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Somatoform and dissociative disorders: assessment and treatment

David Gill & Christopher Bass

The category 'somatoform disorders' was introduced comparatively recently in DSM–III and thereafter in ICD–10: it is the umbrella term currently favoured to cover a heterogeneous group of interrelated and overlapping syndromes, which have been given many names over the years. All these syndromes have in common the process of somatisation: that is, the presence of physical symptoms unexplained by physical disease, with variable degrees of distress and loss of function, about which the patient consults doctors.

Somatisation disorder, formerly known as Briquet's syndrome (St Louis hysteria) comprises 13 or more lifetime somatic complaints causing consultation with a doctor. The patient usually presents with specific symptoms, rather than (as in hypochondriasis) a fear of having a specific disease. Undifferentiated somatoform disorder, consisting of multiple, varying and persistent physical complaints, but not fulfilling the complete, severe picture of somatisation disorder, is thought to be 100 times more common.

Hypochondriasis is a persistent preoccupation with the possibility of having one or more serious and progressive physical disorder. The preoccupation persists despite appropriate medical evaluation and reassurance.

Persistent somatoform pain disorder (chronic pain) is characterised by persistent, severe and distressing pain, which cannot be explained fully by a physiological process or a physical disorder. Psychological factors are judged to have an important role in the onset, severity, exacerbation or maintenance of the pain.

Conversion disorder (e.g. a neurology patient with weakness of a limb for which no physical cause can be found; formerly known as hysterical paralysis) and dissociative disorder (e.g. a patient found wandering, with amnesia that turns out to be psychogenic; formerly known as hysterical fugue) are considered together here as conversion–dissociation disorder.

The protean nature of somatoform symptoms ensures that patients are referred to a variety of specialists, who use their own descriptive terms. For example, a chest physician will use the term hyperventilation, a gastroenterologist refers to irritable bowel syndrome, a specialist in infectious diseases encounters chronic fatigue syndrome, and a rheumatologist diagnoses fibromyalgia.

Sometimes the patient's 'choice' of symptom to present is understandable. For example, chronic pelvic pain is associated with a history of having been sexually abused (Walker *et al*, 1995). Frequently, however, the particular complaint seems arbitrary. On enquiry, the patient may have equally severe symptoms in other body systems which could just as well be the subject of past, present or future consultations.

The present article cannot cover all the above disorders, or the difficulties inherent in present classification systems. Rather, we will concentrate on advances of practical importance to the clinical psychiatrist and his or her patients.

General practitioner referrals of somatising patients

The general practitioner (GP) has a vital role in the management of patients with chronic somatoform disorders: for every 'somatiser' who presents in hospital practice, several more can be identified who are being managed entirely in primary care.

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As the 'gatekeeper' the GP has the potential to limit (or not) the patient's access to specialised hospital resources, many of which are not only expensive, but also carry the possibility of iatrogenic harm. What should be the response of the psychiatrist upon the referral of such a patient? (See Box 1.)

Ideally, the GP and psychiatrist will discuss the referral before it takes place. In some cases, the GP will be seeking reassurance that his long-term containment of a chronic problem is appropriate, possibly in the light of increased distress in the patient after a life event. In other cases, the psychiatrist will effectively be sharing the load of caring for a patient who may be among the most difficult on the GP's list.

Discussion of such a referral is also a learning opportunity for both parties. The psychiatrist has the chance of the GP's insights into his or her experience of caring for such patients continuously, with the waxing and waning of the consulting behaviour of these patients through time. In return, the psychiatrist may have an understanding of the process of somatisation, which is extremely common in the general population and accounts for at least 20% of new episodes of illness in primary care. Some resolve spontaneously over a short period of time without consultation or specific treatment, but doctors need skills to recognise these disorders, the ability to discuss the social and interpersonal setting in which the disorder occurs, the ability to restore hope, and the expectancy of improvement (Goldberg, 1992).

These skills include helping the patient to reattribute the somatic symptoms to an emotional rather than a physical cause by reframing the complaints. For example, "You told me that your headache and fatigue [somatic] began nine months ago, but you also mentioned feeling low and miserable, loss of interest and poor concentration [emotional] during that time; furthermore, all these symptoms began soon after you lost your job [link-making]. I wonder whether you have thought about your complaints in that way? [reflect back]" (for further details see Goldberg *et al*, 1989).

Box 1. Referrals from general practitioners

- Offer full assessment with clear, agreed aims
- Review referrals, investigations, treatment to date
- Identify and treat depression, anxiety and other syndromes
- Harm minimisation: avoid unnecessary physician/surgeon referrals
- Specific psychological treatments, if available
- Follow-up – helps share load in chronic patients
- Learning opportunity for psychiatrist and general practitioner

Management in general hospital practice

The referral process

Inevitably, some general hospital colleagues and departments will be more psychologically-minded than others, but in order to receive appropriate referrals, good relations are essential. These can be built up only by providing what is perceived to be a good service over time. Perhaps the single most important point is to promote the consideration of possible referrals at an early stage, rather than after a string of normal investigations and/or failed therapeutic procedures, at the end of which the patient is pronounced to "have nothing wrong with them – they need to see a psychiatrist".

Assessment: the initial interview

Wherever the patient is seen, adequate assessment is the *sine qua non* of management. The first objective of assessment is to gain an understanding of why this particular person became ill in this particular way at this particular time (see Box 2). This cannot always be accomplished in a single interview, since the patient with medically unexplained symptoms may have mixed or even frankly hostile feelings towards the idea of seeing a psychiatrist. Gaining the patient's trust is thus, perhaps even more than usual in psychiatry, the paramount objective of a first assessment interview. The key to this is to make it clear that you accept the patient's symptoms as real, and that you will try to help as best you can in a pragmatic way, which does not at all require the patient to accept a diagnosis of mental illness.

A sensible way to start is by asking the patient what the referring physician has told him or her

Box 2. Objectives in first assessment interview

- Clarify patient's complaints
- Understand what patient wants
- Elicit fears and beliefs about illness
- Exclude organic disease
- Identify relevant psychosocial stressors
- Identify psychiatric disorder

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about the reasons for referral, and then enquire about the patient's attitude towards seeing a psychiatrist, perhaps mentioning that most people would naturally be apprehensive. It is essential to be clear at the outset about whether the patient feels angry at the referral or continues strongly to believe that his or her symptoms are due to a still undiagnosed physical disease (House, 1995). The psychiatrist must take the complaints seriously and dispassionately, neither accepting an exclusively physical cause for them, nor trying to convince the patient that they are "all in the mind".

It is advisable to proceed with the interview in a sequence which begins with physical symptoms and moves on to psychological topics as the interview progresses (see Box 3).

A chronological account of the current complaints is the natural starting point, including the various contacts with the referring physician and other doctors, treatments received (including 'alternative' therapies) and their effects. Then ask about any disability, limitations of activity or avoidance. This allows the patient to talk about any losses, for example in their work or leisure activity, and may provide an opportunity to respond to mood cues.

During this part of the interview, negative interaction with one or more doctors is frequently disclosed. This should be explored, the patient given the opportunity to ventilate, and appropriate empathic statements made. Past illness history includes not only illness in the patient and family, but importantly overlaps with a personal history, enquiring particularly about attitudes to illness in the family during the patient's upbringing (Bass & Murphy, 1995). After these issues have been discussed (and the patient has the right not to talk about them) it is often easier to explore more emotional aspects of the history and to ask about any past episodes of psychological illness.

The interview should end with a mental state examination with particular emphasis on beliefs and attitudes about the symptoms as well as attitudes to the medical profession. Current mood should be assessed, with specific attention paid to vegetative symptoms of depression, panic and anxiety. It is often helpful at this stage to use a rating scale in an attempt to quantify the physical and psychological symptoms. The Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983) and Whitely Index (Pilowsky, 1967) are particularly helpful.

Assessment may take more than one appointment. The interviewer should try to produce a formulation, distinguishing between predisposing, precipitating and perpetuating factors. Management must focus on the last, which may include disparate factors (see Box 4).

Box 3. Suggested sequence of interview

- Attitude to referral
- Present somatic symptoms and their effects on daily life
- History of present illness
- Previous referrals and treatments
- Current illness beliefs and attitudes
- Medical history – self and family
- Personal history
- Current distress and mental state
- Formulation

Treatment

The treatment offered will depend on both the formulation of the patient's problems and what clinical resources are available to the doctor (see Box 5). Whatever the treatment, compliance is likely to be better if doctor and patient have successfully negotiated a shared explanation of the patient's illness, and if the treatment proposed follows logically from this. Important general aspects of care include listening to the patient and taking his or her complaints seriously; addressing the patient's concerns and expectations; and attempting to provide a satisfactory alternative explanation for symptoms. The prognosis, even in hospital practice, can be good: favourable prognostic factors are those for any mental disorder and include short history, acute onset in association with an identifiable stressor, well-adjusted premorbid personality and good family/social circumstances.

Behavioural and lifestyle change

Helping the patient become aware of tension, to identify sources of stress, and to manage these effectively are important therapeutic techniques.

Box 4. Perpetuating factors – the treatment focus

- Depression
- Anxiety and panic disorder
- Chronic marital and/or family discord
- Dependent or histrionic personality disorder
- Compensation
- Abnormal illness beliefs

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Box 5. Specific treatments for somatoform disorders

General advice
- Lifestyle change
- Gradual increase in activity
- Relaxation

Optimise self-help
- Appropriate patient groups
- Sensible literature

Drug treatments
- Antidepressants and others

Occupational / social
- Liaise with employer
- Occupational counselling
- Problem-solving for social problems

Psychological treatments
- Cognitive–behavioural and other therapies

Clinical experience suggests that many patients with functional somatic symptoms suffer stress because of maladaptive coping strategies including excessively high standards, lack of assertiveness and avoidance of interpersonal conflict. Some may be helped by simple advice about these issues, others will benefit from more specific instruction in relaxation and breathing control. Graded increases in activity and improving physical fitness are of benefit in patients with fatigue and musculoskeletal pain and are a component of the treatment programmes for many functional somatic symptoms (Sharpe *et al*, 1996).

Self-help for patients

Many patients with functional conditions continue to experience symptoms, of greater or lesser severity, for many years. The effect of psychiatric treatment in many cases is to help the symptoms become less of a problem to the patient and cause less impairment of quality of life. Indeed, the main goal of cognitive–behavioural therapy (CBT) is to try to get the patient to take some control of their problems, and self-help is in effect another way of achieving this (see Box 6). It is crucial that the practitioner regards self-help as an ally, and does not belittle any interest expressed by the patient. Rather, he or she should express interest and ask to see further details, printed information, etc. The psychiatrist thus has the opportunity to guide the patient towards sensible, mainstream organisations. For example, the patient with chronic fatigue syndrome has several organisations to choose from. An unsympathetic or patronising hearing may drive the patient towards an anti-psychiatry organisation offering a virus explanation of comforting simplicity, but which is potentially harmful by ignoring the importance of psychological aspects and insisting on prolonged rest, with all its deleterious physical and psychosocial consequences.

Box 6. Patient self-help

For example, *Coping with chronic fatigue* (Chalder, 1993); *Coping with chest pain* (Sanders & Goodwin, 1993)
Should be an ally to the psychiatrist
Guide patient towards sensible organisations and materials

Drug therapy

The antidepressant drugs are universally available and cheap. By default, they may be the treatment of first choice for patients with somatisation, instead of alternative management such as psychological treatment, which is more expensive and in short supply. Nevertheless, a good case can be made for their use. Their applicability extends beyond the treatment of depressive syndromes and includes anxiety and panic, poor sleep and pain (see Box 7). There is evidence of their efficacy in the treatment of chronic pain syndrome, fibromyalgia and irritable bowel syndrome.

Most of the evidence applies to the older antidepressants such as amitriptyline and imipramine. The relative usefulness of newer agents such as the selective serotonin reuptake inhibitors remains to be established, not least because the side-effects of these drugs are so unpredictable, with some patients being made drowsy and others extremely anxious and jittery. Accordingly, they are

Box 7. Successful use of antidepressants for functional symptoms

Worth trying in most patients
Response may not require typical depressive symptoms
Explain that they are non-addictive (not Valium) and applicable for pain and anxiety
Start with small doses, work up gradually
Monitor compliance

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less suitable for patients who may be extremely sensitive to unwanted effects.

Many patients wrongly believe that antidepressants are addictive. Discuss with the patient that the antidepressants are in fact misnamed, and have multiple actions on many systems of the body. So called side-effects can actually be very helpful, with sedative properties helping with anxiety and insomnia. Even the atropinic effects can be an advantage in some cases, for example of irritable bowel syndrome.

Occupational and social factors

The workplace may be a source of both psychological and physical stress and changes in working practice may be important in the management of musculo-skeletal pain and other syndromes. Negotiation with occupational physicians or with the patient's employers can therefore be important in achieving a return to work. Problems with return to work because of dissatisfaction with employment is a major potential obstacle to rehabilitation. A gradual return to full duties is extremely helpful, to which some employers – not usually including the National Health Service – are sympathetic.

Psychological treatment

A good initial assessment and explanation is a powerful psychological treatment in itself. Many patients improve in out-patient follow-up, using simple approaches as outlined above in combination with antidepressants. Finally, however, we come to a consideration of more structured psychological treatment, as it is reasonable to reserve what is at present a scarce resource for patients who have not benefited from the foregoing approaches.

Although there is some evidence for the efficacy of brief dynamic psychotherapy in refractory irritable bowel syndrome (Guthrie *et al*, 1991), CBT is the most commonly practised. It is also the best supported by evidence from randomised trials, for example in non-cardiac chest pain (Klimes *et al*, 1990), patients with medically unexplained symptoms (Speckens *et al*, 1995), and chronic fatigue syndrome (Sharpe *et al*, 1996), so merits a brief description here. It has been well summarised in a recent issue of this journal (Moorey, 1996).

Cognitive–behavioural therapy

Cognitive–behavioural therapy is usually a brief psychotherapy that is principally concerned with overcoming identified problems and attaining specific targets (Sharpe *et al*, 1995). Adequate assessment is an essential preliminary to treatment. Treatment is usually delivered as an individual therapy over five to 20 sessions, but can also be used in groups. The application of CBT to a patient with functional somatic symptoms will be illustrated using the example of a patient with non-cardiac chest pain.

Therapist–patient relationship

The successful practice of CBT requires that the therapist cultivates a special type of relationship with the patient. This is different from the usual doctor–patient relationship and is more like that between a student and a tutor. Rather than giving didactic instructions, therapist and patient work together to discover how the patient's current thinking and behaviour may be maintaining the problem and how positive change may be brought about (case example from Sharpe, 1995).

> A middle-aged man presented as an emergency with chest pain, but notwithstanding normal investigations by a cardiologist, he remained fearful that his pain indicated undetected ischaemic heart disease. His evidence for this belief was that a colleague at work had died at the same age of a heart attack after being told by his doctor that it was indigestion. The pain came on when he was under stress at work. When he felt the pain he thought "this must be a heart attack" and became very distressed and increasingly aware of the irregularities in his heartbeat.

Cognitions and behaviour

The main focus of CBT is on changing the patient's cognitions and behaviour. An assessment of relevant cognitions and behaviour is therefore the first step in treatment.

> The patient and therapist discussed the likely causes of the symptoms. The patient suggested a simple explanation in terms of insufficient oxygen getting to the heart. The therapist helped the patient to develop an alternative formulation based on the assessment. According to this alternative hypothesis the pain resulted from benign stress-related physiological processes (stretching of the intercostal muscles) and was amplified by the patient's excessive although understandable fear of cardiac disease.

The techniques used include diary-keeping, discussion and the identification of thoughts occurring during the treatment sessions. To help patients to choose the most accurate formulation of the problem, they are helped to evaluate the alternatives in the light of all the available evidence. This will include education by the therapist, other information (for example, from books and hand-outs)

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and from trying things out – so-called behavioural experiments.

> After discussion, the patient agreed to consider the alternative formulation that the pain came from the muscles of the chest wall and was aggravated by anxiety and hyperventilation, although he initially thought this was unlikely. Two behavioural experiments were planned to obtain new information about the problem:
>
> (1) In order to assess the effect of hyperventilation the patient voluntarily hyperventilated. This exercise reproduced the pain.
>
> (2) In order to assess the effects of different types of activity on the pain the patient carefully monitored his activity and its relation to pain.
>
> It was hypothesised that if the pain resulted from ischaemic heart disease, this should occur with all vigorous activity, whereas if it arose from the joints and muscles of the thorax it would be more related to exercise of this part of the body. He discovered that vigorous exercise not involving the arms often did not result in pain, whereas light exercise using the arms often did.
>
> The therapist discussed this evidence with the patient, who consequently thought it much less likely that the chest pain was a result of heart disease and more likely that chest wall (muscular) discomfort and hyperventilation were a possible alternative explanation. The patient subsequently recorded his thoughts about the pain and practised writing down the alternative, "benign" explanation whenever he became concerned about his heart.

It is important to realise that the patient's abnormal behaviour can cause real physical changes: for example, many patients with chronic fatigue syndrome rest excessively (Sharpe & Bass, 1992). This leads to loss not only of muscle tone and power, but also of muscle bulk. The patient then feels weaker and becomes very concerned and apprehensive about these real physiological changes. This loss of condition can often be normalised by changing these behaviours with graded activity and exercise (see Sharpe *et al*, 1996). The behaviour of others will also influence the patient's cognitions and behaviour. For example:

> When the patient became aware of chest pain at work he laid down on the floor and his colleagues called the works doctor who performed repeated electrocardiograms. At home his wife was worried that he might die and would not let him out of her sight.

Such influences usually need to be considered in therapy. Other family members may need information about the nature of functional somatic symptoms and it may be appropriate to involve them in therapy. The collaboration of other doctors is also of obvious importance, and it is essential for the person treating the patient to communicate clearly and regularly with them. It may be necessary to make a contract with the patient in which he agrees not to pursue further medical consultations while he or she is receiving CBT (Salkovskis, 1989). The patient's family may be relevant to their illness, for example as a source of stress or abnormal illness beliefs or reinforcement of the sick role. Although formal family therapy has been advocated for the treatment of functional somatic symptoms, it has not been systematically evaluated for this purpose.

The patient with multiple chronic symptoms

A proportion of patients with functional somatic symptoms will not respond to any of the treatments described. Many of these patients will have lifelong problems in functioning, associated with multiple and changing somatic symptoms. This is somatisation disorder, estimated to have a prevalence of 0.2–0.5% in the community. Most GPs will have several on their list, where they have been described as 'heartsink' patients. Some can be helped with a proactive approach, seeing the patient at regular, fixed intervals, when a limited number of complaints will be discussed. A written contract can be helpful. Gradually, the therapist attempts to broaden the agenda to discuss psychosocial as well as physical concerns (see Box 8). Management based on these principles has been shown to reduce health service use and improve physical functioning in patients with chronic somatoform disorders (Smith *et al*, 1986; 1995).

Treatment of conversion and dissociative disorders

Most conversion symptoms remit with nonspecific, supportive interventions incorporating a prominent element of suggestion. Prompt elimination of the symptom is important in order to prevent secondary gains from reinforcing it, thus causing it to persist or recur. If the symptom does not improve rapidly, or if precipitating or perpetuating factors remain, more definitive treatment is indicated.

Initial management focuses on alleviating the conversion by using relaxation and reassuring statements. It is important to identify precipitating stressors and conflicts. Recent events and feelings are discussed in order to do so, as long as this does

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Box 8. Management of severe somatisation disorder

Consider written contract
Regular appointments at fixed, pre-arranged intervals
Patient agrees to stop or reduce demands between sessions
Minimise use of drugs
Gradually try to broaden agenda to psychosocial factors

not heighten anxiety. Occasionally, an 'abreactive' interview, using sedation with amylobarbitone or a benzodiazepine, may be undertaken, especially when there has been a specific traumatic event, although this technique is unproven and now unusual. It is employed to obtain more history, to help the patient re-experience the traumatic event, and to suggest that the symptom will disappear. The therapist should try to understand the personal meaning of the conversion symptom, while also regarding it as an interpersonal communication and a way of dealing with painful affect. The patients learn to say in words what they had been able to say only with their bodies.

When secondary gain is prominent, behaviour therapy and environmental manipulation may be used to reduce it. This may involve working with the patient's family and others in the patient's life, because they may perpetuate the symptom by rewarding passivity and dependency and by being overly solicitous and helpful. These families must learn to reward the patient's autonomy, self-sufficiency and independence.

Uncommon specific syndromes

Patients with these conditions (see Box 9) are uncommon, but if unrecognised, have the potential to cause mayhem in the general hospital. Particularly in the case of factitious disorder, in which the sufferer deliberately produces real disease (for example by injecting himself with infected material in order to produce a "pyrexia of unknown origin"), the patient is not infrequently a member of a health care profession. The question arises of whether he or she is fit to continue with duty. Such cases are thankfully rare, but as a recent article in this journal pointed out (Vinestock, 1996), it is important to assess risk to others as routinely as risk of self-harm.

Box 9. Uncommon specific syndromes

Munchausen's syndrome
Munchausen's syndrome by proxy
Factitious disorder

Appropriate management consists of 'supportive confrontation': that is, the physician or surgeon gently but firmly makes it clear to the patient that the origin of the symptoms is clear, and that there will be no further physical investigations or treatments, while simultaneously offering further assessment and help with psychological or social problems.

The approach during such an interview should be non-punitive and supportive, stressing the recognition that the patient is a sick person. It is helpful to have the psychiatrist present when the patient is confronted, and then to stay to discuss matters more fully. Although only about one-third of patients acknowledge causing their disorders following this approach, many improve and a minority become asymptomatic.

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Multiple choice questions

1. The prevalence of somatisation disorder in community studies is approximately:
   a 10%
   b 5%
   c 0.2–0.5%
   d 15%
   e 0.001%

2. Patients with somatoform disorders are unduly susceptible to the effects of psychotropic drugs for the following reasons:
   a a heightened sensitivity to and awareness of physical sensations
   b more rapid absorption of drugs from the stomach
   c higher risk of tolerance and dependence
   d a greater likelihood of these patients to abuse psychotropic drugs
   e interactions with other medications.

3. The most important skill in the assessment and management of the patient with a somatoform disorder is:
   a attempting to 'engage' the patient in treatment
   b titrating psychotropic drugs against somatic symptoms
   c dealing with the transference
   d ending treatment
   e using appropriate rating scales.

4. The following treatments have been found to be effective in randomised controlled trials in a range of somatoform disorders:
   a psychoanalytic psychotherapy
   b cognitive–behavioural therapy
   c psychodrama
   d analgesic drugs
   e transcendental meditation.

5. Referrals for psychiatric assessment of patients with somatoform disorders in the general hospital are more likely in the following circumstances:
   a a well-resourced liaison psychiatry service in the general hospital with established links to a number of clinical teams
   b the nearest opinion is in the local mental hospital
   c the general hospital has a good supply of psychiatric social workers
   d the medical and surgical team refer the patient to the local community mental health care team
   e a consultant in general psychiatry is assigned two sessions per week to cover this task.

MCQ answers

1	2	3	4	5
a F	a T	a T	a F	a T
b F	b F	b F	b T	b F
c T	c F	c F	c F	c F
d F	d F	d F	d F	d F
e F	e F	e F	e F	e F

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