

Somatisation Disorder

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Treatment of somatisation disorder can be difficult and sometimes frustrating.

A patient with somatisation disorder has a physical complaint that cannot be explained. They often have a history of many physical complaints beginning well before about 30 years and these complaints often occur over a period of several years and result in the patient seeking treatment. The disorder may also significantly impair the patient's social, occupational, or other important areas of functioning.

Times of emotional distress can often lead to the individual developing more symptoms. It may be worth considering somatisation disorder if an individual is experiencing many of the following complaints:

- pain related to at least four different areas or functions (e.g., head, abdomen, back, joints, extremities, chest, during menstruation, sexual intercourse, or urination),
- at least two gastrointestinal symptoms other than pain (e.g. nausea, bloating, diarrhea, or intolerance of several different foods),
- at least one sexual or reproductive symptom other than pain (e.g. sexual indifference, erectile or ejaculatory dysfunction, irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy), and
- at least one symptom or deficit suggesting a neurological condition not limited to pain (e.g. impaired coordination, paralysis or localised weakness, difficulty swallowing, aphonia, urinary retention, hallucinations, loss of touch, double vision, seizures; amnesia; loss of consciousness).

A diagnosis of somatisation disorder is most likely if it is also found that:

- after appropriate investigation, each of the physical symptoms cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g., drug of abuse, a medication), or
- when there is a related general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected.

This frustrating disorder requires regular management by a GP. Patients should maintain brief visits to have their symptoms monitored. Physical examinations should be performed but only to directly target the symptom or complaint. Diagnostic tests are best avoided unless clearly indicated. The symptoms are viewed as emotional phenomena rather than a precursor to disease, although the experience of pain should not be discounted.

It is often useful to complement medical management of a patient with somatisation disorder with psychological treatment. This treatment essentially involves cognitive-behavioural therapy and sometimes the use of antidepressant medication (many of these patients are also depressed and some consider somatisation disorder to be an atypical presentation of depression). The basic goal is to reinforce appropriate, nondependent behaviours and to discourage inappropriate, dependent behaviours, as well as develop strategies to help the patient manage.