The Psychological Significance of Somatic Complaints

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Patients experiencing psychological distress often come to their physicians with primarily somatic complaints. While patients provide their physicians with multiple clues that there is a functional cause to their complaints, physicians often fail to recognize these. Psychological states, including depression, schizophrenia, hypochondriasis, malingering, conversion reactions, anxiety states, the "identified patient" in a dysfunctional family, and the patient with a "hidden agenda" are examples of this somatization process. Physicians may recognize these problems and avoid needless interventions if they consider these diagnostic possibilities and ask their patients questions that differentiate the various psychological possibilities.

Family physicians are regularly exposed to ambulatory patients with a variety of psychopathological conditions. Because these patients are often seen early in the course of their distress, and because patients often feel that they need to describe physical complaints to their physician, psychological distress often presents to the family physician at least in part with somatic complaints.[1-5] The intent of this paper is to present a differential diagnosis for the psychologically distressed patient who presents to the physician primarily with somatic complaints.

There are reasons that the somatic complaint often functions as an entree to the physician for the distressed patient. People learn that they go to their physicians because there is something wrong with them physically. Most patients see physicians because something hurts. Physicians often play into this role of the physician-patient relationship by attending to the patient's somatization to the exclusion of how the patient's complaint is presented or of other clues of psychological distress. Often the result is an inability to find anything wrong with the patient, provoking the tendency to label the patient "a crock" or one who is considered psychiatrically disturbed only by default. Feelings of frustration and anger are common in physicians who fail to recognize that somatic manifestations of psychological distress are unconscious processes rather than contrived attempts to manipulate the physician. The malingerer, who consciously deceives for personal gain, makes up a small percentage of somatizing patients.

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Clues to Functional Nature of Somatic Complaints

The way in which symptoms are presented to a physician may give clues to their functional nature. Distressed people come to their physicians with multiple symptoms or symptoms that often fail to fit any recognizable pattern of medical illness. These patients might say yes to any question posed by the physician; as a result, the description

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of their symptoms will not help the physician in considering a specific medical entity. Distressed patients also are prone to develop new symptoms as previous symptoms have been appropriately cared for. A variation is the distressed patient who is given appropriate symptomatic medication and fails to comply with the medical regimen, stating that the medication was worse than the symptom or, "I tried it for one day and it didn't do any good." These patients often describe symptoms that may occur only during stressful events in their lives. For example, symptoms may occur only in the presence of a particular individual or in a particular setting, such as the home or the work setting. Patients may have symptoms throughout the week and feel better on the weekend, or the opposite may be true. Symptoms that occur only at a certain time of the year often correlate with previous losses or personal frustrations.

Patients may present with a full range of emotions as they describe their symptoms to their physician. Some may describe their symptoms in a way that conveys primarily sadness and loneliness. These patients may say that nobody cares if they get better or not. Others convey a feeling of guilt, stating that they deserve to have their symptoms and do not deserve to have relief from them. Others may describe symptoms in more bizarre or confusing ways. These patients may leave their physicians not only confused but also doubtful that there is anything organically wrong. Patients often describe their symptoms in a way that gives the physician a feeling of impotence or a feeling that these patients do not believe or expect or even want their symptoms to go away. These patients often make statements to the effect that no one has been able to help them, and no one is likely to help them in the future.

There are many other clues from patients' histories that somatic complaints represent psychological disturbances. The patient who has a history of seeking help from many physicians, none of whom have significantly helped his or her problem, should cause the physician to consider the possibility that those symptoms represent distress. The patient who has a long history of failure to comply with the physician's recommendations may be telling his physician that he has failed to identify his real concerns. A patient who has a history of psychiatric problems, especially problems that have a significant somatic component, should make the physician consider these possibilities. Patients who are undergoing stresses in their lives also commonly develop somatic symptoms.

Differential Diagnosis of Functional Somatic Complaints

Depression

Depressive states commonly present with multiple, vague somatic complaints.[6] While gastrointestinal and musculoskeletal complaints seem to predominate, any body system may be involved. Depression may also be a component of patients with chronic pain in the absence of obvious organic pathology.[7] These patients often appear to be sad, but their affect may be more dominated by irritability, anger, and resentment. They are likely to state they are not worthy of treatment or do not deserve to feel better. They are likely to make their physicians feel somewhat depressed and hopeless as the patients describe their symptoms. Physicians should thoroughly question such patients, looking for vegetative signs of depression, feelings of worthlessness, loss of hope, recent mood changes, and recent losses.

Clinical Example A 28-year-old man came to his physician complaining of severe bitemporal headaches and stomach irritability for three weeks. He was obviously anxious, manifesting gross tremor and pressure of speech. He stated that he had been involved in a number of arguments at work recently and that he no longer enjoyed being with his wife or his child because of his inability to relax. He had previously been treated with mild analgesics and antacids for similar symptoms in the past. On further questioning, he admitted to waking early in the morning and losing interest in athletic activities and sex. He said that he had lost his appetite, that his favorite foods tasted dull to him. The diagnosis of agitated depression was made, and he was started on a tricyclic antidepressant and supportive counseling with considerable improvement over the next two months.

Because of the high frequency of depression in primary care practices, physicians should consider this diagnosis in any patient with multiple somatic complaints in the context of sadness, guilt, anger, and irritability.

Impaired Cerebral Function

Somatic delusions are often part of the schizophrenic process.[8] Chronic schizophrenics often provide vivid and bizarre explanations for their bodily complaints. For example, a chronic schizophrenic patient presented to his family physician with a chief complaint of abdominal distress. He had had these symptoms for many years and early in the interview told his physician that his symptoms were related to the belief that "my girlfriend is trapped within my stomach." A more difficult problem for the primary care physician is recognizing the new schizophrenic who presents initially with multiple, vague, or bizarre somatic complaints. Schizophrenia in its prodromal phase may present with this type of pattern. The clue to the family physician is the attribution applied to the symptoms by the patient. The schizophrenic describes his symptoms in a bizarre and unshakeable way, often in the context of other schizophrenic characteristics, such as other delusions, hallucinations, inappropriate affect, and other signs of psychotic thinking.

Clinical Example A 50-year-old woman made multiple visits over the course of a week to the family medicine center for multiple somatic complaints, including knee and ankle pain, chronic cough, headache, and "problems with my diaphragm." Despite a variety of attempts at symptomatic treatment, she failed to get better; in fact, she increased her frequency of calls to the clinic. She was eventually seen in psychiatric consultation and admitted to the physician that all of her problems were emanating from "my medulla." On further discussion, she admitted to confusion, having trouble thinking straight, and having multiple intruding thoughts about her past life. A presumptive diagnosis of schizophrenia was made, but the patient refused antipsychotic medication. A week later she became acutely schizophrenic and needed inpatient hospitalization.

Hypochondriasis

For some patients sickness seems to be a way of life. These patients have a long history of being ill, with exacerbations around times of personal stress. Their symptoms are usually vague, involve multiple body systems, and are rarely helped by usual medical interventions. They are likely to describe a strong desire for getting better, yet give the impression that no one has been able to help them in the past. The key to the diagnosis is a lifetime of illness claiming behavior and a sense that the physician will not be able to help the patient relieve his symptoms. The importance of any early diagnosis of hypochondriasis lies in the avoidance of excessive diagnostic evaluations and unnecessary treatments as well as the avoidance of the inevitable anger on the part of the physician as the patient fails to give up his symptoms.

Clinical Example A 50-year-old man was seen by his physician with multiple symptomatic complaints dominated by a sense of fatigue and an inability to get anything done. When the patient was asked why he thought this was so, he stated that "people expect too much of me." After many visits during which he was extremely talkative and seemed to enjoy describing the details of his life to his physician, he eventually spent less time talking about his symptoms and more time talking about how hard life was for him. Even though the physician had done nothing specific to relieve his symptoms, the patient continued to have regular 15-minute visits weekly in which the patient described the events of the previous week. These regular visits, using a supportive, nonjudgmental approach and allowing the patient his symptoms, should be the hallmark of treating the somatizing hypochondriacal patient.

Conversion

Conversion refers to the process by which acute emotional distress may overwhelm a person's defenses and become "converted" into a physical or somatic symptom. While this process has been considered one that occurs primarily in women who have a history of dramatic behavior, it in fact occurs in both sexes and at times in otherwise psychologically healthy individuals. The clue that a conversion is occurring is a sudden and dramatic onset of a new symptom that often prevents the patient from performing certain activities and that occurs around a period of acute stress.

Clinical Example A physician was called to the home of a 30-year-old man by his 10-year-old son. The patient's son told the physician that his father was unable to get out of bed. When the physician arrived, the patient stated weakly that he was un-

able to move. He had been fine up until going to bed the night before, but woke up in the middle of the night unable to move. The patient was admitted to the hospital and evaluated for myasthenia gravis, Guillain-Barré syndrome, potassium abnormalities, and polymyositis. All of these conditions were ruled out by laboratory evaluation. Psychiatric consultation was requested, and the patient disclosed to the psychiatrist that he had been fighting with his wife for the past few weeks and that the night of the incident his wife had left home stating she was never coming back. The physician was able to get the patient's wife to visit him in the hospital, and after a number of joint discussions including an agreement for marital counseling, the patient was able to return to normal activity.

Malingering

Malingering implies a conscious attempt on the part of the patient to misrepresent the presence or seriousness of symptoms for personal gain. The syndrome often occurs in a context that reinforces illness behavior, such as in institutions that afford continued hospital care or financial benefits contingent on continued illness. The Münchausen syndrome is an exaggerated form of malingering in which the patient presents outrageous symptoms seemingly with the intent of befuddling physicians.[9] There are frequent hospitalizations requiring extensive evaluation and treatment. The clue to malingering behavior is the presence of vague complaints, often pain related and always difficult to verify by any objective measurement. There is a tendency to "protest too much" about the symptom, and there is always a failure to improve with the usual therapeutic efforts. It usually becomes clear to the physician during the course of an interview with such a patient that the patient's agenda is something other than the relief of symptoms, ie, pain medication or the completion of various forms that not only validate the symptoms but provide the patient with financial gain or excuse him from work or other activities.

Clinical Example A 24-year-old white man presented to his physician with back pain. He stated that the pain began following some heavy lifting at work. He was found to have minimal lumbar muscle spasm and was treated with bed rest, a muscle relaxant, and a short course of codeine. During the next few weeks he made multiple after-hours telephone calls requesting increasing doses of the codeine but did not ask for refills on the muscle relaxant. After two weeks he returned saying that he was no better and again asked for more pain medication. This prompted a telephone call to the patient's previous physician who reported a similar history two years previous, which required six months of pain medication as well as multiple requests by the patient for assistance with disability insurance. The patient was confronted with this information and failed to return for further visits.

The Hidden Agenda

Physicians expect patients to request help when feeling sick or in pain. At times the patient's primary interest is not with relief of pain or the removal of a disease but rather the relief of various anxieties about the symptom or the relief of anxieties that have nothing to do with the presenting symptom.[10] For example, many parents believe that an acute illness of their child is the result of something that they failed to do correctly.[11] Patients may be concerned about the seriousness or other implications of a symptom or may want to talk to their physicians about frustrations in their lives that have nothing to do with the particular symptom. When the physician fails to recognize this, patients often intensify other symptoms or develop new ones as a way of maintaining contact and with the hope that their real agenda will eventually be identified.

Clinical Example A 28-year-old woman in the first trimester of her pregnancy had multiple extra visits for a variety of somatic complaints. Her complaints were the usual ones of the first trimester of pregnancy but seemed more intense and failed to respond to the usual therapeutic intervention. Despite reassurance by her physician that the symptoms would improve as the pregnancy progressed, she requested frequent visits. Her physician finally asked if there was something that the patient was not telling him. At this, she broke into tears and said that she was afraid that the baby was not her husband's. She admitted to having a casual affair four months earlier because of chronic feelings of unhappiness and dissatisfaction with her husband. After speaking to her physician, she was eventually able to share this information

with her husband. Continued discussion with her and her husband and reassurance by her physician that the pregnancy was not the result of her other relationship (dating her pregnancy by careful calculation) produced a significant lessening in the patient's symptoms.

The Identified Patient

A persistent somatic complaint is often a manifestation of serious psychological dysfunction within that patient's family. When a family is in distress, the primary care physician may see only those members who manifest their distress with somatic symptoms. Minor symptoms in children are often used as an entree to the physician by a family undergoing stress.[12] Frequently, patients who come to physicians with a headache, backache, or fatigue forbode a more complicated story likely to include depression, alcoholism, or other manifestations of marital discord.[13]

Clinical Example A 23-year-old moderately retarded woman came to her physician with a chief complaint of vomiting (occasionally bloody) for one month. She denied any other symptoms. A thorough medical and radiologic evaluation failed to clarify the source of the problem, and the patient was treated symptomatically with antacids and anticholinergics. The symptoms persisted for over one month, and she was seen with her mother for a more thorough history. During this interview she described vomiting occurring only at home and only at mealtimes. She stated that her father had been retired for six months and that he had remained quite inactive and essentially stayed at home since retirement. He had begun drinking more heavily since that time, usually starting at about noon. At mealtime he would walk around the table while the rest of the family was eating "giving everyone a hard time." It was during these episodes that the patient developed vomiting, which would be relieved only by leaving the table and going into her room. As she put it, "My father makes me nervous and then my stomach gets upset." With this further history it became obvious that her father's inability to deal with his retirement appropriately and his subsequent increased use of alcohol was leading to significant family disruption and somatic symptoms on the part of the identified patient.

Table 1. Differential Diagnosis of the Somatic Complaint
Decreased Cerebral Function
Schizophrenia
Organic brain syndrome
Various toxic psychoses
Depressive States
Personality Disorders
The addictive personality
Hypochondriasis
The dependent personality
The chronic pain patient
Conversion Reactions
Anxiety States and Responses to Life Stresses
Malingering
The Identified Patient
Somatic complaints representative of family stress
The Hidden Agenda
The attempt to get the physician's attention for something other than treatment of medical disease
Syndromes That Are Mixtures of the Above States

Anxiety Reactions

The somatic manifestations of anxiety are generally caused by excessive sympathetic discharge. Thus, palpitations, tremor, upset stomach, swallowing difficulties, muscle tension, and fatigue are often seen as part of the syndrome. Anxiety may be acute and focal, as a response to a relatively sudden threat to a person's physical or emotional integrity, or chronic and diffuse (ie, effort syndrome, neurocirculatory asthenia) in certain people who appear to be stressed by the demands of everyday life. These patients are likely to be distractable and have pressure of speech, sleep disturbances, and excessive worries. Their discomfort is obvious to the physician who is placed in the position of relieving the patient's many symptoms while considering the many endocrinologic, neurological, and infectious causes which could explain such symptoms. Because of this, the physician should always seek acute stresses that may explain the patient's symptoms.

Table 2. A Guide to Psychiatric Significance of Somatic Complaints

Diagnosis	Duration of Symptoms	How Symptoms Are Presented	Presence of Stress	Type of Symptoms	Other Psychiatric Symptoms	Feeling Engendered in Physician
Depression	Often chronic with exacerbations	Sadness, guilt, does not deserve to feel better	Initiated by recent losses	Multiple, vague symptoms, fatigue, chronic pain, vegetative signs	Depressed mood, vegetative signs, loss of hope, loss of interest	Sad, helpless, identification with patient's needs
Schizophrenia	May be part of fixed delusional system; acute with exacerbations	Bizarre description and attribution; symptoms are unshakeable	Initiated by recent loss or crisis	Often multiple and with peculiar attribution	Delusions, hallucinations, inappropriate affect	Confusion, disbelief
Conversion reaction	Very sudden Onset	Without insight, "belle indifference"	Usually precipitated by acute stress	Usually single, often simulate neurological problem	Variable	Need to look for serious medical illness
Hypochondriasis	Long history of illness-claiming behavior, often precipitated by actual organic illness	Long-suffering, conveys belief no one can help	Symptoms always present, worse under acute stress	Usually vague and with multiple fatigue and pain syndromes, "hypoglycemia" patient states he has never been well	Inability to perform at home and work, may be depressed	Feeling that you cannot really help the patient and that patient wants to keep his symptoms
Malingering	Usually multiple episodes of illness	Sense that patient "protests too much," may say what he wants at end of inteview	No obvious source of stress	Vague pain syndromes, often work related	May be history of disregard for others	Feeling patient is using symptoms for personal gain, physician feels angry and abused
Hidden agenda	Variable	Conveys feeling that there are more important isues than symptoms	Patient has a current concern, worry, fear	Usually single, new symptoms emerge as physician fails to identify agenda	Variable may be anxious depressed	Feeling there are issues beyond the presenting complaint patient wants to talk about
Anxiety state	Usually brief with onset correlating with life stress	Very uncomfortable and seeking relief	Usually a recent life stress or transition	Usually reflect increased sympathetic discharge, palpitations, tremor, upset stomach	Distractibility, insomnia, pressure of speech	Identification with patient's distress
The indentified patient	Variable	Variable	Chronic or acute family disruption	Variable, may symbolize the family's distress	Variable; evidence of distress in family members	Feeling there are issues beyond the presenting complaint

Clinical Example A 37-year-old white man was seen by his physician with complaints of rapid heart beat, nervousness, racing thoughts, and trouble falling asleep. He readily mentioned that he had felt this way for two weeks, since he was told by his wife that she was filing for divorce and taking their children to another city. He stated that he could not get the thought of this out of his mind and at times had thoughts of hurting his wife as well as ending his own life. He was placed on a minor tranquilizer throughout the day and a hypnotic at bedtime, and he agreed to return every few days until he felt he had better control over his situation. He gradually improved and was able to handle the divorce.

Diagnostic Approach to a Suspected Somatizing Patient

Family physicians would do well to lower their threshold for considering functional explanations for certain patients with somatic complaints. Clues for the likely functional nature of the somatic complaint have been previously stated. Once psychological distress is suspected, physicians need to actively consider various diagnostic possibilities (Tables 1 and 2). The following questions should help physicians differentiate the various diagnostic possibilities.

1. How does the patient present his symptoms? Is he sad, angry, guilt ridden? Are the symptoms bizarre, or do they confuse the physician? Does the physician get the feeling that the patient wants to get rid of his symptoms?
2. Is the patient looking for something other than symptom relief? Does he give the impression that there is something else that he wants to talk about or that his needs are not being met by symptomatic treatment?
3. Is the patient looking for something other than medical treatment (eg, an excuse from work, pain medication, validation of his illness)?
4. In what way have the symptoms changed the patient's life? Do they keep him from work or from other activities and responsibilities?
5. How have the patient's symptoms influenced his family life? Does the family support his symptoms, and has his role in the family changed since the onset of symptoms?
6. Are obvious stresses occurring in the patient's life? Is he or his family going through a life transition? Are the symptoms occurring at the time of a significant anniversary of a previous loss? How does the patient describe his level of satisfaction with his home and work situations?
7. Is there evidence of concurrent psychiatric disease (eg, depression, schizophrenia, organic brain syndrome, hypochondriasis, conversion reaction)?
8. Is there a previous history of a psychiatric decompensation? Have there been previous episodes of psychotic thinking, depressive affect, or hysterical behavior? Has there been a lifetime of illness-claiming behavior?

If "crocks" are patients who manifest their psychological distress with somatic complaints, the obligation of physicians confronted with such patients is to understand as well as possible what the somatic complaint represents. Persistent somaticizing can be a manifestation of a wide variety of psychological phenomena, all of which are treatable in their own way once they are clearly recognized.

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