Cognitive Behavioral Therapy for Somatoform Disorders

Lesley A. Allen, PhD[a,*], Robert L. Woolfolk, PhD[b,c]

KEYWORDS

- Somatoform disorders • Somatization
- Conversion disorder • Hypochondriasis
- Body dysmorphic disorder • Cognitive behavioral therapy

OVERVIEW

Somatoform disorders are characterized by physical symptoms that suggest a medical condition but are not fully explained by a medical condition.[1] Physical symptoms with uncertain etiologies are some of the most common presentations in primary care. As many as 25% of visits to primary care physicians are prompted by physical symptoms that lack any clear organic pathology.[2] Patients presenting with medically unexplained physical (somatoform) symptoms provide significant challenges to health care providers. These patients tend to overuse health care services, derive little benefit from treatment, and experience protracted impairment, often lasting many years.[3] Often, patients with somatoform symptoms are dissatisfied with the medical services they receive and repeatedly change physicians.[4] Likewise, physicians of these treatment-resistant patients often feel frustrated by patients' frequent complaints and dissatisfaction with treatment.[4,5] Because standard medical care has been unsuccessful in treating somatoform disorders, alternative treatments have been developed. Cognitive behavioral therapy (CBT) has been the most widely studied alternative treatment for these disorders. This article summarizes the research on the efficacy of CBT for somatoform disorders.

Funded, in part, by NIH grant P20 MH074634.
[a] Department of Psychiatry, Robert Wood Johnson Medical School, University of Medicine and Dentistry of New Jersey, 671 Hoes Lane, Piscataway, NJ 08854, USA
[b] Department of Psychology, Rutgers University, NJ, USA
[c] Department of Psychology, Princeton University, 18 Turner Court, Princeton, NJ 08540, USA
* Corresponding author.
E-mail address: allenla@umdnj.edu

Psychiatr Clin N Am 33 (2010) 579–593
doi:10.1016/j.psc.2010.04.014 **psych.theclinics.com**
0193-953X/10/$ – see front matter

SOMATIZATION DISORDER AND SUBTHRESHOLD SOMATIZATION

Overview of Disorder

Diagnostic criteria and prevalence

According to the current *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition) (*DSM-IV*)[1] somatization disorder is characterized by a lifetime history of at least 4 unexplained pain complaints (eg, in the back, chest, joints), 2 unexplained nonpain gastrointestinal complaints (eg, nausea, bloating), 1 unexplained sexual symptom (eg, sexual dysfunction, irregular menstruation), and 1 pseudoneurological symptom (eg, seizures, paralysis, numbness). For a symptom to be counted toward the diagnosis of somatization disorder, its presence must be medically unexplained or its degree of severity be substantially in excess of the associated medical pathology. Also, symptoms counted toward the diagnosis must either prompt the seeking of medical care or interfere with patients' functioning. In addition, at least some of the somatization symptoms must have occurred before the patients' thirtieth birthday.[1] The course of somatization disorder tends to be characterized by symptoms that wax and wane, remitting only to return later or be replaced by new unexplained physical symptoms. Thus, somatization disorder is a chronic, polysymptomatic disorder whose requisite symptoms need not be manifested concurrently.

Epidemiological research suggests that somatization disorder is rare. The prevalence of somatization disorder in the general population has been estimated to be 0.1% to 0.7%.[6–8] When patients in primary care, specialty medical, and psychiatric settings are assessed, the rate of somatization is higher than in the general population, with estimates ranging from 1.0% to 5.0%.[9–13]

Although somatization disorder is classified as a distinct disorder in *DSM-IV*, it has been argued that somatization disorder represents the extreme end of a somatization continuum.[14,15] The number of unexplained physical symptoms reported correlates positively with the patients' degree of emotional distress and functional impairment.[16] A broadening of the somatization construct has been advocated by those wishing to underscore the many patients encumbered by unexplained symptoms that are not numerous or diverse enough to meet criteria for full somatization disorder.[14–16]

DSM-IV includes a residual diagnostic category for subthreshold somatization cases. *Undifferentiated somatoform disorder* is a diagnosis characterized by 1 or more medically unexplained physical symptoms lasting for at least 6 months.[1] Long considered a category that is too broad because it includes patients with only 1 unexplained symptom *and* those with many unexplained symptoms, undifferentiated somatoform disorder never has been well validated or widely applied.[17]

As an alternative to the wide-ranging category of undifferentiated somatoform disorder, 2 groups of researchers have suggested alternative categories for subthreshold somatization using criteria less restrictive and requiring less extensive symptomatology than the *DSM-IV* standards for full somatization disorder. Escobar and colleagues[14] proposed the label, *abridged somatization*, to be applied to men experiencing 4 or more unexplained physical symptoms or to women experiencing 6 or more unexplained physical symptoms. Kroenke and colleagues[15] suggested the category of *multisomatoform disorder* to describe men or women currently experiencing at least 3 unexplained physical symptoms and reporting a 2-year history of somatization.

Both of these subthreshold somatization categories appear to be significantly more prevalent than is *somatization disorder* as defined by *DSM-IV*. Abridged somatization has been observed in 4% of community samples[14] and 16% to 22% of primary care samples.[2,9,18] The occurrence of multisomatoform disorder has been estimated at 8% of primary care patients.[15,19]