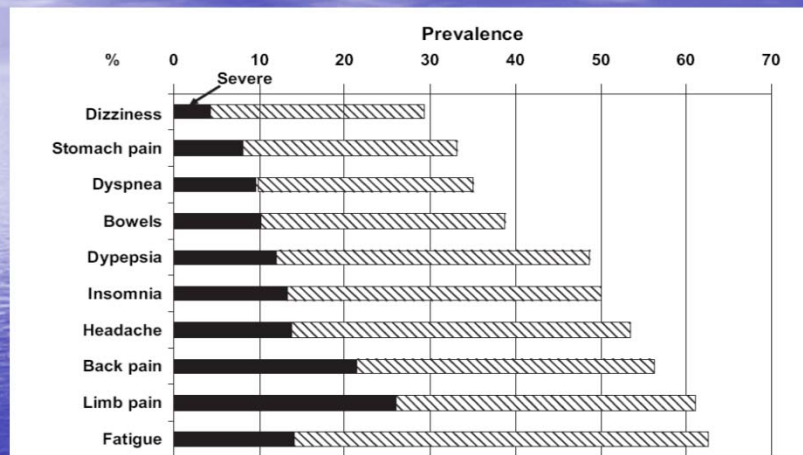
- Bodily sensations refer to a person's experience of their own body or its functioning
- Some bodily sensations become symptoms when they are considered to indicate disease
- Diseases are defined by doctors as abnormalities of bodily organs or systems

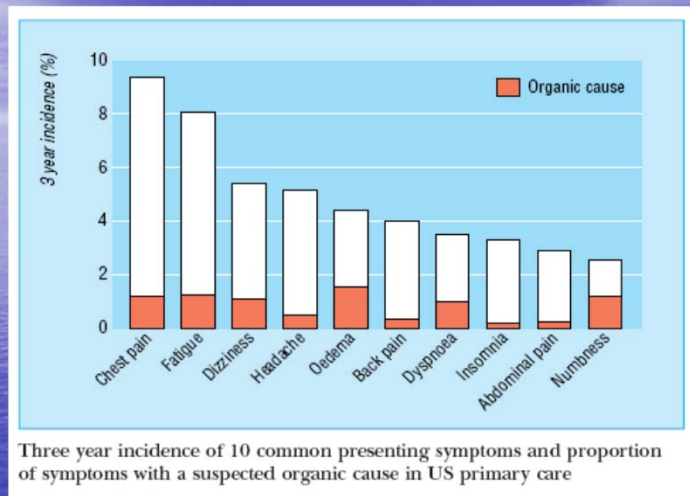
Somatization is the association of unexplained somatic symptoms with psychological distress and health seeking behaviour



Somatization in primary care

- Somatic symptoms account for more than half of all outpatient encounters
- At least one-third of these somatic symptoms are unexplained
- Somatization is present in at least 10-15% of patients in primary care
- Together with depression and anxiety constitute the 3 most common psychiatric disorders seen in primary care





Impact of somatization

- Commonly perceived as less serious or debilitating than symptoms occurring in the context of an identifiable disease
- Evidence, however, indicates that patients with somatization have similar levels of disability compared to those with a disease
- Significantly higher rates of unemployment (29% vs. 15%) and impaired occupational functioning (55% vs. 14%) compared to non-somatizing patients

Impact of somatization

- Generates significant health care costs (one study estimated it to represent up to 10% of total costs)
- Can lead to iatrogenic harm to patient from unnecessary tests and treatments
- Damage to the doctor/patient relationship

Spectrum of somatization

- Low end (mild or acute) – stress-related exaggeration of common symptoms such as headache, lightheadedness or low back pain (may constitute 80% of somatizing patients)
- High end (more severe or chronic) – includes unrelenting problems that can leave a patient completely disabled personally and occupationally (remaining 20%)

Co-morbidity

- Up to 60% of patient with somatization may have depression
- Up to 50% may have anxiety
- The greater the number of unexplained physical symptoms the greater the likelihood of a comorbid anxiety or depressive disorder
- Personality disorders often present in patients with more severe forms of somatization

Course of somatization

- 4%-10% go on to have an organic explanation
- 25% persist for over 12 months
- More severe forms are typically chronic and intermittently relapsing

Classification

- Functional syndromes
- Somatoform disorders in DSM-IV-TR
- Medically unexplained symptoms (MUPS)
 - Term used more in European literature

Functional syndromes

- Irritable bowel syndrome, chronic fatigue syndrome and fibromyalgia are examples
- Assumes that symptoms arise from an abnormality of bodily function

Functional somatic syndromes by speciality

Gastroenterology	Irritable bowel syndrome, non-ulcer dyspepsia
Gynaecology	Premenstrual syndrome, chronic pelvic pain
Rheumatology	Fibromyalgia
Cardiology	Atypical or non-cardiac chest pain
Respiratory medicine	Hyperventilation syndrome
Infectious diseases	Chronic (postviral) fatigue syndrome
Neurology	Tension headache
Dentistry	Temporomandibular joint dysfunction, atypical facial pain
Ear, nose, and throat	Globus syndrome
Allergy	Multiple chemical sensitivity

Somatoform disorders in DSM-IV-TR

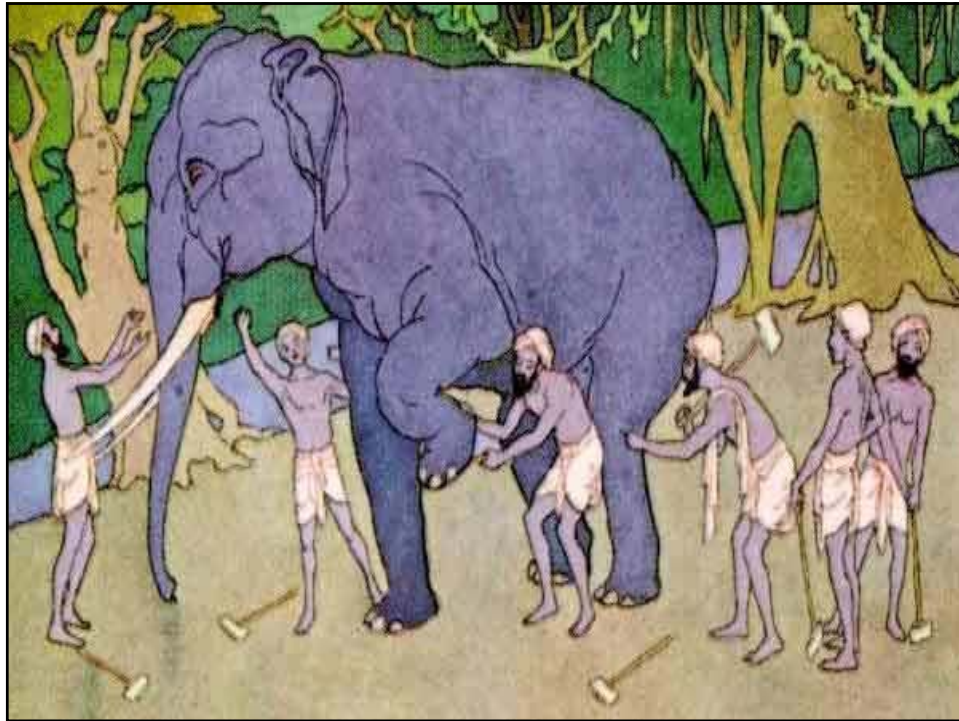
- Category of mental disorders characterized by physical symptoms that suggest physical illness or injury but cannot be explained fully by a general medical condition, the direct effect of a substance or attributable to another mental disorder (e.g. panic disorder)
- Symptoms are not intentionally produced or feigned (as in malingering and factitious disorder)

Somatoform disorders

- Somatization disorder
- Hypochondriasis
- Conversion disorder
- Pain disorder
- Body dysmorphic disorder
- Undifferentiated somatoform disorder

Undifferentiated somatoform disorder

- One or more unexplained physical symptoms present for more than six months
- Probably the most applicable psychiatric diagnosis for many patients seen in primary care



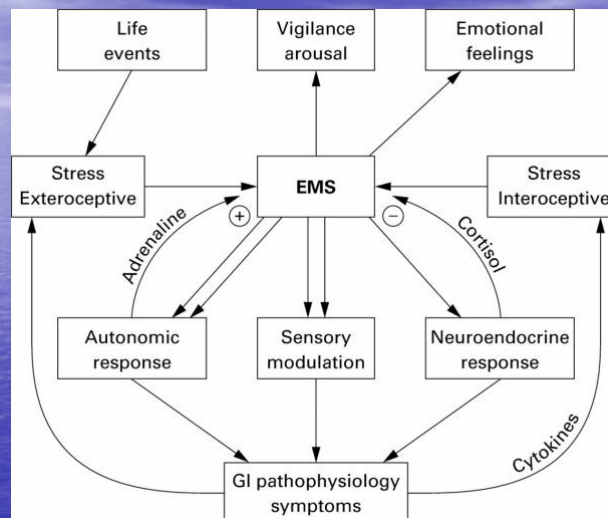
Etiology of somatization

- Fink et al (*Psychosomatic Medicine* 69:30-39, 2007) propose that functional somatic syndromes may simply be an artifact of medical specialization and may be different manifestations of a common latent phenomenon
- Propose a new syndrome which they call *bodily distress disorder*
- Suggest that bodily distress may be triggered by stress rather than being distinct diseases of noncerebral pathology

Etiology of somatization (contd)

- Postulate that cardiopulmonary and GI factors may be accounted for by abnormalities of the autonomic nervous system
- Musculoskeletal factors may be related to malfunction of the reticular system in the brain stem and medulla
- Also may involve the hypothalamic-pituitary-adrenocortical (HPA) axis

Emotional motor system (EMS) pathways.

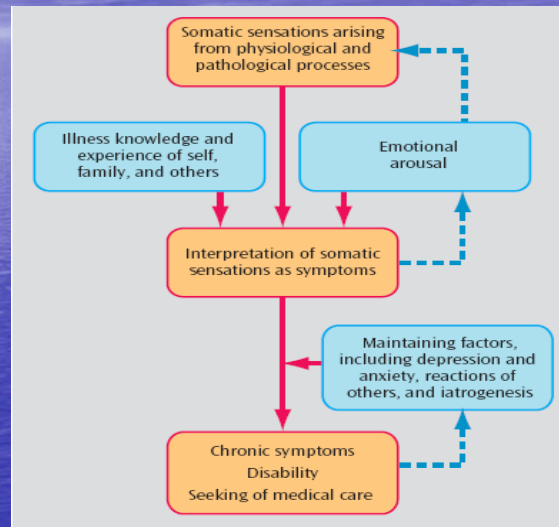


MAYER E A Gut 2000;47:861-869

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Possible etiology of somatization



Other factors that may be relevant in etiology

- Childhood sexual abuse and recent exposure to physical and sexual violence are consistently associated with somatization in women
- Increased incidence of functional GI disorders, nonspecific chronic pain, psychogenic seizures and chronic pelvic pain found

A rectangular image with a blue background depicting a calm ocean under a sky with light, wispy clouds. The horizon line is visible in the upper third of the frame.

Management of somatization

A rectangular image with a blue background depicting a calm ocean under a sky with light, wispy clouds. The horizon line is visible in the upper third of the frame.

Diagnosis

Evaluation of somatization

- **Step 1** - Evaluate for medical conditions (this is an ongoing process)
- **Step 2** - Evaluate for psychiatric disorders associated with somatic complaints (depression, anxiety, substance abuse)
- **Step 3** - Pursue a positive diagnosis of somatization

Evaluating for medical conditions

- History and physical exam may suffice for milder cases
- In chronic or more severe cases investigate as you would for any patient but avoid investigations that carry significant risk if not clinically indicated
- Keep vigilant for presence of symptoms that set off "alarm bells" that may indicate further investigation is warranted

Diagnostic features suggesting chronic somatization

- Multiple symptoms often occurring in different organ systems
- Symptom that are vague or that exceed objective findings
- Chronic course
- Presence of a psychiatric disorder
- History of extensive diagnostic testing
- Rejection of previous physicians

PHQ-SADS

PHQ-SADS

- Comprised of 4 components:
 - PHQ-15 for possible somatization
 - GAD-7 for anxiety
 - 5 Panic disorder questions
 - PHQ-9 for depression

PHQ-15

- Measure of somatic symptom burden
- Patients with high screening score should be further questioned to determine which symptoms might be medically unexplained
- Total symptom counts are predictive of somatoform disorders and correlate strongly with psychological distress, functional impairment and health care utilization

**PHYSICAL SYMPTOMS
(PHQ-15)**

During the past 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered at all (0)	Bothered a little (1)	Bothered a lot (2)
a. Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain in your arms, legs, or joints (knees, hips, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Menstrual cramps or other problems with your periods <i>WOMEN ONLY</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Constipation, loose bowels, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Nausea, gas, or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Feeling tired or having low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(For office coding: Total Score T ____ = ____ + ____)

GAD-7

- Designed to establish a probable diagnosis of Generalized Anxiety Disorder (GAD)
- Also has good sensitivity and specificity, however, as a screener for Panic Disorder, Social Anxiety Disorder, and Post Traumatic Stress Disorder

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T ___ = ___ + ___ + ___)

Panic Disorder Questions

- Positive response to the first question alone has a sensitivity of 93% and a specificity of 78% for panic disorder
- Each additional "yes" response to the remaining questions increases the specificity with only a minimal decline in sensitivity

C. Questions about anxiety attacks.

	NO	YES
a. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?.....		
If you checked "NO", go to question E.	<input type="checkbox"/>	<input type="checkbox"/>
b. Has this ever happened before?.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Do some of these attacks come <u>suddenly out of the blue</u> — that is, in situations where you don't expect to be nervous or uncomfortable?.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Do these attacks bother you a lot or are you worried about having another attack?.....	<input type="checkbox"/>	<input type="checkbox"/>
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, or your heart racing, pounding or skipping?.....	<input type="checkbox"/>	<input type="checkbox"/>

PHQ-9

- Widely-used and well-validated depression rating tool
- Can be used as diagnostic algorithm to make a probable diagnosis of major depressive disorder
- Can also be used as a severity measure of depressive symptoms

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING: 0 + _____ + _____ + _____
=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring for PHQ-15, GAD-7 and PHQ-9

Symptom Burden	Score
Mild	5
Moderate	10
Severe	15

Scoring of PHQ-15, GAD-7 and PHQ-9

- A score of greater than or equal to 10 is the most commonly recommended cutpoint for clinically significant symptoms

Utilization and acceptability of PHQ

- Median time for full review by physician is less than 2 minutes
- Can be administered as a self-report or as part of an interview
- In validation studies totaling over 6000 patients 87-89% of physicians found it very or somewhat useful

Where to find PHQ-SADS

- <http://www.phqscreeners.com/>

For additional info on how to use
PHQ-9 in depression care go to:

- <http://www.depression-primarycare.org/>
 - Go to Resources for clinicians> Clinical practice tools > PHQ-9

Case #1

- 30 year female with multiple anxiety disorders (GAD, PTSD and SAD), and endometriosis
- frequent presentations to her family physician with various physical symptoms especially during periods of stress
- At times presentation appear related to a flare-up of her endometriosis but this was not always clear

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o. Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

(For office coding: Total Score T = 7 + 8)

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GAD-7

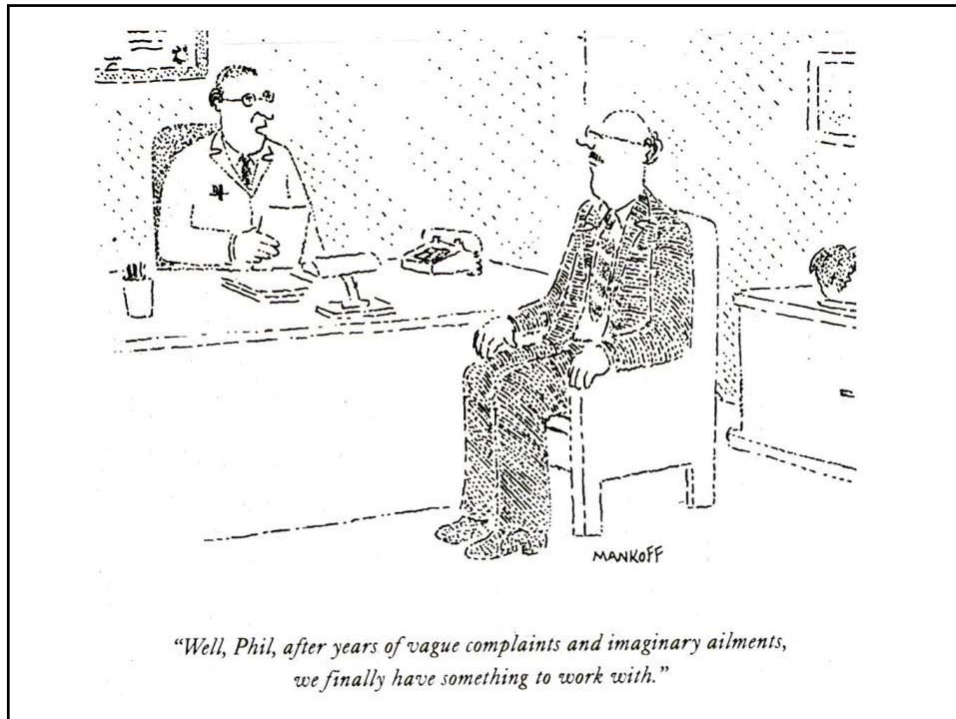
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2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T ___ = ___ + ___ + ___)

19

Treatment

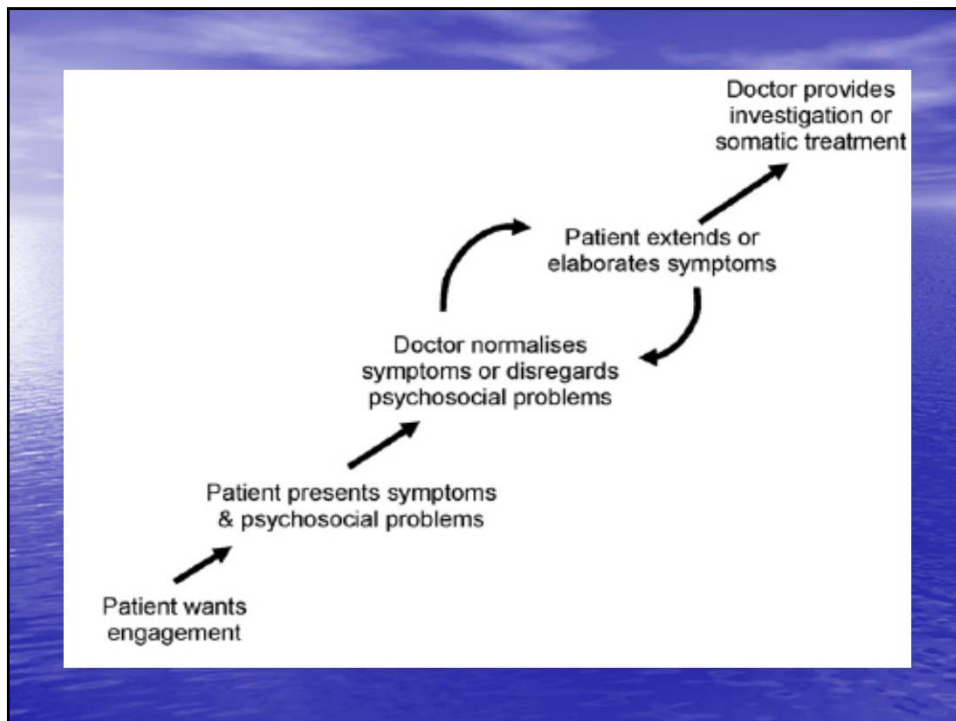


Common doctor-patient problems in somatization

- Doctors may feel that patient needs to address underlying psychological issues and so become frustrated with patient
- Doctors may feel their competence is being challenged
- Patients may feel they are misbelieved and that doctor feels they are fabricating their symptoms

How do doctors respond to somatization?

- May minimize or normalize symptoms or treat empirically
- May assume that patients want more than they do and so order more tests and make more referrals than are necessary



What do studies show that patients with somatization want?

- Explanations
- Emotional support
- Reassurance that the doctor has considered all the possibilities
- May accept uncertainty now but want assurance that their symptoms will be taken seriously and reassessed in future

So what helps?

- In mild cases the primary techniques are normalization and reassurance
- Explain there is no disease and that symptoms are benign or self-limiting
- Must know the patient's own illness perceptions and tailor explanations accordingly
- Encourage patient to be physically active in order to prevent adoption of sick role

What about in chronic or complicated cases of somatization?

- **Key is to establish a trusting doctor-patient relationship**
- First principle is to understand the patient's suffering and develop a concerned attitude
- Suffering is a subjective phenomenon and is poorly correlated with the extent of tissue damage

Key areas to address in interview

- What are the symptoms?
- Take a full history of the onset of all symptoms, exacerbating factors and relieving factors ("drain the symptoms dry")
- Ask patient what his or her main concern is about symptoms and what he or she thinks is causing them
- Ask how much impairment the symptoms cause
- What is a typical day like?
- See if you can establish a connection between the symptoms of patient's emotional state and social situation

The interview of the somatizing patient

- Acknowledge and validate the patient's sense of suffering
- Watch for signs you are not "hearing" the patient – repetition, amplifying of symptoms etc.

Assessment of somatizing patient

- Ask about past history of anxiety, depression and unexplained physical symptoms
- Ask about history of sexual, physical or emotional abuse
- For patients not known to you obtain previous medical records when indicated

Successful approaches involve:

1. Providing an acceptable explanation of the symptoms to the patient
2. Establishing reasonable treatment goals
3. Arranging for brief but regularly scheduled office visits

Snapshots at jasonlove.com



"I'm afraid that your irritable bowel syndrome has progressed. You now have furious and vindictive bowel syndrome."

Discussing the diagnosis

- Defining moment
- Explain that ominous conditions have not been found, especially the one the patient is concerned about e.g. MS, cancer etc.
- That surgery, further testing and additional testing are not required
- Let them know that you believe the problem is "real" and in their body and they are not making it up

Discussing the diagnosis (contd.)

- To the extent that functional syndrome diagnoses (e.g. **fibromyalgia**, **IBS**) facilitate the doctor-patient relationship, help focus the patient towards better functioning and provide helpful treatments there is no harm in using them
- With some patient a psycho-physiologic may be helpful e.g. *tension headaches*, *chronic muscle strain* to explain many pain syndromes, *hyperventilation*

Discussing the diagnosis

- One possible statement which may be useful in some cases:
 - “The results of my examination and of the tests we conducted show that you do not have a life-threatening illness. However you do have a serious medical condition, which I often see but which is not completely understood. Although no treatment is available which can cure it completely there are things that can help” (American Family Physician 1999)

Successful approaches involve:

1. Providing an acceptable explanation of the symptoms to the patient
2. **Establishing reasonable treatment goals**
3. Arranging for brief but regularly scheduled office visits

Goal of Treatment

- “Caring not curing”

Goals of treatment

- Focus on modifying illness behaviour and functioning
- Initial goals might be to decrease the urgency or frequency of unscheduled visits and telephone calls
- Decrease the number and duration of workups or hospital admissions

Later goals

- Help the patient feel more in control of themselves and their symptoms
- Improve social and occupational function
- Help patient find ways to communicate their distress without symptoms

Successful approaches involve:

1. Providing an acceptable explanation of the symptoms to the patient
2. Establishing reasonable treatment goals
3. Arranging for brief but regularly scheduled office visits

Why schedule regular visits?

1. Removes the dependency of visit on new or worsening symptoms thus rewarding the patient with earlier visits
2. Decreases the patient's fear of abandonment by the physician
3. Permits regular evaluation of the patient's complaints so that no objective findings are missed

Frequency of visits

- 15 minute visit once per month may be enough for some
- Others may require 20-30 minute visit every 2-4 weeks or even more frequently
- May be able to diminish intensity of visits over time

During the visit

- Listen for any new symptoms
- Conduct a brief physical exam (benefit of "laying on of hands")
- Gradually begins to shift focus away from physical symptoms to the psychosocial context
- Ask " How have your symptom interfered with your everyday life?"
- May lead to important life information that links life circumstances with symptoms
- Focus on improved functioning

Treat co-morbid psychiatric illness

- Identify and treat co-morbid depression and anxiety
- Also identify if substance abuse or dependence present

Somatization and medications

- When treating depression and anxiety important to start with low doses and go slowly in order to avoid side effects which could lead to their discontinuation
- SNRIs (duloxetine and venlafaxine) may have role in pain patients
- Several studies have found that antidepressants prescribed for medically unexplained symptoms improved symptoms considerably (NNT 4)
- Assess all medications patient is taking (both regular and prn) and rationalize where possible. Note: this could take one year or more to accomplish.

Activity

- Randomized controlled trials show that advising activity rather than rest for back pain, fatigue and fibromyalgia is helpful
- Activity should be agreed with the patient and be structured so that it gradually increases
- Ask patient to chart their activity
- Walking is often easiest activity to begin with
- Pacing is important – do not let patient overdo it
- Increase activity in small increments with goal of getting patient into cardiovascular training range (30 minutes of activity 5 days per week) if not medically contraindicated. This may take 6 months or longer.

Other potentially helpful interventions

- Improve sleep with sleep hygiene advice +/- medications
- Acupuncture, massage, chiropractic treatment may help some
- Biofeedback, meditation, yoga
- These interventions do not challenge patient's view of being ill but helps them take responsibility for their health

psychotherapy

- Cognitive-behavioural therapy (CBT), both individually and in group format, shown to be helpful in somatization, although it is difficult to obtain and results may not be long-lasting.
- Focus is often on reducing "stress" associated with having illness or which may be exacerbating it
- Supportive psychotherapy by primary care provider can be extremely helpful
- May be helpful to involve family in treatment



Problems in management



Setting unrealistic goals

- Avoid focusing on complete resolution of symptoms
- Focus instead on improved functioning by encouraging:
 - Pleasurable activities
 - Productive activities
 - Meaningful activities

Requests for diagnostic tests

- Remind patient that they will be followed regularly
- Sometimes performing a lab test becomes a “negotiating” process to give the patient some control over what test is performed
- In these cases need to discuss the meaning of a normal test

Request for medications

- Best to avoid opiates if possible
- If using opiates or benzodiazepines evaluate whether use is associated with an improved level of functioning and that side effect profile is acceptable
- Should be told the goal of treatment is to make the symptoms tolerable (not remove them) and to restore function

Frequent phone calls

- May threaten doctor-patient relationship
- may tell patient "it is hard for me to give you the proper care and attention that you deserve when I find myself spending so much time on the telephone with so few positive results for you"
- May propose more regular visits or set a limit on the number and length of calls between visits

Managing your reaction to the patient

- Important to acknowledge that somatizing patient may trigger difficult emotions (e.g. irritation or frustration) rather than acting out these feelings on patient
- Helpful strategies include:
 - Finding something you like about patient
 - Taking pleasure in small gains
 - Being realistic about what can be achieved with some patients
 - Not working harder than the patient
 - Being good to yourself after a difficult patient encounter

Case #2

- 55 year old woman with a history of abdominal pain and migraines dating back to her childhood
- As an adult developed fibromyalgia and later depression leading to her having to go on disability

Outcome of Case 2

- Initial PHQ-9 was 14
- After one year PHQ-9 had decreased to 8 and she appeared visibly less depressed and her functioning had improved
- Her PHQ-15 however remained elevated at 16 indicating ongoing somatic symptoms

So what was the treatment?

- Gabapentin for pain seemed to help slightly
- Duloxetine 120 mg po daily improved depressive symptoms
- One of the most significant factors was exercise which she gradually increased – she now goes to the gym 5-6 times per week
- She also identified ongoing support from the family health team as a key factor as well as focusing on the importance of family in her life as a motivating influence to get better

In summary

- Somatization is one of the most common psychiatric disorders seen in primary care
- PHQ-SADS can be a useful tool to assist with the diagnosis and management of these conditions
- While “curing” patients when these conditions are chronic is unlikely there is much that can be done to alleviate their suffering and improve their functioning

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