An Overview of Somatization in the Refugee Population

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Abstract

Somatization, or the expression of medically unexplained symptoms that cause distress and impairment, is a common problem in the refugee population. Refugees are often subjected to traumatic experiences and repeated stressors, such as torture, abuse, and postmigration living difficulties, which can lead to the development of trauma-related disorders, such as anxiety, depression, and somatization. The pathogenesis of somatization in refugees can be explained by multiple mechanisms such as an undiagnosed physical illness, the result of past trauma, and cultural stigma. There is a well-documented co-occurrence of somatization with other psychological disorders, especially with PTSD. With the increasing numbers of refugees encountering the western health system, it is important that physicians and other healthcare providers are able to recognize and treat conditions that affect this population, especially somatization. Many patients require psychological treatment in addition to their medical treatment, and cognitive-behavioral therapy has been found to be the most effective psychological therapy for depression, anxiety, and somatization. General treatment tenets for somatization and related disorders include building a strong, positive relationship between the physician and the patient, scheduling frequent, supportive visits, and avoiding medication or testing when the interventions are not indicated. It is also important to keep in mind the barriers to treatment that refugees may face, such as language, health literacy, or cultural stigma.

Introduction

Mrs. S is a 55 year old woman who presents to her primary care physician with unrelenting pain in her abdomen, knees, and lower back. Her symptoms have been worsening for five years. Seven years ago, she was forced to flee Afghanistan after witnessing several family members be murdered by a terrorist group. After arriving to the United States as a refugee, she was at first overwhelmed with joy and gratitude to finally have a safe place to call home for her children. However, when her symptoms began, she underwent an extensive medical work-up, including imaging studies, blood tests, and gastroenterological procedures, only to reveal normal results. Today, she continues to live with debilitating pain, and she can see no end in sight. Mrs. S feels that her symptoms are being dismissed by the many physicians who have worked with her, and her medical bills continue to pile up. This situation is not only frustrating and disheartening for Mrs. S, but also for her physicians, whose goals are to find and treat the cause of Mrs. S's pain. Somatization, or the expression of physical symptoms causing distress and impairment that cannot be medically explained, is a term used to describe this situation. In this paper, I will discuss somatization, what it is and how it manifests, what factors make it a common problem for refugees, and how we can address it.

Background

As of 2020, there are currently 26.3 million refugees, or persons who have been forced to leave their country in order to escape war, persecution, or natural disaster, worldwide.[1] Sadly, this number continues to grow by about 1% each year.[2] Refugees often experience multiple and prolonged traumatic events and post-migratory distress, which can lead to the development of mental health conditions. In fact, the prevalence of mental health disorders are high in this population, with around 55% of refugees in European countries reporting at least one current mental health disorder. Commonly reported mental health conditions in this population include posttraumatic stress disorder (PTSD), depression, anxiety, and somatization.[3]

It is estimated that 5-7 percent of patients in the general United States population suffer from somatization.[4] For many reasons that will be discussed in this paper, a high level of medically unexplained symptoms occur in refugees. Common somatic symptoms in refugees include stomach aches, muscle, bone, and joint problems, weakness, and insomnia.[5] These symptoms can cause important obstacles to diagnosing and treating refugees, and can lead to disability and great suffering for the patients.[3] It is important that physicians be trained to recognize trauma symptoms, particularly somatization, in order to improve the mental health of refugees and increase the utilization of mental health services.[6]

What is somatization?

Terminology

The diagnosis of somatic symptom disorder was introduced in the Diagnostic and Statistical Manual of Mental disorders, Fifth Edition (DSM-5), which was published in 2013. Somatic symptom disorder is defined as persistent physical symptoms accompanied by excessive thoughts, anxiety, and/or behaviors that cause significant distress and are not necessarily explained by a recognized medical condition. This diagnosis was meant to combine and replace the older diagnoses of somatization disorder, undifferentiated somatoform disorder, hypochondriasis, and pain disorder, which were included in the prior edition of the DSM. These diagnoses were collectively referred to as somatoform disorders.[7] However, some researchers and physicians continue to recognize the more specific diagnoses under somatoform disorders, and these diagnoses are still retained by the World Health Organization's International Classification of Diseases – 10th Revision (ICD-10).[8] Another term that is also commonly used is somatization, which is a broad construct used to describe patients with medically unexplained symptoms that cause distress and impairment, but is not a formal DSM-5 diagnosis.[3,7] Somatization is the term used in this paper unless otherwise noted.

Epidemiology

It is estimated that somatization occurs in 5-7% of the general United States population.[4] Patients with functional disorders such as irritable bowel syndrome and fibromyalgia have a higher prevalence of somatization.[10] Risk factors for somatization include family history of chronic illness, health anxiety, childhood neglect, female sex, chaotic lifestyle, fewer years of education, lower socioeconomic status, history of alcohol and substance

abuse, concurrent medical or psychiatric disorders, and history of abuse or trauma.[4,7] Patients with somatic symptom and related disorders typically present to primary care and general medicine clinicians rather than psychiatrists, which emphasizes the importance of training all physicians, especially generalists, to diagnose and manage these conditions.[9]

Health care utilization

By definition, patients with somatization and related disorders have physical symptoms that cause emotional and behavioral distress. These patients are therefore more likely to use the healthcare system than other patients. This can lead to an excess of healthcare dollars spent, which emphases the need for identification and treatment of this condition.[5,7]

Clinical symptoms

Somatization symptoms range from mild to severe, and encompass all organ systems. Common symptoms include: pain symptoms; nonspecific symptoms such as fatigue, syncope, and dizziness; cardiopulmonary symptoms; gastrointestinal symptoms; neurological symptoms; and reproductive organ symptoms. The most common burdensome symptom reported in patients with somatization is pain.[11]

Prognosis

Symptoms of somatic symptom disorders generally wax and wane, and are chronic. Patients can recover. It is estimated that 50-75% of patients with somatization improve, whereas 10-30% deteriorate. Presenting with fewer physical symptoms and better baseline functioning are considered better prognostic indicators.[4]

Pathogenesis of somatization in refugees

There are many plausible explanations of somatization in refugee populations, and many of these explanations are also valid for non-refugee patients. First, it's important to emphasize that somatization or somatic complaints may be caused by an undiagnosed physical illness. Therefore, clinicians must first provide patients with a thorough somatic examination. It's imperative to keep this in mind since barriers such as poor language and poor knowledge of the Western health system make the refugee population especially vulnerable to misdiagnosis and dismissal. Additionally, in some cases, a patient may warrant a re-examination, as some illnesses have a latency period and are undetectable until a later phase.[5]

Another possible cause of somatization in refugees is trauma. Research indicates that refugees are approximately 10 times more likely to experience psychological trauma than the general population, and many refugees have also suffered physical trauma.[6] It has long been documented that patients who have experienced psychological and physical trauma can present with somatic symptoms that lack a medical explanation. For instance, patients who have been tortured often have chronic pain in the parts of their body that were physically tortured, without any objective signs of pathology or injury. This same phenomenon is also encountered in war veterans who have been previously wounded. For example, the Gulf War syndrome is a chronic disorder linked to a wide range of somatic symptoms such as pain, fatigue, and diarrhea affecting returning veterans of the Gulf War. This syndrome is thought to be caused by a combination of physical and

psychological factors. It can also be difficult to distinguish physical disease from psychological distress, as one can be responsible for or exacerbate the other, and vice versa. Psychotherapy should be added to the somatic treatment in these cases, as it has been stated that sometimes psychological distress can prevent somatic symptoms from being cured.[5]

Another possible explanation is the stigma that patients fear they may encounter for expressing mental health issues. This can lead patients to present physical problems rather than psychological problems, sometimes unconsciously. Additionally, the health system is biased towards physical illnesses. There are more resources, training, and diagnostic tests available for somatic issues than for psychological issues. Furthermore, many patients feel that a physical disease legitimizes their illness. For example, in many non-Western countries, people see psychiatry as a service specifically for patients diagnosed with schizophrenia, and they are fearful of stigmatization if they were to seek psychiatric treatment. [5] Therefore, stigma plays a role in all patients with somatization, but refugees are more vulnerable due to their cultural background.

Somatization and PTSD

By definition, refugees have experienced persecution, and are therefore often subjected to traumatic situations, including torture, bereavement, and life-threatening experiences. In addition, refugees often experience postmigration stressors, including unemployment, discrimination, insecure visa status, and family separation.[12] Considering the well-documented dose-response relationship between trauma exposure and psychological distress in refugees, it is unsurprising that refugees experience high rates of trauma-related mental health conditions, such as PTSD, anxiety, depression, and somatization.[12,13] In fact, research has shown that refugees are 10 times more likely to have PTSD than age-matched individuals in the general population.[5]

There is a frequent and well-documented co-occurrence of PTSD and unexplained somatic symptoms. Furthermore, there is a particularly high comorbidity rate of PTSD and somatization in refugee populations.[12] There are several possible mechanism through which somatization may be associated with PTSD. These mechanisms include: traumatic injuries sustained in the traumatic event; autonomic, immunologic, and neuroendocrine dysregulation resulting from PTSD; somatoform disorders associated with elevated stress levels; or genetic predispositions. These mechanisms result from psychological, behavioral, and biological factors, in addition to the complex interactions between these factors.[12]

Several studies have focused on elucidating the interaction between PTSD and somatization in refugees. A study by Morina et al. found that different patterns of somatic symptoms are associated with different clusters of PTSD symptoms. For example, DSM-5 PTSD Criteria D "alterations in cognitions and mood" and E "alterations in arousal and reactivity" were primarily related the somatic symptom of weakness.[12] In another study, Spiller et al. demonstrated that that somatization, explosive anger, and postmigration living difficulties were positively correlated with PTSD severity.[13] These findings have a

number of implications. One is that PTSD should be routinely screened for in refugees with nonspecific or medically unexplained somatic complaints and pain, and vice versa. In addition, when treating refugee patients with somatization and/or PTSD, a close and interdisciplinary collaboration is advisable in order to distinguish between complaints in need of somatic treatment and those accessible for psychological interventions.[12,13]

Somatization treatments for refugees

With the increasing number of refugee patients encountering western medical services, it is especially important that clinicians be trained in identifying and treating the health problems commonly affecting this population, including somatization and other trauma-associated disorders. General treatment tenets for somatization and related disorders include building a strong, positive relationship between the physician and the patient, and scheduling frequent, supportive visits. It is also important to avoid medication or testing when the interventions are not indicated.[4]

In the last 20 years, research into psychological and pharmacological treatments for migrants afflicted with mental health conditions has increased, and many of these treatments have been shown to be effective. A meta-analysis by Sambucini et al. was recently conducted that included 52 studies over a 24 year period on the effectiveness of psychological treatments on three psychiatric disorders in migrants, including refugees. This study found that all treatments used in the studies, which included cognitive behavioral therapy (CBT), narrative exposure therapy, psychodynamic therapy, and combined pharmacological and psychological treatment, were found to have significant effects on depression, anxiety, and somatization. Based on qualitative observations, the probability of significant pre-post treatment effects in trials with outcomes of depression, anxiety, and somatization were 56%, 44%, and 42%, respectively. Cognitive behavioral therapy was found to be the most effective treatment. The paper noted that the studies on dynamic therapies used observational designs, and therefore need further investigation due the lack of randomized control trials (RCT). Of the three outcomes, somatization had the fewest number of studies on treatment for migrants, which suggests the need to conduct more studies focused on testing the efficacy of psychological treatments for somatization in refugees.[2]

As previously noted, since many of the psychological disorders affecting refugee patients are associated with past physical or psychological trauma, it is imperative that their treatment focus on any trauma they may have experienced. The best practice interventions for psychological trauma is considered to be holistic, community-oriented, and culturally appropriate, with a view to building on strengths within individuals and communities rather than focusing on deficits. In addition, testimonial based and emotion focused therapies are considered an important part of any trauma informed intervention.[6] Therefore, treatments for refugees suffering from somatization or other trauma-associated conditions could result in better outcomes by combining medical and psychiatric assessments and treatments.[5]

It is also important to realize that engagement with the mental health care system is a critical part of obtaining treatment for psychological trauma. Unfortunately, there are numerous barriers at both the system level and individual level preventing the refugee population from obtaining care including language, cost, health literacy, transportation, stigma (especially for mental health), availability of services, training for clinicians working with refugees, and the cultural appropriateness of care. In fact, a systematic review by Due et al. found that for refugees with psychological problems, access rates of mental health services were low, while general healthcare access was comparable or greater than the general population.[6]

Conclusion

In conclusion, for reasons such as an undiagnosed physical illness, past trauma, repeated stressors, and cultural stigma, somatization is a common problem in the refugee population.[5] With the number of refugees increasing worldwide, it is especially important for physicians and other healthcare providers to be able to diagnose and treat conditions that commonly affect this population, including somatization. To treat somatization, many patients require psychological treatment in addition to their medical treatment, and cognitive-behavioral therapy has been found to be the most effective.[4] It is also important to keep in mind the many barriers to treatment that refugees may face.

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