Problems in Family Practice

A Clinical Approach to the Somatizing Patient

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Patients with chronic, unexplained physical complaints are evaluated diagnostically in two steps in primary care: (1) brief consideration of three specific, but rare, disorders (somatic delusion, conversion, and malingering); and (2) extensive consideration of the remaining three common but overlapping disorders (somatization disorder, hypochondriasis, and psychogenic pain). Because of frequent confusion in differentiating among the common somatizing disorders and because the treatment is similar for all, the family physician can be content with the general designation of "common somatization syndrome" when unable to distinguish among them. This diagnosis can be easily established by a good history and physical examination.

Psychiatric referral is required for the rare somatizing disorders. The primary physician can manage the majority of the common somatizing patients by observing the following principles: develop a good physician-patient relationship, apply techniques of behavior modification, engage the patient at the somatic level but extend it to include associated life stresses, strategically use symptomatic measures, treat depression with full doses of antidepressants, and accept the importance of ongoing contact with the patient irrespective of symptoms. When these therapeutic principles are employed, decreased morbidity, medical utilization, and cost can be expected to follow.

Because of their chronic, unexplained physical symptoms, somatizing patients have long posed diagnostic and therapeutic challenges to physicians.[1-3] In the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), the majority of disorders in this group are defined as somatoform disorders,[4] the four specific disorders being conversion, somatization disorder, hypochondriasis, and psychogenic pain. Two other types of somatizing patients, those with somatic delusions and malingering, are classified elsewhere in DMS-III. Somatoform disorders are defined as having physical symptoms with no explanatory organic find-

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ings or known physiologic mechanisms and with evidence that the symptoms are linked to psychological factors.[4] Ford defines somatization somewhat more broadly as a process, usually unconscious, in which the body is used for psychological purposes or personal gain[5]; this explanation encompasses all six of the foregoing somatizing disorders. It is useful to consider somatization as an alternative way (somatic) to express psychiatric disease or psychological distress when the patient is unable to use the emotional route of expression.[6]

Not only is the somatizing patient a common problem for physicians,[7] representing at least 40 percent of a medical outpatient population,[8,9] but his disease predisposes him to increased morbidity, mortality, and iatrogenic complications.[4,5,10] Further, somatizing patients consume an inordinate portion of the medical care dollar,[10] estimated to be at least $20 billion per year excluding the extensive cost to society from disability and time lost from work.[5]

Although psychophysiologic, psychosomatic, and factitious disorders have psychological components, these disorders are usually associated with well-defined pathologic and physiologic abnormalities and should not be confused with the somatizing patient.[4,11]

While unrecognized psychiatric diagnoses are frequent in primary care,[12,13] a recent study of physicians by Oxman et al[2] also shows much diagnostic confusion in distinguishing among the specific somatizing disorders themselves. This paper, in addition to reviewing the differential diagnosis of the somatizing patient, will attempt to clarify the diagnostic approach by separating the diseases into a rare group (somatic delusion, conversion, and malingering) and a common group (somatization disorder, hypochondriasis, and psychogenic pain), and then by considering the diagnostically confusing disorders in the common group as a single diagnostic entity when a more precise diagnosis cannot be made. Finally, a therapeutic approach, applicable in primary care, is outlined to aid in the management of somatization.

The Rare Somatizing Disorders

This group is united only by the rarity of each member, a unique clinical presentation of each in most instances, and by their seldom being confused with the clinical characteristics of the common group. Further, because of the rarity and frequent association with severe psychopathology, psychiatric consultation should be obtained to guide both diagnosis and treatment. Nonetheless, the primary physician should remain involved, accept the problem as real, and protect the patient from doctor shopping and ill-advised interventions.[5]

Somatic Delusions

There are two clinical presentations of this psychotic disorder[14]: (1) as an isolated delusional somatic complaint, and (2) as part of a generalized psychiatric disease in which the somatic delusion is just one of many psychotic symptoms. With either, the clinical presentation of the somatic delusion takes one of the following three forms[14]: (1) dysmorphophobia, (2) delusions of bromosis, and (3) delusions of parasitosis. Patients with dysmorphophobia believe that the face, nose, hair, breasts, or genitalia are deformed and frequently consult surgeons for reconstructive or other procedures; it seems reasonable to include patients with delusions of internal organ deformity or dysfunction[15] in this category also. Patients with delusions of bromosis have delusions of offensive body odors and frequently consult primary care physicians and dermatologists. Patients with delusions of parasitosis have delusions of infestation by parasites and frequently consult dermatologists. The diagnostic task in each is to establish that the patient has deluded thinking.

Conversion Disorder

A conversion disorder is conservatively defined in DMS-III as a rare, isolated, and nonpain-related neurologic problem such as paralysis, blindness, convulsions, mutism, and tunnel vision; it often occurs with stress in a patient with earlier experience with the symptom, and is most often seen in patients who live in rural areas, are uneducated, and are from lower socioeconomic strata.[16] Although this paper uses this restricted definition of conversion, the mechanism of conversion may be more widely applicable.[4,15] To establish a diagnosis of conversion disorder is difficult and usually

requires psychiatric and neurologic consultation. Under certain circumstances conversion disorder is difficult, if not impossible, to differentiate from malingering. In other circumstances, conversion disorder has been difficult to distinguish from organic disease; in follow-up studies of patients with a diagnosis of conversion disorder, approximately 25 percent later exhibited organic disease that could explain the conversion symptom.[16]

Malingering

Malingering is the voluntary (conscious) production of physical complaints to obtain personal gain.[4] It can present with any type of symptom and can usually be detected when organic disease is excluded, secondary gain is prominent, and the voluntary nature of the symptoms is detected. It is important to view malingering as a symptom of underlying psychopathology rather than a disease entity, since past studies have shown that 90 percent had some type of psychopathology, often a personality disorder.[5]

The Common Somatizing Disorders

Because the common somatizing disorders (somatization disorder, hypochondriasis, and psychogenic pain) have many overlapping symptoms, some have suspected that they represent one disorder rather than three.[1,5] A more general and purely descriptive term, the *common somatization syndrome,* is proposed here to designate the three disorders as a single entity when confusion about the specific diagnosis arises; it is also proposed that differentiating among the specific disorders is not essential to the primary care physician, since a similar therapeutic approach is applied to all. In this paper, each of the three disorders will be presented individually, as usually conceptualized,[4,17] and later reformulated as a single diagnostic entity, the common somatization syndrome, for the reader's consideration in otherwise confusing patients.

Somatization Disorder

This chronic nonremitting disorder involves women almost exclusively and always begins before the age of 30 years.[4] Fourteen of 37 nonspecific somatic complaints, including pain, must be present to make this diagnosis. While these symptoms are nonspecific, their style of presentation may be more specific.[18] Although not part of the DSM-III critiera, a histrionic personality style is frequently associated with somatization disorder and, for the most part, is what defines Briquet's syndrome.[5,18] These patients may express considerable affect, but it is usually superficial. They frequently show evidence of depression and often relate chaotic personal lives. There is also a family history of disrupted upbringing in many, of sociopathy and substance abuse in the men (and husbands), and of hysteria in the women.[18]

Hypochondriasis

Hypochondriasis is also a chronic and nonremitting disorder, and it involves men and women in equal proportions.[4] It may begin at any age but is usually diagnosed in middle and older age. These patients typically present with multiple and nonspecific somatic complaints of virtually any type including pain.[19] Their style of presentation, however, may be very specific; in contrast to Briquet's syndrome, the patient's concern is characteristically obsessive. Their style is very controlled and independent, although a certain subset may be quite dependent.[20] These patients show minimal affect and, in the psychological dimension, relate problems with depression, difficult personal lives, and disrupted upbringing.

Psychogenic Pain

Psychogenic pain is diagnosed when pain is the predominant disturbance.[4] Reported to occur at any age, it seems to involve women more than men. Acute symptoms, often following injury, persist and become chronic without a satisfactory underlying organic explanation for the typical syndromes of low back pain, neck pain, facial pain, or pelvic pain. As do patients with Briquet's syndrome and hypochondriasis, these patients also have high scores for histrionic, hypochondriacal, and depressive traits on the Minnesota

Multiphasic Personality Inventory.[21] According to Engel,[22] who has described additional psychological characteristics of the "pain-prone" patient, these patients often come from homes where aggression, pain, illness, and suffering were common. Abusive and often alcoholic parents frequently paid attention to the child only when sick. Suppressed anger were present in many homes, and pain was a symbolic form of punishment. However, these characteristics are not specific and may also be found in somatization disorder and hypochondriasis.[23,24]

The Common Somatization Syndrome

The overlapping characteristics found among somatization disorder, hypochondriasis, and psychogenic pain define a more general diagnostic alternative, the common somatization syndrome. While a more precise diagnosis is ideal, diagnostic confusion among the three disorders often precludes precision.

The common somatization syndrome can be described as a chronic and nonremitting disorder with usual onset in the teens or early 20s; it may be of later onset, especially at times of stress. These patients present with multiple and chronic nonspecific somatic complaints of virtually any type including pain. These somatic complaints seem to exist on a continuum.[19] At the milder end of the scale are those patients who use somatic complaints as a "ticket"[10] to obtain access to the medical care system. Extending beyond these patients are those who develop symptoms only with stress. More severe are those with persisting complaints, some of which progress to incapacitation.

This spectrum of somatic complaints parallels the patient's underlying psychological structure, progressing from normal to neurotic at the milder end to more severe character traits and even psychotic manifestations at the opposite end.[20,25] As many as 50 percent of these patients are also depressed,[26] often with only vegetative changes, and there is an increased risk of suicide.[4,27] These patients are responsive to antidepressants,[28] but the depression is often unrecognized because the vegetative symptoms are "masked" by the other somatic complaints[29]; vegetative complaints must be carefully sought during the interview of any somatizing patient.[3] Anxiety is also prominent in many; moreover, patients with panic disorder usually present somatic complaints.[30] With more severe degrees of psychopathology, disruptive behavior and extreme behavioral shifts may be observed.[27]

Patients with common somatization syndrome are usually unable to express their emotions maturely and often show histrionic or obsessive styles. Varying degrees of masochism, repressed hostility, guilt and need for punishment, and dependency are also present.[20,22-24] There is often a childhood history of overt or subtle deprivation in an unhealthy family structure. Moreover, there is frequently a story of personal or family experience with illness.

These patients are also subject to numerous, predominantly iatrogenic, complications; there is an increased history of surgical procedures and invasive laboratory tests as well as complications from multiple medications.[4,5,10] Substance abuse is also more prevalent in these patients.[4] The social consequences of somatization are high and there is increased medical cost.[5]

The diagnosis of the common somatization syndrome can be made by its characteristic mode of presentation: chronic and refractory physical complaints for which there is no satisfactory organic explanation and for which there is evidence of psychological gain. A careful history and physical examination are often sufficient to determine whether there is an organic explanation; laboratory testing should be obtained only when there are objective data suggesting organic disease. The first clue to the diagnosis usually comes after several contacts when the physician recognizes that the patient is not responding appropriately (with relief) to explanations that there is no serious organic disease.[31] Rather, the somatizing patient persists in believing and behaving as though organic disease were present. Psychological gain, usually in relation to some current life stress, can almost always be found by a careful patient-centered inquiry. Neither psychological testing nor psychiatric consultation is necessary to make the diagnosis in most cases.

Because of already high rates of diagnostic error and confusion in primary care,[2,3,12,13] it is un-

likely in the clinical dimension that harm will come from oversimplification in condensing these three disorders into one. From a research standpoint, however, the entire area of somatization continues to require much careful attention,[32] which must include a search for distinctive somatizing entities. The intriguing findings from the St. Louis group[18] linking poor education, low socioeconomic status, and lack of psychological sophistication with Briquet's syndrome underscore this need; likewise, their work indicating an association of hysteria and sociopathy in families suggests its importance. On the other hand, it is important to consider the possibility that the old system of labeling may itself be stifling research.[32] Nevertheless, significant research advances with a unified approach will require more precise standardization and description of somatizing behaviors.[31] Pilowsky et al[31] have recently developed a promising instrument that can be used reliably by trained interviewers for this purpose.

Treatment of the Common Somatizing Disorders

Treating the common somatizing patient requires realistic goals.[19] It is unrealistic, for instance, to expect a cure, a happy patient, insight, easy expression of affect, or a simple thank you. The following goals, however, are more realistic: decreased medical utilization, decreased disruptive behavior, improved work record, and improved personal relationships.

Beginning Treatment and Establishing a Therapeutic Relationship

The first and always foremost task in working with these patients is to establish and maintain a good relationship.[5] It is important to begin by conveying acceptance of the somatic nature of the patient's problem,[33] and after careful medical evaluation, to explain that ominous conditions have not been found, that surgery and further testing are not necessary, and that the physician knows the diagnosis and will reassess the situation periodically. Since these patients are somatically oriented and may also need to "save face" with family and employers, it is appropriate to give them meaningful but benign somatic explanations for their problems (such as excessive muscle tension, muscle strain, chest wall muscle spasm).

Gradually, the physician must develop the concept that the role of "stress" (avoiding any connotation of psychiatric) is important. When this concept is introduced, the patient will usually ask whether the problem is "all in my head." It is crucial for the physician to convey that he believes the physical complaint to be real, but that emotions and body changes cannot be separated. In making this point, the example of blushing can be used to demonstrate how an emotion, embarrassment, can be associated with a physical change, reddening of the face (". . . in the same way, being upset about your new boss seems to relate to the muscle spasm in your chest"). By establishing this mind-body unity, the patient does not have his somatic complaint threatened and is introduced to the possibility of psychological factors.

It is important, next, for the physician to convey that it may not be possible to cure or remove the patient's complaint, but that it may be possible to live a more productive life by moving the problem from the center of the patient's life. By approaching treatment in this manner, the physician not only avoids setting himself up for failure (by promising cure), but also avoids threatening the patient with removal of a physical complaint that is perhaps essential for his psychological stability.[20,23,25] This approach, at the same time, presents a paradox to the habitually contrary patient and leaves room for hope in the overwhelmed patient. For the many patients who are masochistic,[23,24] it is important to acknowledge clearly their plight ("you've really had a rough time with this") and to avoid reassurance; they benefit from praise of their efforts in face of hardship. For the many who are also dependent,[23,24] it is essential for the physician to emphasize that he will be involved in helping them ("together, I think we can improve things").

It is important in initial contacts to develop, in the patient's own words, that the usual multiplicity of therapeutic agents did not work and were attended by harmful side effects. After learning,

for instance, that meperidine did not alleviate a patient's chronic pain and was associated with depression, the physician can then make his point: he will respect and treat the patient's discomfort but he will not use agents that either do not work or that seem to be more harmful than helpful. By using the patient's own observations, potential arguments about medication are greatly reduced.

Using the Relationship and Medications

After establishing a good relationship, the physician can be even more effective if he is willing to use it. Behavioral modification principles[34,35] should guide the physician. Praise and other positive reinforcers are used to encourage healthy behaviors that are absent in the patient's life (working, social relationships, family activities, and recreation). Withholding praise and paying minimal attention to illness behaviors (somatization) is equally essential; encouraging family, employers, and others to adopt this approach is also necessary.[36]

The very act of doing or prescribing something is often helpful. As long as there is a good rationale and the results are not inherently more harmful than useful, nonnarcotic analgesics,[34] physical therapy, and exercise programs can be beneficial. As Lipsitt indicates,[23] it is important to use that which has worked before. All recommendations should be prescribed on a time-contingent basis to avoid a somatization-reinforcing symptom-contingent regimen.[17,34] Antidepressants should be prescribed in adequate doses for patients who have vegetative or affective manifestations of depression.[17] Anxiolytic agents are rarely, if ever, necessary.

Long-Term Care

In ongoing management, it is not necessary to work up every complaint, but it is important to engage the patient briefly at the somatic level when he presents physical complaints; limited physical examination is usually all that is required. Not only must the physician avoid reinforcing the somatic component, but he also should reinforce the patient for talking about his current life stresses. The physician should keep discussion of the psychological aspects of the patient's life structured and based on reality, and he should not foment affect; his task is to shift the focus of discussion, allow appropriate affect, and promote mature behavior.

It is essential to understand that occasionally physicians may have to give in to patient requests and perform tests when they otherwise might not be ordered; in these circumstances, inexpensive and harmless studies often can be substituted for those the patient requested. The physician, however, must never accede to patient demands for ill-advised tests. If the patient threatens to leave, it is best to acknowledge his right and power to end the relationship and to indicate that such a move would be a mistake. Many respond well to (respectfully proffered) firm limits. It is with this more difficult subset of patients with common somatizing disorders that some type of explicit negotiated agreement can be helpful, not only to resolve specific issues, but to serve as an overall guideline for the long-term relationship.[37]

A frequent mistake in long-term management is to ask somatizing patients to return only when they are having problems. This instruction increases the likelihood that they will develop symptoms. The preferable alternative is to schedule regular follow-up appointments to be kept irrespective of the symptoms.[23,33] This management technique conveys the physicians's interest in the patient rather than the patient's symptoms and reduces the chances of patients developing symptoms as a means to return to the physician. Follow-up visits should be limited to 10 to 20 minutes and occur every two to eight weeks, the interval determined by what seems to work best. It is often important to negotiate a somewhat shorter interval with the very independent patient and a longer one with the dependent patient, especially as time passes. The physician should establish beforehand the limited amount of time available and ask the patient to plan accordingly.

The care of these patients is performed best in a medical setting. A psychiatric referral should be considered with suicidal ideation, severe psychi-

atric disease, severe disruptive behaviors, or if requested by the patient. The family physician, however, should continue to be involved and follow the patient. In the more severely ill and the difficult patients, ongoing joint care by the family physician and psychiatrist using the supportive approach described can be very effective. Insight psychotherapy is seldom useful.[23] In many instances stress counseling, family work, and biofeedback are valuable.[36] For more severe patients, inpatient behavior modification is very useful.[34] The vast majority of patients, however, can be managed successfully by the primary physician. By applying these principles of medical management early in the course of treatment for the patient with acute low back strain that does not respond promptly or for the young woman with multiple complaints who begins to consult many physicians, the primary care provider can function in a preventive way. It has been shown that early detection is especially beneficial in the more severe cases in which the course of illness can be shortened and the number of unneeded physical evaluations are reduced.[38]

Countertransference

Throughout this paper the physician-patient relationship has been emphasized as the most important factor in treating the patient. Yet poor physician relationships with somatizing patients are the rule rather than the exception.[23,32,33,39] To correct this countertherapeutic state, it is helpful to explore why the physician frequently dislikes the somatizing patient. One approach is to examine what physicians appreciate in a "good patient," typically described as one who presents with a clear-cut and treatable organic disease, follows directions, makes no demands upon the physician, gets well, and expresses appreciation to his successful physician.[5] It is clear that the common somatizing patient has few or none of these qualities.[39]

Ford,[5] however, probes deeper. He posits that the psychological fragility of these patients often creates stress in the physician by reminding him of his own conflicts. For instance, patients who are chronically dependent can be expected to reactivate normal dependency conflicts in caretakers. Patients' fears of affect and preoccupation with body integrity may also tap into potential conflicts that exist in many physicians. These activated conflicts result in negative feelings toward patients that stem from the physician's unconscious and are unrecognized by him. The negative feelings are important because they may lead to harmful responses toward the patient (anger, avoidance, disinterest) and a poor physician-patient relationship. These unrecognized feelings occur as a result of countertransference[40] and are nearly universal.[41,42] Because they are so common, they must be considered a normal phenomenon.

Recent shifts in thinking in some psychoanalytical circles have eschewed the original notion that countertransference pointed to a flaw in the work of the physician. This theory has been challenged by an alternative conviction that the physician's role is enhanced by recognizing and working with his countertransference.[40] Kernberg[40] has warned specifically against the assumption that unrecognized feelings automatically suggest something wrong with the physician; he emphasizes that such feelings may be quite natural and justifiable as well as valuable both diagnostically and therapeutically. To consider that they reflect abnormality in the physician serves only to reduce the likelihood that physicians will ever address them. Physicians are probably no more abnormal than lawyers or clerks, and they probably interact with patients much as others do with their clients and customers. The problem is that in medicine (most notably with somatizing patients), unlike other disciplines, outcome is largely determined by the type of interaction.[43] Thus, while the physician-patient relationship and the physician's role in shaping it must be addressed,[42] it is unwise and unwarranted to label all physicians having countertransference issues as somehow abnormal.

The role for education is clear, since these common, but potentially harmful, unrecognized feelings can be addressed successfully through special educational programs.[44,45] To do so may seem a large task, but the physician-patient relationship is the essential ingredient in the successful care of somatizing patients, and visits by these patients constitute 40 percent or more of all outpatient visits.[8,9] Moreover, satisfactory care of

these patients results in decreased utilization and cost.[46,47] Nonetheless, few educators consider countertransference an important issue.[42] Physicians can also address countertransference themselves through self-help efforts and through individual or group psychotherapy. Although predominantly used outside this country, Balint groups may also be a useful way to address countertransference problems in dealing with somatizing patients.[48]

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