SOMATIZATION

BEHAVIORAL DEFINITIONS

1. Complains of a physical malady that seems to be caused by a psychosocial stressor triggering a psychological conflict.
2. Preoccupied with the fear of having serious physical disease, without any medical basis for concern.
3. Exhibits a multitude of physical complaints that have no organic foundation but have led to life changes (e.g., seeing doctors often, taking prescriptions, withdrawing from responsibilities).
4. Preoccupied with chronic pain beyond what is expected for a physical malady or in spite of no known organic cause.
5. Complains of one or more physical problems (usually vague) that have no known organic basis, resulting in impairment in life functioning in excess of what is expected.
6. Preoccupied with pain in one or more anatomical sites with both psychological factors and a medical condition as a basis for the pain.
7. Preoccupied with an imagined physical defect in appearance or a vastly exaggerated concern about a minimal defect (Body Dysmorphic Disorder).

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LONG-TERM GOALS

1. Reduce frequency of physical complaints and improve the level of independent functioning.
2. Reduce verbalizations focusing on pain while increasing productive activities.
3. Accept body appearance as normal even with insignificant flaws.
4. Accept self as relatively healthy with no known medical illness or defects.
5. Improve physical functioning due to development of adequate coping mechanisms for stress management.

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SHORT-TERM OBJECTIVES

1. Verbalize health concerns and/or negative feelings regarding body as well as feared consequences of perceived body abnormality. (1, 2, 3)

2. Complete psychological tests designed to assess the depth and breadth of the presenting problem(s). (4)

THERAPEUTIC INTERVENTIONS

1. Build a level of trust and understanding with the client by listening to his/her initial complaints without rejection or confrontation.
2. Nurture a trusting relationship throughout therapy by not dismissing or trivializing health complaints while simultaneously advancing a psychosocial treatment approach.
3. Assess the history of the client's complaints including symptoms, fears, effect on functioning, stressors, and goals of treatment.
4. Administer surveys tailored to the presenting complaint to assess its nature and severity (e.g., *the Body Dysmorphic*

Disorder Examination; the Whiteley Index; the *Illness Attitude Scale* for health anxiety); discuss results with client; readminister as needed to assess progress.

3. Disclose any history of substance use that may contribute to and complicate the treatment of somatization. (5)

5. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a DSM diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)

6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better

understanding of the client's behavior.

9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Cooperate with an evaluation by a physician for psychotropic medication. (10)

10. Arrange for the client to have an evaluation by a physician for a prescription of psychotropic medications (e.g., SSRIs).

6. Take psychotropic medications consistently. (11)

11. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals.

7. Participate in individual or group Cognitive-Behavioral Therapy. (12)

12. Use a cognitive-behavioral/Stress Inoculation Training approach to help the client conceptualize the stress-somatization relationship and learn and implement tailored skills (e.g., calming and coping skills, communication, problem-solving, exposure) for managing stressors, decreasing fears, overcoming avoidance, and increasing present-day adaptation through problem-focused coping (see *Stress Inoculation Training* by Meichenbaum; *Treating Health*

Anxiety by Taylor and Asmundson; *Body Dysmorphic Disorder* by Veale and Neziroglu).

8. Verbalize an understanding of the rationale for treatment. (13)

13. Educate the client, with sensitivity to defensiveness, about the role of biased fears and avoidance in maintaining the disorder; about the role of stress in exacerbating symptoms; discuss how treatment serves as an arena to desensitize fears, to reality-test fears and underlying beliefs, build skills in managing stress, and build confidence and self-acceptance regarding appearance, health, and/or other concerns.

9. Identify and replace biased, fearful self-talk and beliefs with realistic, accepting self-talk and beliefs. (14, 15)

14. Use Cognitive Restructuring techniques to explore the client's self-talk and underlying beliefs that mediate his/her fears and related avoidance or reassurance seeking (e.g., "I have never been a healthy person," "These sensations indicate a problem," "My receding hairline is repulsive"); assist him/her in generating thoughts that challenge and correct for the biases (see *Treating Health Anxiety* by Taylor and Asmundson; assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma).

15. Conduct behavioral experiments that repeatedly test biased and alternative beliefs; review; reinforce successes; problem-solve obstacles toward a shift in fearful beliefs.

10. Discuss current stresses that may influence physical complaints. (16)

16. Discuss how stress may be exacerbating the focus and/or experience of physical symptoms to a degree that the client can accept it and provide a rationale for learning personalized stress management skills.

11. Participate in repeated imaginal and/or live exposure to feared external and/or internal cues. (17, 18, 19)

17. Assess external triggers for fears (e.g., persons, situations, sensations) and subtle and obvious avoidant strategies (e.g., wearing concealing clothing for BDD, reassurance-seeking for hypochondriasis).

18. Direct and assist the client in construction of a hierarchy of fear triggers; incorporate exposures that gradually increase the client to what he/she fears while reducing subtle and obvious avoidant habits.

19. Select initial exposures that have a high likelihood of being a successful experience for the client; be a participant model, do cognitive restructuring within and after the exposure; incorporate response prevention if needed (e.g., asking the client with BDD to refrain from concealing the undesirable physical feature, agreeing not to seek reassurance; adhering to a reasonable schedule of medical evaluations).

12. Learn and implement calming skills to reduce overall anxiety and manage anxiety symptoms. (20, 21, 22)

20. Teach the client calming/relaxation skills (e.g., applied relaxation, progressive muscle relaxation, cue controlled relaxation; mindful breathing; biofeedback) and how to discriminate better between relaxation and tension; teach the

client how to apply these skills to his/her daily life (e.g., *Progressive Relaxation Training* by Bernstein and Borkovec; *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay). EBT

21. Assign the client homework each session in which he/she practices relaxation exercises daily, gradually applying them progressively from non-anxiety-provoking to anxiety-provoking situations; review and reinforce success while providing corrective feedback toward improvement. EBT

22. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *New Directions in Progressive Muscle Relaxation* by Bernstein, Borkovec, and Hazlett-Stevens; *Mastery of Your Anxiety and Worry—Workbook* by Craske and Barlow). EBT

EBT 13. Learn and implement problem-solving strategies for realistically addressing worries. (23)

23. Teach the client problem-solving strategies involving specifically defining a problem, generating options for addressing it, evaluating the pros and cons of each option, selecting and implementing an optional action, and re-evaluating and refining the action (or assign "Plan Before Acting" in the *Adult Psychotherapy Homework Planner* by Jongsma). EBT

EBT 14. Complete homework assignments involving exposure to feared external and/or internal cues. (24)

24. Assign the client homework exercises in which he/she strengthens new skills through repeated exposures between sessions while recording

responses (or assign "Gradually Reducing Your Phobic Fear" in the *Adult Psychotherapy Homework Planner* by Jongsma); review during next session, reinforcing success and problem-solving obstacles toward improvement. ▽

15. Implement the use of the "thought-stopping" technique to reduce the frequency of obsessive thoughts. (25, 26) ▽

25. Teach the client to interrupt critical self-conscious thoughts using the "thought-stopping" technique of shouting "STOP" to himself/herself silently while picturing a red traffic signal and then thinking about a calming scene. ▽

26. Assign the client to implement the "thought-stopping" technique on a daily basis between sessions (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner* by Jongsma); review. ▽

16. Express thoughts and feelings assertively and directly. (27, 28, 29) ▽

27. Using instruction, role-playing, and behavioral rehearsal, teach the client assertive, respectful expression of thoughts and feelings. ▽

28. Train the client in assertiveness or refer him/her to an assertiveness training class (recommend *Your Perfect Right: Assertiveness and Equality in Your Life and Relationships* by Alberti and Emmons). ▽

29. Reinforce the client's assertiveness as a means of him/her attaining healthy need satisfaction in contrast to passive helplessness. ▽

17. Learn and implement guided self-dialogue to manage ▽

30. Teach the client a guided self-dialogue procedure in which

thoughts, feelings, and urges brought on by encounters with trauma-related situations. (30)

he/she learns to recognize maladaptive self-talk, challenges its biases, copes with engendered feelings, overcomes avoidance, and reinforces his/her accomplishments; review and reinforce progress, problem-solve obstacles toward developing an effective consolidated approach.

18. Learn about health/appearance anxiety through completion of prescribed reading. (31)

31. Assign the client who has accepted the role of anxiety in their health/appearance concerns to read about health anxiety in self-help books consistent with the therapeutic model (e.g., *Stop Worrying About Your Health* by Zgourides; *The BDD Workbook* by Claiborne and Pedrick; *Managing Chronic Pain: A Cognitive-Behavioral Therapy Approach Workbook* by Otis).

19. Implement maintenance strategies for managing possible future lapses. (32, 33, 34, 35)

32. Discuss with the client the distinction between a lapse and relapse, associating a lapse with a temporary setback and relapse with a return to a sustained pattern thinking, feeling, and behaving that is characteristic of the disorder.

33. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

34. Instruct the client to routinely use strategies learned in therapy (e.g., continued exposure to previously feared external or internal cues that arise) to prevent lapses into former patterns of internal focus on physical complaints, self-conscious fears, and/or avoidance patterns.

35. Schedule periodic "maintenance sessions" to help the client maintain therapeutic gains.

20. Discuss causes for emotional stress in life that underlie the focus on physical complaints. (36, 37, 38)

36. Refocus the client's discussion from physical complaints to emotional conflicts and expression of feelings.

37. Explore the client's sources of emotional pain—feelings of fear, inadequacy, rejection, or abuse.

38. Assist the client in acceptance of connection between physical focus and avoidance of facing emotional conflicts.

21. Identify family patterns that exist around exaggerated focus on physical maladies. (39)

39. Explore the client's family history for modeling and reinforcement of physical complaints.

22. Verbalize the secondary gain that results from physical complaints. (40)

40. Assist the client in developing insight into the secondary gain received from physical illness, complaints, and the like.

23. Participate in Acceptance and Commitment Therapy (ACT) for health/appearance worries. (41, 42, 43)

41. Use an ACT approach to help the client experience and accept the presence of worrisome thoughts and images without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson).

42. Teach mindfulness meditation to help the client recognize the negative thought processes associated with PTSD and change his/her relationship with these thoughts by accepting thoughts, images, and impulses that are reality-based while

noticing, but not reacting to, non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [Audio CD] by Zabat-Zinn).

43. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into everyday life (or assign *Living Beyond Your Pain: Using Acceptance and Commitment Therapy to Ease Chronic Pain* by Dahl and Lundgren).

24. Increase social and productive activities rather than being preoccupied with self and physical complaints. (44, 45)

44. Assist the client in developing a list of pleasurable activities that can serve as rewards and diversions from bodily focus (or assign "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma).

45. Assign diversion activities that take the client's focus off himself/herself and redirect it toward hobbies, social activities, assisting others, completing projects, or returning to work.

25. Decrease physical complaints, doctor visits, and reliance on medication while increasing verbal assessment of self as able to function normally and productively. (46, 47)

46. Challenge the client to endure pain and carry on with responsibilities so as to build self-esteem and a sense of contribution.

47. Structure specific times each day for the client to think about, talk about, and write down his/her physical problems while outside of those times the client will not focus on his/her physical condition; monitor and process the intervention's effectiveness (or assign "Controlling the

Focus on Physical Problems" in the *Adult Psychotherapy Homework Planner* by Jongsma).

26. Engage in normal responsibilities vocationally and socially without complaining or withdrawing into avoidance while using physical problems as an excuse. (48, 49)

48. Give positive feedback when the client is not focusing on and talking about symptoms but is accepting of his/her body as normal and is performing daily work, family, and social activities without avoidance or excuse.

49. Discuss with the client the destructive social impact that consistent complaining and/or negative body focus have on relationships with friends and family; ask him/her to reflect on this and recall how others have reacted negatively to complaints.

27. Make and attend an appointment at a pain clinic. (50)

50. Refer the client to a pain clinic to learn pain management techniques.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.7	Body Dysmorphic Disorder
	300.11	Conversion Disorder
	300.7	Hypochondriasis
	300.81	Somatization Disorder
	307.80	Pain Disorder Associated With Psychological Factors

307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition
300.81	Undifferentiated Somatoform Disorder
300.4	Dysthymic Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
300.7	F45.22	Body Dysmorphic Disorder
300.11	F44.x	Conversion Disorder
300.7	F45.21	Illness Anxiety Disorder
300.81	F45.1	Somatic Symptom Disorder
307.80	F45.1	Somatic Symptom Disorder, With Predominant Pain
307.89	F54	Psychological Factors Affecting Other Medical Conditions
300.4	F34.1	Persistent Depressive Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

EB indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.