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THE EVIDENCE FOR TREATMENTS FOR SOMATOFORM DISORDERS

A View From the Trenches

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The somatizing patient can be the nemesis of the primary care physician. A good proportion of our patients may seem to us to have inappropriate worries about their health—what makes an otherwise competent adult come to the doctor's office for a runny nose?—but among them are a hardcore few who occupy a vastly larger space in our cumulative frustration quota than their numbers would suggest. Out of the 10,000 or so patients I've seen during 30 years of practicing general internal medicine, I'd say that I have seen several hundred with persistently exaggerated somatic concerns, and that the couple of dozen with true somatization disorder or unshakeable single-symptom conditions are permanently etched on my memory.

What makes these patients so frustrating is our inability to make a satisfying medical diagnosis combined with our fear of missing one (at least one of my "somatizing" patients turned out to have multiple sclerosis), the great difficulty in getting any improvement, and the hostility and otherwise distorted illness behavior that are often on display. The result is patients who desire particularly much attention and emotional support from their physicians,[1] and receive particularly little.[2]

Formulating a somatoform diagnosis can be a double-edged sword for physicians on the front line. On the negative side, it may breed diagnostic sloppiness and therapeutic nihilism, leading to overemphasis on the psychological components in so-called "functional" disorders and underemphasis on interactions between mind and body in organic disorders such as coronary artery disease. The very line between "organic" and "functional" is becoming blurred as we recognize, for instance, that migraine can cause stroke and that the symptoms of many "irritable bowel syndrome" patients are demonstrably caused by lactose intolerance, mild celiac disease, or microscopic colitis. "Medically unexplained" can be a code word for our exasperation and/or ignorance, and unreasonable distress related to physical symptoms can exist in all kinds of disorders including the most anatomically severe.

On the positive side, diagnosing a patient as having the psychological characteristics of somatization disorder or undifferentiated somatoform disorder can be invaluable. For one thing, it validates the clinician's frustration. The cognitive reframing can defuse some negative attitudes and enable the physician to shift his or her aims from diagnosis and cure toward management, a more feasible goal. It can open the way toward focused and specific approaches toward management. In ad-

dition, recognizing the centrality of a disturbed physician-patient relationship may increase the chances of restructuring that relationship in a constructive direction.

Controlled treatment trials of treatments for somatoform disorders, as summarized by Dr. Sumathipala, highlight the successes of cognitive-behavioral therapy and other psychological approaches. From the primary care practitioner's point of view, the major problem with this literature is its emphasis on therapies provided by psychiatrists or psychologists—in our own experience, on the contrary, the major burden of managing these patients lies on us. Even when patients are undergoing cognitive-behavioral therapy, it is our waiting rooms they will haunt when they feel unwell; the research literature tends to leave us in the lurch.

If there is as yet no clear evidence-based treatment strategy for the practitioner at the point of first impact, what approach can he or she use? Fortunately many accomplished clinicians have published their advice,[3–5] and drawing on their experience as well my own I would propose

1. Patience. Somatization disorders are deeply rooted, resistant to change, and embedded in destructive and often mutually suspicious physician-patient relationships, so it is essential for the physician to take a long-term perspective about achieving any improvement.
2. Selective referral. Patience and selectivity are particularly important when it comes to referring somatization disorder spectrum patients for psychologically based treatments. In my experience it is generally best, unless you know a patient very well indeed, to reserve referral of these patients to psychiatrists or psychotherapists for the usual indications of subjective psychological distress, not for what is perceived by the physician as excessive somatic concerns. Difficult somatizing patients are not likely to accept psychiatric referral, and the attempt can damage the rapport between the patient and the referring physician to the point of driving the patient away altogether—which may sometimes be the unwittingly desired outcome.
3. "Consultation letter" principles. When somatizing patients do receive and accept a psychiatric referral they frequently return from the consultant with standard recommendations for the referring practitioner that reflect the general concepts listed in Smith's "consultation letter":[6] legitimize the patient's physical symptoms, avoid extensive examinations and unnecessary tests, give appointments at regular intervals, perform repeated brief physical examinations, provide frequent reassurance, and invite the patient to talk about personal issues. Given the wide applicability of these simple principles of management and their reported potential for improving both health outcomes and medical costs,[7,8] educators should try to ensure that they are familiar to all medical graduates.
4. Don't miss depression, which not infrequently manifests as excessive somatic concerns.

5. Consider antidepressants. They may play a useful role even if the patient is not depressed, since selective serotonin reuptake inhibitors and especially tricyclic drugs can be effective for irritable bowel syndrome, migraine, and a variety of undiagnosed pain symptoms, often in doses that would be subtherapeutic for psychiatric indications.[9]
6. Make common cause with your patient. The statement that a strong therapeutic alliance is the key to management of somatizing patients is likely to draw ironic shrugs from primary care practitioners, who are accustomed to trying and awkward relationships with these patients that can verge at times on the reciprocally antagonistic.[10] But a physician who accomplishes the difficult task of transforming his or her relationship with a somatization disorder patient into a collaborative one will find the endeavor highly rewarding in terms of therapeutic results as well as in terms of the reduction in anger and frustration on both sides. A solid alliance means that both sides have accepted the other's good will. Once that has been established, the patient is more likely to accept psychiatric referral and perhaps more likely to benefit from cognitive-behavioral therapy or other psychologically based treatments, if indeed these are still necessary.

The physician him- or herself often needs some cognitive restructuring to make the shift from a conflictual to a collaborative relationship; there is some evidence that this skill can be taught.[11] The chances of success are greatest if the physician takes the patient's symptoms seriously and empathizes with suffering; expresses interest in the patient's life situation and psychological state; inquires directly and non-judgmentally about the possible influence of stress and distress on physical symptoms; refrains from pressing to detect links between psyche and soma and doesn't rush to communicate even those links that seem apparent; provides medications for supportive symptomatic treatment, a concrete sign of caring; and encourages patients to participate actively in treatment decisions.

What are the prospects for cure? The somatization spectrum disorders tend to be chronic and treatment resistant, at least when not secondary to a depressive disorder. In rare instances, however, even deep-rooted somatization disorders can enter prolonged remission. These cases can be instructive, even though our usual therapeutic aim will still remain limited to management, symptom control, and cost containment. The few patients of my own who have achieved what could be called a cure of their somatization disorder had all undergone profoundly life-altering experiences that loosened the grip of their intense focus on bodily functioning. One such experience whose curative effect I have observed has been traditional psychoanalysis—somewhat surprising since depth psychotherapy is often held to be inappropriate and fruitless for most somatizers. Others have included religious conversion, the assumption of caretaking for a family member with severe chronic disease, and in one case the impact of the September 11 terror attacks.

But what, finally, are the risks of inappropriately high somatic concern? Frustration, misery, and wasted resources. And what about the risks of inappropriately *low* somatic concern? This is a disorder that is less present in the diagnostic classifications, and yet it can be much more serious: every physician has seen nonchalant self-neglect lead to severe illness, even death. Perhaps this paradoxical thought can be of some consolation to practitioners struggling to handle their somatization disorder patients on the front lines.

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