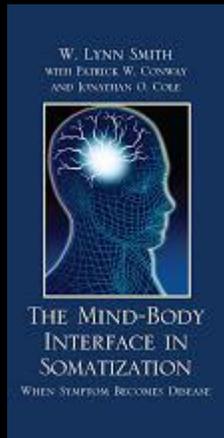


SOMATIZATION AND THE DIFFICULT PATIENT

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DISCLOSURES



The ideas presented here stem from a lively professional collaboration between neuropsychologist and specialist in somatizing syndromes, the late W. Lynn Smith, PhD ABPN and psychiatrist, author, and professor, the late Jonathan O. Cole, MD ABPN, and myself, and are expressed in detail in our shared work, *The Mind-Body Interface in Somatization: When Symptom Becomes Disease*, Jason Aronson Pub. 2009

PURPOSE

- Present a practical approach to thinking about somatization as it presents in the primary care office
 - Facilitate better understanding of how and why somatization functions as it does
 - Promote better overall patient-doctor relationships
 - Improve patient management
 - Reduce clinician burnout

GOALS

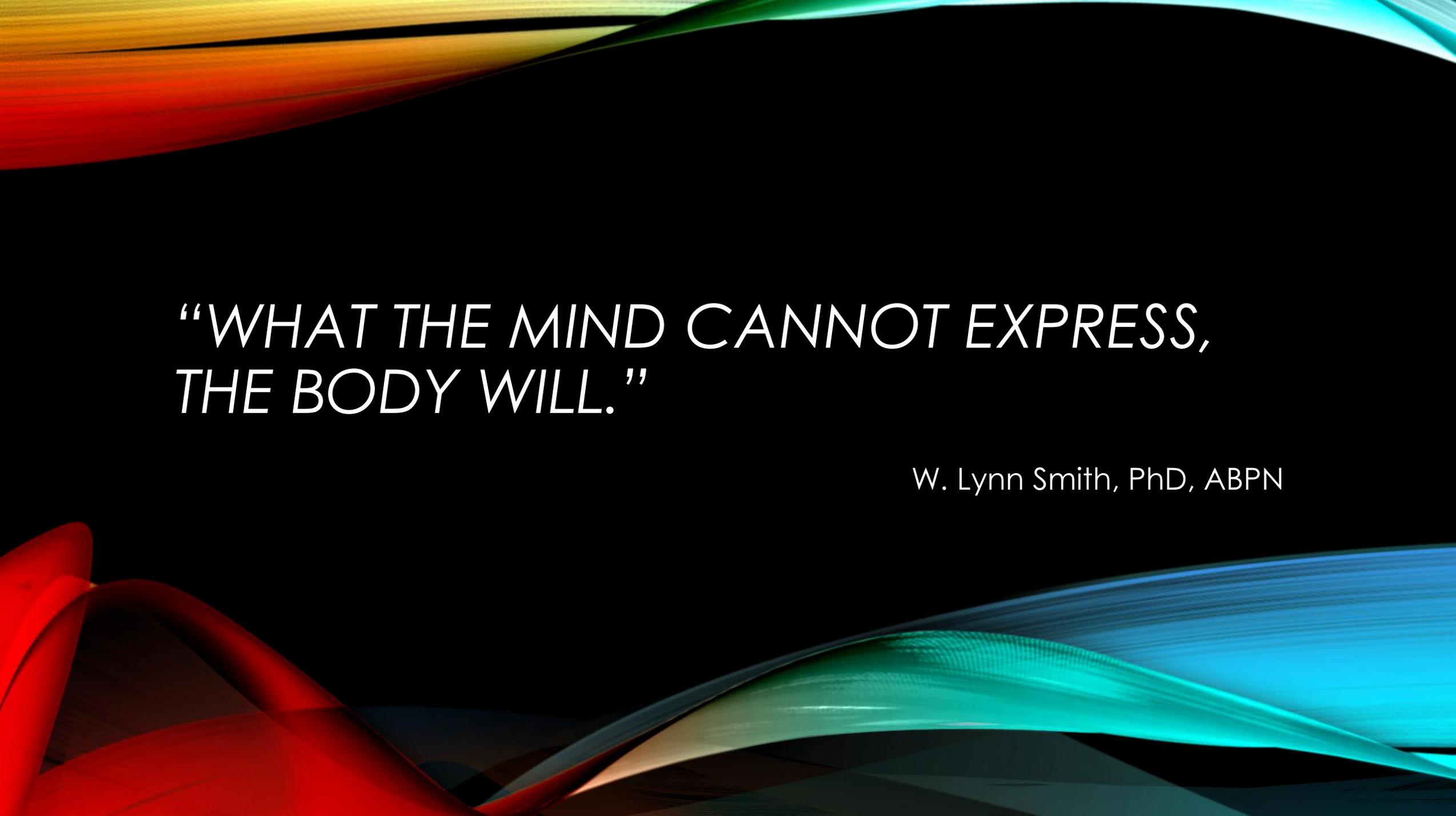
- At the end of this presentation be able to:
 - Distinguish between “chronic” and “situational” subtypes of somatization
 - Explain underlying problems associated with each subtype
 - Identify personality types more likely to present with somatization
 - Identify the appropriate interventions for each subtype
 - Verbalize one’s own presumptions and predispositions about working with this patient population

WHY THE “DIFFICULT” PATIENT?

- Prevalence of somatization in primary care as high as 49% internationally (1).
- Associated with high cost of care and disability (2).
- Is underdiagnosed and undertreated. Why?
- Difficult to identify:
 - DSM not specific
 - Diagnosis of exclusion (“diagnosis of last resort”)
- Difficult to treat
 - Time consuming
 - Resistant to psychological intervention
 - Limited training in behavioral medicine
 - Limited evidence of effective treatments
- Difficult to get along with (like most of us from time to time) (3).

WHAT IS SOMATIZATION?

- DSM (Diagnostic and Statistical Manual) category:
 - Somatization Disorder – DSM-IV/TR
 - Somatoform Disorders – DSM-IV/TR
 - Somatic Symptom Disorders – DSM-5
- Psychiatric symptom – e.g. pain associated with depression or PTSD
- Psychological defense – physical symptoms express psychological distress – tension headache, indigestion
- A **process** in which poor ego functioning undergoes somatic displacement → (in most cases) illness as a way of life



*“WHAT THE MIND CANNOT EXPRESS,
THE BODY WILL.”*

W. Lynn Smith, PhD, ABPN

SUBTYPES OF SOMATIZATION

- Chronic Somatization
 - More commonly encountered
 - “Classic” somatizing patient
- Situational Somatization
 - Deficits less obvious
 - Can become chronic if undiagnosed and untreated

CHRONIC SOMATIZATION

- Illness complaints a prominent feature across the lifespan – “always sick”
- Multiple system complaints not unusual
- Core problem: ego-Integrative defect → poor executive functioning
 - Concrete thinking process
 - Reduced capacity for imagination
 - Difficulties in problem solving
 - Alexithymia – inability to describe or differentiate between emotions
 - Interpersonal ambivalence – strained relationships
 - Intrapersonal ambivalence – decompensate under ↑ stress

SITUATIONAL SOMATIZATION

- Generally higher functioning than chronic subtype
- Independent, responsible, conforming to social norms
- Ambivalence more intrapersonal than interpersonal
- Somatization is response to illness perceived as existential threat
- Shame a key factor in promoting and maintaining somatization
- Treatment addressing existential threat/crisis is most helpful intervention

AMBIVALENCE AND PROGRESSIVE DISORGANIZATION

- Somatizing patients are “inherently ambivalent. Their physical symptoms function as an ego-integrative principle and defense against intrapersonal disorganization...somatization maintain(s) the appearance of ego integrity.” (4)
- Intrapersonal ambivalence & progressive disorganization are critical to understanding somatization
 - Chronic -- ambivalent about life and being overwhelmed by its demands
 - Situational -- ambivalent about losing ability to function
 - Chronic – needs progressive disorganization to make somatization possible
 - Situational – progressive disorganization is a constant threat
- Chronic – dependency needs are readily apparent (though often denied)
- Situational – “look better” than they actually are; functionality is fragile

AMBIVALENCE & THE CLINICIAN

- Ambivalence mainly interpersonal
- Physician (nurse, PA) grows to resent patient's "refusal to get well," insistence their symptoms are physiological, and apparent rejection of physician's advice and expertise
 - Predictable, very normal response
 - Working with somatizing patients requires self-awareness
 - Consult with psychiatry/clinical psychology, refer patient if necessary
- Uncertainty about mind-body interface (mirrors patient ambivalence)
 - Scientific method based on mind-body split (René Descartes)
 - Countered by well-documented placebo effect and neural plasticity in psychotherapy (5, 6)

WHO USES SOMATIZATION?

- Establishing a “somatizing personality type” has been elusive
- Personality traits
 - Masochism (harm avoidance – “George McFly”), guilt, hostility, dependence, anger, associated with somatization (7, 8)
- Personality Disorders
 - Frequently diagnosed with comorbid somatization/somatiform disorders (9)
 - Borderline, histrionic
 - Common developmental problems noted between personality disordered and somatizing populations, e.g. anxious attachment

WHO USES SOMATIZATION?

Interpersonal Theory of Personality – four “types” more prone to somatize

- Hyper-normal – responsible, independent, strong sense of duty, intolerant of weakness, laziness, dependency within themselves – “flight into health” (situational)
- Dependent – compliant, friendly, hopes others will take the lead – anxiety avoidant (chronic)
- Overly Conventional – pleasant, “nice,” cooperative – rarely acknowledged rage lies beneath the façade (chronic)
- Managerial-Autocratic – energetic, independent, competent, achievement-oriented – unexpressed dependency needs drive somatization (situational)

COMMON ELEMENTS

- Between all four types
 - Tremendous fear of disowned/unconscious traits
 - Even greater fear that exposing those traits will lead to progressive disorganization – loss of functioning, social standing, the “end of the world”
 - Tend to be suspicious, skeptical, distrusting (paranoid) in the examination room
 - Resistant to discussing the “meaning” of their symptoms
 - Difficult to work with because of the demands they place on the clinician

IDENTIFYING THE “FOUR HORSEPERSONS”

- Listen
- Observe
- Look for the disparities between what is said and what you observe
- Trust your impressions – don't trick yourself into thinking you're being “fair” when you're really just in denial. Beneath your patient's nice, socially acceptable facial expression there really is a blow torch waiting to be set off. So, be careful, Tread softly.

AVOIDING IMPASSE RESISTANCE

- Patient's stated goal ("get well, get rid of this pain, find a cure") is not their true intention
- Patient's true intention is revealed by their behavior
- Example:
 - You initiate treatment with new med to reduce symptoms and two days later, pt calls, saying they can't tolerate the side effects. You change meds, augment, etc. and at their next visit, they report no change. Pattern may continue until both doctor and patient are frustrated. Why?
 - We presume they want to be "well"
 - They want something very different
 - Oops

AVOIDING IMPASSE RESISTANCE II

- Focus on patient's real intention:
 - “We don't yet know the cause of your symptoms, but there are some things we can do to genuinely help you”
 - Stress importance of coping skills, tracking symptom severity, and working as a team (helps fulfill patient's strong dependency needs)
 - Urge Cognitive-Behavioral Therapy or Dialectical Behavior Therapy – employing the mind to control anxiety (both support ego functioning)
 - Acknowledge, support and do not question patient's illness beliefs (allow somatization to persist)
 - Regularly spaced follow-up appointments (supports ego functioning and meets dependency need)

CHRONIC SOMATIZER IN TREATMENT

- Focus on symptom management, anxiety reduction, improved coping, decreasing interpersonal conflict with family members
- Cognitive-Behavioral Therapy – well documented; employs psychoeducation; focuses on correcting distorted, unrealistic thinking (“Nobody cares how badly I’m suffering”); short-term with tune-up appointments (helps manage interpersonal ambivalence)
- Dialectical Behavior Therapy – well documented; employs group skills training with 1:1 follow-up; skills related to mindfulness, problem-solving, distress tolerance, emotion management (perfect for somatizers to shore up frontal lobe/ego functioning). Big problem? Finding a group! Start one!
- OMM – underdeveloped, under-researched, and underdocumented but very viable treatment option

TREATMENT OF SITUATIONAL SOMATIZATION

- Treatment of choice – Short-Term Existential Psychotherapy
- Why? Because situational arises in response to existential threat
- Just as clinician avoids directly disturbing somatization in chronic subtype, so here: we sidestep somatization in favor of addressing the existential crisis and in the process, the somatization resolves
- Avoids anxiety associated with addressing somatization
- Time limits reduce anxiety associated with interpersonal ambivalence
- Why not CBT/DBT? Because those models are geared toward maintaining somatization as ego support

PSYCHOPHARMACOLOGY

“We seem to be uncertain about identifying what constitutes diagnosable somatization and tend to fall back onto somatic complaints associated with other psychiatric disorders or functional somatic syndromes...Because we aren't certain how to identify and classify the “pure” somatizers, s/he gets relegated to the periphery. Yet, ironically, this is generally the type of patient commonly seen in the primary care setting.”

Jonathan O. Cole, MD

Nosological uncertainty underlies much of the ambivalence about initiating psychopharmacologic treatment.

PSYCHOPHARMACOLOGY, CONT.

- Antidepressants useful for depressive, anxious, or obsessive-compulsive features.
- Some limited evidence for mood stabilizing meds – carbamazepine, gabapentin
- Benzodiazepines problematic b/o high incidence of personality disorders and the potential for abuse
- Antipsychotic evidence very limited – problems with metabolic syndrome, liability, off label use.
 - Olanzapine low dose – better overall functioning – “ego glue.”
 - Preliminary evidence for SSRI augmentation with aripiprazole for treatment-resistant somatoform disorder (11)

PRINCIPLES FOR DRUG TREATMENT

- Polypharmacy is common -- multiple providers coupled with patients who think concretely: take multiple meds “because the doctor told me to” – drug holiday can be helpful.
- Begin with an SSRI
- No response? Go to second SSRI or SNRI
- Poor response? Augment with antipsychotic or mood stabilizer
- Also be mindful of their need to continue somatization
- Strive to maintain stable doctor-patient relationship

SUMMARY

- Key difficulties in obtaining effective treatment for somatizing patients include:
 - Lack of resources
 - Limited access to resources that exist
 - Clinicians and patients operating from a different set of expectations
 - Failure of doctor to empathetically comprehend the importance of somatization in the life of a vulnerable patient
 - Resistance to including somatization early in the differential diagnosis



DON'T FORGET!

*“What the mind Cannot Express,
The Body will.”*



THANK YOU!

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