VII. Study unit: Psychotherapy of somatization

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Aim:

Psychotherapeutic skills are necessary for guiding somatizing patients.
By acquiring the knowledge introduced in this chapter, you will be better able to employ those psychotherapeutic techniques, which are extensively used for the management of somatic complaints that have no organic causes behind them.

Introduction

Introduction

In this chapter you will become familiar with some non-pharmacological treatment methods, with which somatizational complaints (suffering caused by somatic complaints that have no organic causes behind them) and health anxiety can be treated even in general medical practice.

Target group: General practitioners and medical students

Suggested study methods:

Important

Read the texts together with the dialogues linked to them.
Following this, answer the comprehension questions.
If you were not able to answer all the questions, survey the problematic parts in the texts again.
Finally do the self-check tests.

We recommend to survey the study material in two separate parts:

VII./1 – VII./2.1 in one go, then
VII./2.2 and VII./3 in also one go.

Recommended Reading:

Literature

Mayou R, Farmer A (2002). ABC of psychological medicine. Functional somatic symptoms and syndromes. BMJ 325;265-268

Content of Chapter:

VII./1.: Clinical characteristics
- VII./1.1.: Symptoms
- VII./1.2.: Additional symptoms and behaviours
- VII./1.3.: Prevalence, clinical significance
- VII./1.4.: Connection between somatization and hypochondriasis

VII./2.: Therapy of somatization
- VII./.2.1. Psycho-education, non-specific interventions of psychotherapeutic effect
  - VII./2.1.1.: A communication that renders the mental background of somatic complaints acceptable right from the beginning of the examinations
  - VII./2.1.2.: Reassurance and the explanation of the results of the examinations
  - VII./2.1.3.: Other non-specific and complementary methods

	VII./2.2 Specific psychotherapeutic interventions VII./2.2.1 Cognitive behavioural therapeutic model of somatization VII./2.2.2 Bulding up therapy VII./2.2.2.1 Developing symptom- and behaviour monitoring VII./2.2.2.2 Restructuring catastrophizing thinking VII./2.2.2.3. Gradual decrease of daily preoccupation with symptoms and seeking of reassurance, and the development of an active health behaviour and lifestyle instead VII./2.2.2.4. Stress management and a plan for treating everyday difficulties **VII./3 Efficacy**

Important	**VII./1.: Clinical characteristics** The phenomenon of somatization is described by the current diagnostic systems (BNO X, DSM IV) in the form of a number of different disorders (Chronic pain disorder, somatoform vegetative dysfunction, somatizational disorder, irritable bowel syndrome, etc.), and the terminology itself is not self-consistent in the current medical practice. In connection with the forthcoming reformation of diagnostic systems, the simplification of categories is to be expected in the near future, and somatization presumably becomes a generic term for the multidimensional symptoms discussed in the chapter. **VII./*1.1.: Symptoms*** ▪ The subject matter of somatization comprises those chronic somatic complaints (pains, discomfort, vegetative functional disorders) **that have no somatic illnesses or functional disorder behind them**, or even if there is an existent organic problem or lesion, that in itself does not justify the gravity of the complaint. ▪ The complaints **cause such suffering and functional disorder** to the patient, **as if he indeed had severe somatic lesions**. ▪ Patients **do not simulate**, they are neither able to induce, nor able to reduce their symptoms voluntarily. They are much rather characterized by **a total helplessness as far as the symptoms are concerned**. ▪ **In the background** of the complaints **psychosocial factors** may be revealed. Such factors may be: traumas (e.g. abuse suffered in childhood or in the current life situation); the dissolution of the balance of stress and coping; cognitive factors: beliefs and perception regarding the complaints and illnesses; as well as the so-called illness behaviour – all those behaviours which have evolved in connection with the complaints (e.g. the constant seeking and watching of symptoms), and – partly – serve the overcoming of the complaints. ***VII./1.2.: Additional symptoms and behaviours***

Important

Question: What additional behaviours are associated with somatizational complaints?

- **Increased self-monitoring**, watching and seeking of somatic symptoms
- **Worries on account of the somatic symptoms** and their (presumed) consequences
- Developing an **increasingly passive lifestyle** – the loss of importance and abandonment of everyday activities, while the patient spends more and more time with his illness (gathers information, sees doctors, buries himself in books and the Internet, keeps a close watch on himself, seeks alternative therapies)
- Insufficiency of the skills serving the treatment of **everyday stress**

VII./1.3.: Prevalence, clinical significance

Somatization is a prevalent illness. In a family physician based survey 22.1% of the patients met the criteria of somatizational disorder. Other communal surveys specify the prevalence of the different somatization-like complaints at 6-36%, only a small percentage of which becomes specifically diagnosed. Somatizational disorder has for a long time been surrounded by relatively little attention in epidemiology and in therapeutic research, in spite of the fact that we are talking about such an everyday problem that constantly burdens numerous areas of the medical practise (family medicine, internal medicine, neurology).

VII./1.4.: Connection between somatization and hypochondriasis

Important

There is a strong connection between somatization and hypochondriasis (healthy anxiety disorder). While, however, in most somatizational disorders the somatic symptoms causing concrete suffering are the ones which dominate (*"I don't know what the nature of my affliction is, but I suffer so much …"*), in the case of hypochondriasis the chief source of subjective suffering is the fear of the existence or the development of some dangerous disease (*"I'm afraid, I've got cancer…"*). The hypochondriac consults a physician primarily because he needs to be assured that he has got no severe disease. In the case of somatization, patients, besides seeking reassurance, are looking for a solution for their somatic complaints as well. On account of all these, the didactic separation of somatization and hypochondria, as outlined above, is generally hard to realize in practice.

VII./2: The therapy of somatization

Basic principles of the therapy of somatization

1. The **treatment of** possible **comorbid illnesses** –somatisation complaints often connected to real somatic conditions, but these do not justify the intensity of the complaints and the degree of the subjective suffering (e.g. an adequately treated hypertension the gravity of the headache, or an insignificant vertebral calcification the severe lower lumbar pains). Depression and certain anxiety disorders (e.g. panic disorder) are also prevalent comorbid diseases. With somatizing patients their symptoms should always be looked for, and in the case of their existence, they should be treated according to the appropriate treatment guidelines of these

conditions.

Important

2. Psycho-education, **non-specific interventions of psychotherapeutic effect**

3. **Cognitive behavioural therapy**

4. **Additional treatments**. In somatizational disorders concomitant with pain, for the sake of avoiding medicine abuse, medicinal pain relief applied with strict control and a time limit, as well as dietary and lifestyle counselling.

VII./2.1 Psycho-education, non-specific interventions of psychotherapeutic effect

Summary

1. Communication that renders the possible contribution of psychological factors (e.g. stress) in the somatic complaints acceptable right from the very beginning of the diagnostic procedure

2. Reassurance and the explanation of the results of the examinations

3. Other non-specific and complementary methods

VII./2.1.1. A communication that renders the contribution of psychological factors in somatic complaints acceptable right from the beginning of the examinations

Question

How to communicate in the course of the examination of patients in whose cases the doubt of somatizing arises?

We emphasize to the patient right from the beginning of the examination that his complaints are not necessarily connected to somatic diseases, and it is possible that we will not find anything during the examination, for just as the complaints may be connected both to diseases and to the somatic signs of psychological processes such as stress.

We emphasize that **somatic complaints without a somatic lesion are common occurrences**, and are typical not only for psychologically problematic people. We also emphasize that body and soul are inseparable from each other, and taking the psychological factors into account is a natural part of medical practise.

In the individual steps of the examination, we should explain what the purpose of the examination is, and if possible, we should appraise **the approximate probability of finding organic cause.**

VII./2.1.2. Reassurance and the explanation of the results of the examinations

After the examination (if the diagnosis of somatization is confirmed) we emphasize that not finding organic lesion in the background of the complaints, is a **common, and well-known** occurrence.

We should avoid using the reassuring formula: "you've got no serious problem", since for the patient the complaints are real, and cause him suffering.

Summary

It is very important to **explain to him using commonplace examples, how the somatic occurrences might be connected with psychological ones** (e.g. idioms of the standard language: *"fear gripped his heart", ""he is a pain in my neck", "he had his heart in his mouth ", "it hurts me so much that you said that"*) and the stress! The exploration of the patient's own related experiences (does he usually have diarrhoea before exams; is he aware of the somatic signs of nervousness) is also very useful.

Deliberating on the connection with stress is particularly important, for the treatment of stress is an important step towards overcoming the complaints.

VII./2.1.3. Other non-specific additional methods

The complaints of a large number of patients will not cease just from the reassurance, and in the first round, the deployment of many aspecific techniques may be successful. These are the following:

A. **Discussing the patient's fears**. Simple reassurance is often insufficient, for many fears feed on misunderstandings or misconceptions (e.g. "MRI examinations are performed when cancer is suspected"). Anxiety is often indissoluble even by adequately informing the patient; in such cases the application of cognitive therapeutic techniques may be necessary.

B. Supporting the patient in gradually **returning to his usual everyday activities**. Its aim is the gradual reduction of patient behaviour.

C. **Support in managing the everyday difficulties** of the patient, even with the involvement of a relative. Its aim is to facilitate the problem-solving of situations causing everyday tension.

D. **Teaching stress-management skills**. It is generally characteristic of patients suffering from somatizational disorders that they have poor stress managing skills, thus the development of these may, in the longer term, help patients in solving situations causing everyday tension.

E. **Learning relaxations**. Besides being an excellent routine stress treating method, relaxation also helps controlling the complaints connected to the vegetative nervous system. Nevertheless, teaching relaxation as a single intervention is insufficient for the treatment of somatization, in most cases,.

F. In many cases **a physiotherapist and/or a nutritionist** needs to be involved and by their assistance a personal physical exercise and dietary programme needs to be developed. Its aim is partly to directly decrease complaints (physiotherapy in the case of locomotor complaints, and a diet in the case of an irritable bowel syndrome), and partly to turn thinking from being illness-centred into being health-centred, that is the replacement of activities continuously trying to seek and control symptoms with health developing activities.

G. As an additional treatment, especially in cases concomitant with chronic pain or depression, the employment of antidepressants, as pharmacotherapy, may be of great help. At the same time, it is important to mention that although antidepressants improve moods and pain symptoms efficiently, they do not, in themselves, change the way of thinking and the

Important	complex patient behaviour associated with somatization. ## VII./2.2 Specific psychotherapeutic interventions ### *VII./2.2.1 Cognitive behavioural therapeutic model of somatization* The cognitive behavioural therapeutic model of somatization has been summarized in Figure 1. P_1_figure_VII_2_2_chapter See at the Appendixes of the paper!
Summary	The common determinants of somatization disorders are the following: 1. Anxious thoughts about the symptoms occur; the dangerous or humiliating nature of the symptoms are overrated (**catastrophization**) 2. For this reason **the patient gets more and more preoccupied with his symptoms, he continuously monitors himself, and neglects other areas of life** (amusement, leisure time activities, certain work areas) or subordinates them to the illness. On account of this, the patient gets more and more isolated, and his social successfulness decreases. 3. On account of the increased attention and the anxieties, the **threshold of pain and the threshold of stimulus connected to body perception lowers.**
Task Describe the cognitive model of somatization.	4. **On account of the lowering of the threshold of stimulus, pain and other symptoms strengthen subjectively,** and this further increases the anxieties and the chatastrophizing thinking. And this again further strengthens the self-destructive circle of catastrophization – self-monitoring – further lowering of the threshold of stimulus and strengthening of symptoms. 5. **Reassurance-seeking behaviour**. The patients are anxious that their complaints are the signs of some serious disease, and they see doctors partly because they seek reassurance. But since the complaints exist independently of the examinations (on account of the model detailed in the first 4 points), the value of the reassurances continuously decreases, and a distrust related to the health system ("they cannot diagnose my problem…") may evolve in the end.
Summary	The majority of somatization disorders start with a disease concomitant with a specific, real somatic condition (e.g. the irritable bowel syndrome starts with an acute enteral infection, and the pain disorders start with a condition concomitant with some real – mostly minor injury –related - nociceptive pain), with the progress of time, however, the original problem usually heals, but the symptoms remain. This is because sooner or later anxious thoughts associate with the symptoms, and the above detailed self-destructive circle gets going. **The aims of psychotherapy:** - elimination of the preoccupation with symptoms - through the reduction of catastrophizing thinking, the reduction of

	anxieties connected to the symptomsTurning the disease-centred thinking into a health-centred thinking: i.e. instead of the continuous searching for symptoms, the realization of positive health-behaviour (e.g. healthy lifestyle). ***VII./2.2.2 Building up the therapy***
Summary	The first and most important task is a communication that renders the pyshcological background of somatic complaints acceptable right from the first contact with the patient (see VII.2.1.1), and all those specific interventions, which have been detailed in the subchapter VII.2.1.3. Further specific steps can be read below, but it is important, however, that point No.2 (dealing with thinking) often has to be started at the very beginning of the therapy, because, since patients at first do not really believe that their complaints are of somatic origin, they are reluctant to accept a psychological approach. 1. Establishing symptom- and behaviour monitoring 2. Restructuring catastrophizing thinking 3. Gradual decrease of the daily length of time the patient is preoccupied by his symptoms and by reassurance-seeking; developing an active health-behaviour and an everyday lifestyle instead 4. Teaching stress management skills
Important	**VII./2.2.2.1 Developing symptom and behaviour monitoring** Its aim is to turn subjective experiences into objective data, the monitoring of therapeutic progress, and the objective verification of the following: - the time spent on the symptoms and the intensity of the symptoms are interdependent - on days spent more actively and with other activities, the symptoms are less intense - in connection with the stress situations the symptoms intensify In Figure 2. we show a diary-outline (P_2_figure_VII_2_2_chapter See at the Appendixes of the paper!), but it is much more useful, if the symptom-diary we develop for our patient, is personally and therapeutically tailored. **VII./2.2.2.2 Restructuring catastrophizing thinking** Patients in the beginning are reluctant to accept their complaints to be treated by psychological methods, and they often presume that doctors do not take them seriously. **As a first step of the establishment of the therapeutic alliance, we express that we accept and understand the patient's complaints.** This maybe attained in the following way: - We listen attentively to the patient; **we try not to interrupt him.** By doing this, we express that we take his complaints seriously. - **We emphasize** that these **symptoms** are indeed **real** (it is not the patient "getting it into his head") and **prevalent** too, and we also emphasize that we are fully aware what great suffering this type of symptoms may cause.

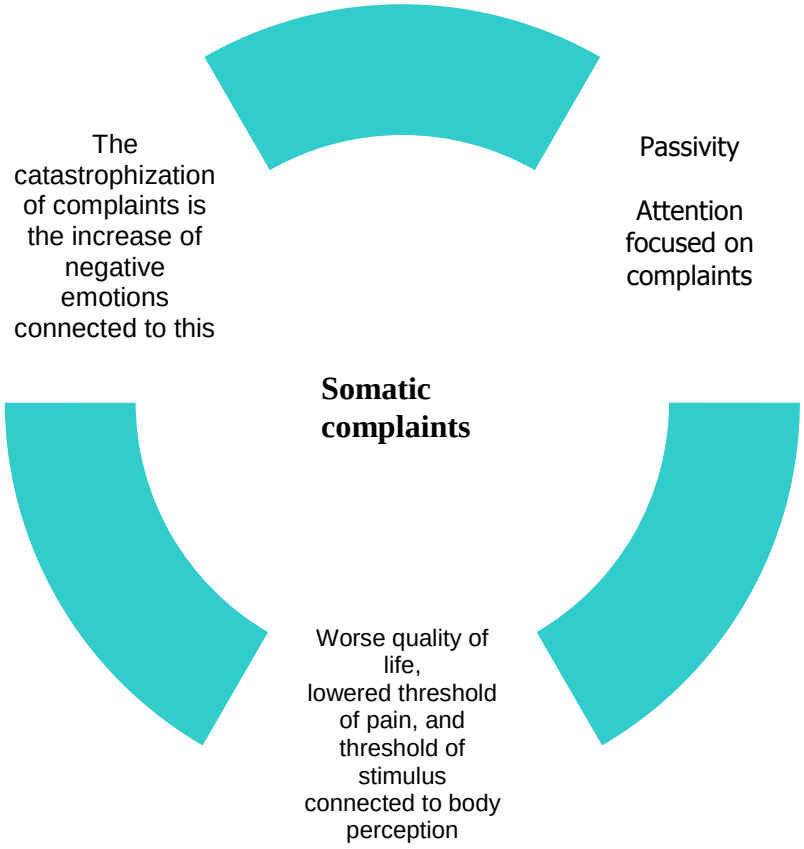
Summary History	- **We carefully read through the earlier examination results**, even if we feel they do not influence our opinion**.** - We question **the patient about his own ideas** of his illness. In supplement 2. (P_2_supplement_VII_2_2_chapter) we have summarized the fields the knowledge of which helps us most in getting acquainted with the patient's own conceptions. As a second step we attempt to **get the patient to accept (partly at least) that his conceptions of his complaints not necessarily correspond to the facts, and that psychological factors might also stand in the background.** Here, in the course of the questioning, we attempt to reveal three areas: ▪ How the duration of the complaints relate to the disease feared by the patient. ▪ What happens differently in those periods of time when the symptoms are worse and in those when they are more tolerable. ▪ How everyday stress and nervousness affect the symptoms. The method of Socratic questioning can be of help in this as well. (P_3_supplement_VII_2_2_chapter) *Supplement 3. An example of the Socratic questioning in somatization See at the Appendixes of the paper!* With the help of the above methods a majority of the patients accept that, at least partially, psychological, life-situational factors may also play a role in the remission and relapse of complaints, and they are open to further cooperation. A minority of the patients, however, cannot be involved in this way, and in this case **the method of "two theories"** may be employed. In such a case we suggest that there are two theories explaining the complaints: one of them is the theory of the patient, according to which some somatic disease causes the complaints, and the other is of the therapist, according to whom psychological factors are much more determinant of the complaints than a contingent somatic disease is. We further suggest that we do not wish to persuade the patient of our own truth, rather we propose that while we are trying to ameliorate the symptoms, we should examine together which theory is supported by which evidence and which evidence points in the other direction; and we should also examine what kind of joint theory may be developed. Subsequent to this we ask the patient to keep a diary. After a week of keeping a diary we explain to the patient with the help of the diary the self-destructive circle of self-observation and the cognitive model of the complaints (Figure 1). P_1_figure_VII_2_2_chapter. See at the Appendixes of the paper! Patients do not necessarily accept the model merely on the basis of the diary; they often treat it as a hypothesis, which needs further verification. We may encourage patients, who, in connection with their complaints, have become experienced in gathering information on health issues (e.g. from the Internet), to google with the keywords somatization and health anxiety as well. The first step in the restructuring of catastrophizing thinking is that through discussing a specific real-life situation with the method of Socratic questioning we demonstrate that the feelings connected to the situations are not determined by the situations themselves, but by the thinking connected to the situations. In the next step we collect those anxious thoughts of the patient which are related to his

Link By throwing light upon the connection between somatic complaints and stress. Summary	complaints. Subsequent to this, we may employ many tools in the restructuring process. We may use the method of standard questions – a version of this, which has been modified for somatization and health anxiety, can be found in Figure 2. P_2_figure_VII_2_2_chapter See at the Appendixes of the paper! We may delineate with the help of a pie chart which factors and in what proportions may cause the actual complaints. With health anxiety we may also employ the five column method, which is presented in Supplement 4. P_4. supplement : *The five column method* **VII/.2.2.2.3. Gradual decrease of daily preoccupation with symptoms and seeking of reassurance, and the development of an active health behaviour and way of living instead** With the help of the diary we make the patient assess, which have been the least useful illness-controlling activities for him during the past week (e.g. reading through the same patient information leaflet repeatedly on the Internet, etc.). We urge the patient to abandon these and ask him to replace these with some other active activity which he deems important, but which should not be anything connected to the illness. Patients are often unwilling regarding this also, thus at first we may ask them to take part in a behavioural experiment: for a day they should behave as if they were healthy and check how this affects the perception of their complaints. It is very important that we plan the whole day in advance together with the patient, setting up particular items in the daily agenda. If we do not structure this "test day" in advance, the experiment often ends in failure. It may be an extra assignment for the patient to seek literature not about diseases but about the promotion of health, and report the next time on what he has read. We should try from meeting to meeting to decrease the length of time spent with the symptoms, and in the meantime attempt the restoration of the patient's everyday conduct of life. In the beginning it is worth strengthening those activities, which engross the patient's attention (e.g. being together with others), for in the case of the more passive activities (reading, watching television, browsing the Internet) thoughts associated with the illness may automatically return. **VII./2.2.2.4. Stress management and a plan for handling everyday difficulties** Analyzing with the method of Socratic questioning the relationship between the specific, recently experienced stress situations and the complaints may be of help for the patient in accepting the psychological background of the complaints. In the treatment of everyday difficulties we may employ the method of the gradual approach. We ask the patient to draw up a list of the everyday problems he needs to cope with. Subsequent to this we analyse for each problem the steps leading to a solution. Then we encourage the patient to break up the solutions to the problems into short-term (1 week – 1 month), manageable steps with sub-aims. Then we ask the patient to think over by means of what concrete steps he thinks the sub-aims can be solved. It is important for us to ask what outside help (e.g. of a relative or a friend) the patient is able to mobilize for reaching his aims. The general tools of stress-management have already been detailed in the chapter about insomnia; in the following we briefly list them again: - Developing a regular exercise programme

	- Sharing problems with relatives - The method of constructive anxiety: In a fixed point of time of the day, the patient is to include, as a regular daytime activity, a 10-20 minute period, when he thinks his problems over, and writes down what he may do in order to solve them the next day, in a week, in a month, etc. If he experiences anxious thoughts in a different period of the day, but especially in the evening, before falling asleep, he should write them down on a piece of paper, and the next day he should deal with them in the same period of time. - Other stress reducing methods (relaxation and cognitive restructuring) ## VII./3 Efficacy On the basis of a systematic survey of efficacy analyses done within the domain of somatization it may be contended that cognitive behavioural therapy is one of the most efficient treatment methods of complaints. In the course of the survey, Raine and his colleagues examined 61 randomized and controlled investigations, in which they found the cognitive behavioural therapeutic methods to be efficient not only in psychotherapeutic specialist consultations, but also when integrated into basic health care and other specialist consultations.

Appendix

Figure 1. The cognitive model of somatization



The most frequent items used in sleep log

Date 2014 ../..:	Time of going to bed and of getting up the next day	Total sleep time	Total time spent in bed (including periods spent awake in bed):	What did you do when trying to fall asleep? if you have taken some medicine or some curative substance, please, record it here.	What happened during the day that may make falling asleep difficult?	Number of night awakenings (estimated)	Sleep loss effects, daytime energy level 5: fully relaxed 1: so sleepy that you are not able to work	Have you manage yo loss? If ye
.../../Monday	…h…m …h…m							
../../Tuesday	…h…m …h…m							
../../Wednesday	…h…m …h…m							
../../Thursday	…h…m …h…m							
../../Friday	…h…m …h…m							
../../Saturday	…h…m …h…m							
../../Sunday	…h…m …h…m							

Supplement 3.

An example of the Socratic questioning in somatization

Therapist:
You told me that because of your abdominal pains you've been seeing a doctor for at least four years.

Patient:
Yes, that's right.

Therapist:
If I remember well, it has also occurred to you that you might have a cancer of the liver…

Patient:
Yes, that's right. I can't get that out of my mind.

Therapist:
Is there anything that might support your belief that you have cancer of the liver?

Patient:
My uncle died of it, and his symptoms began very similarly. He went from doctor to doctor, and no-one found anything. Then he turned yellow, and then very soon he was done for…

Therapist:
That must have been very dreadful for you too. How long was the period when your uncle was seeing doctor after doctor, but nothing was found? Before he turned yellow…

Patient:
It lasted a long time.

Therapist:
Could you tell me the timescale more exactly.?

Patient:
Yes, let me see… he started to complain about his stomach just after the summer vacation… yes, first they thought he had eaten something… by Christmas he was already yellow, and he died in March.

Therapist:
So from the beginning of the complaints approximately half a year had passed?

Patient:
Yes.

Therapist:
Have you perhaps heard about how speedily a cancer of the liver develops or grows worse generally?

Patient:
I've read quite a lot about this. I've heard that from the beginning of the complaints it is only a few months.

Therapist:
And seeing it from this prospective, how does the fact that you've been having complaints for 4 years support your presumption of having a cancer of the liver?

Patient:
Well, this is against it, indeed…

Supplement 3

An example of the Socratic questioning

Therapist:
In which period of the day, do you think, sleeping is most useful?

Patient:
I've heard that the sleep before midnight is the most useful. It's dreadful, 'cause the most I sleep is a couple of hours around dawn…

Therapist:
What is so dreadful for you in this situation?

Patient:
That sooner or later I'll be done for if I cannot fall asleep before midnight.

Therapist:
Yeah, this thing about "beauty sleep" or the usefulness of the sleep before midnight has been a very popular notion; one could even read about it even in old specialized textbooks… Let's see how true it may be on the basis of your experiences so far. Do you know, or have you heard, about any person, who does not fall asleep before midnight?

Patient:
My husband, for example. I don't quite understand how he can take it.

Therapist:
Do you know anybody else? Let's try to gather as many persons like that from your environment as possible…

Patient:
Well, my father was also like that… and my colleague is always grumbling that her son plays on the computer the whole night …

Therapist:
And do these people have any problems?

Patient:
No, nothing. My husband is as fit as a fiddle. Moreover, if he falls asleep, one cannot wake him up even with gunshots.

Therapist:
This a very important issue, we'll come back to it, because it is no accident (we'll come back to it at the education about the biorhythm). If the sleep before midnight is so important, why, do you think, these people don't have any problems? How long has your husband been sleeping like this?

Patient:
Since I've known him, for at least 20 years. I don't know why they don't have any problems because of it.

Therapist:
If we consider these relatives of you for instance, how important, do you think, the sleep before midnight is?

Patient:
Well, if we consider only this, perhaps it is not that important, after all…

Psychotherapeutic techniques – behavioural experiments

Therapist:
Last time we mentioned that it would be better if you didn't keep looking at your watch before falling asleep. Have you tried it?

Patient:
Yes.

Therapist:
And what effect did you experience?

Patient:
Well, I don't know, really… I slept better, after all… perhaps…

Therapist:
Let's see, in these evenings, when you tried, how much did you score for evening tension in the sleeping diary.

Patient:
Last week I scored 2 or 3 points.

Therapist:
Now let's see the diary entries for the previous week, when you didn't have this rule that you should not keep looking at your watch.

Patient:
4 or 5 points. I scored 3 only once.

Therapist:
Can this be the effect of this technique? How, do you think, it may affect your level of tension if you keep checking your watch every half hour, and you see: "It's 10 o'clock, and I'm not sleeping, it's half past 10 and I'm still not sleeping," etc.?

Patient:
It makes me nervous.

Therapist:
And how does nervousness influence falling asleep?