Guest Editorial

Somatization in Primary Care

Wayne Katon, MD
Seattle, Washington

Sometimes I feel like we are two gladiators fighting over her illness with the patient rooting for the illness.

Family medicine resident reflecting on a somatizing patient in Balint group

Two recent National Institute of Mental Health studies have demonstrated that 50 to 60 percent of the patients with mental illness are exclusively treated in primary care.[1,2] Moreover, patients with mental illness tend to be overrepresented in studies of patients who are high utilizers of primary care clinics. Hankin and Oktay,[3] in a review of existing studies measuring utilization in patients with mental illness, found that these patients use two to three times as much nonpsychiatric medical care. A large subset of patients with mental illness present with somatic symptoms initially and are treated symptomatically without accurate recognition of the underlying psychological or social problems.[4]

Smith's review,[5] "A Clinical Approach to the Somatizing Patient," in this issue of *The Journal* is helpful in defining several types of somatization as well as in providing an intervention recommendation that has been found in a recent study to decrease medical care utilization and resulting medical costs. Smith et al[6] demonstrated in primary care patients with somatization disorder that one psychiatric consultation interview and the resulting report to the primary care physician (1) confirming the diagnosis of somatization disorder, (2) recommending regularly scheduled visits, (3) recommending workup of problems when there were demonstrable signs found objectively on physical examination, not on subjective patient report, and (4) avoiding referral to specialists unless objective signs of illness were documented significantly decreased medical costs when compared with controls.

In addition to Smith's description of the characteristics of the common chronic somatoform disorders, recent research at the University of Washington has helped elucidate other historical factors that aid in the recognition of somatization in patients with chronic pain.[7] In a study of 52 patients with chronic pain who were treated at the University of Washington inpatient pain program, structured psychiatric interviews revealed that 40 percent had abused alcohol and 60 percent had present or past major depressive episodes. Moreover, 50 percent of patients had either abused alcohol or had one or more depressive episodes prior to when their chronic pain began. Family history revealed strong modeling of pain behavior with 65 percent of patients having one or more first-degree relatives with chronic pain and 35 percent of patients having two or more relatives with chronic pain.

Primary care physicians see patients at earlier stages of psychiatric illness as well as prior to the development of chronic illness behavior. Many patients are seen in the first few months of a depressive illness or with their first anxiety attacks or during acute and subacute stages of "pain" and subsequent illness behavior. It is essential during these early stages that accurate assessment of the clinical problem is made and specific treatment instituted. When the primary care physician suspects that stressful life events, an underlying acute mental illness, or a chronic mental illness is the cause of the patient's symptoms, several historical points are useful:

1. All patients' complaints should be understood in the context of the patient's life, ie, is the patient going through a divorce, leaving home for

From the Division of Psychiatry Consultation–Liaison Services, Department of Psychiatry and Behavioral Sciences, School of Medicine, University of Washington, Seattle, Washington. Requests for reprints should be addressed to Dr. Wayne Katon, Division of Psychiatry Consultation–Liaison Services, RP-10, Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, WA 98112.

the first time, being laid off from work. With their longitudinal view of patients and their families, family physicians often have the unique advantage of a prior psychosocial database.

2. All patients suspected to be somatizing should be screened for panic disorder and major depression. Primary care studies have documented that 87 percent of the patients with psychiatric problems in primary care experience depression or anxiety. Further, Goldberg[8] has documented that 50 percent of the patients with depression and anxiety present with a somatic complaint. A recent prospective study from the University of Washington Family Medicine Clinic demonstrated that patients with depression see their physician more frequently, have more medical evaluations, and telephone their physician more over a one-year period when compared with a nondepressed control group. The depressed patients also presented over this one-year period with more psychophysiologic complaints and nonspecific complaints as well as nondepressive psychological complaints. Studies have documented that major depression occurs in 6 to 10 percent of primary care patients and that panic disorder occurs in 7 to 13 percent of primary care patients.[9] Both panic disorder and major depression can be essentially cured with antidepressant medications or psychotherapy; thus, intensive screening for these disorders in all somatizing patients is essential.

3. Patients having chronic problems with somatization, ie, psychogenic pain, somatization disorder, and hypochondriasis, can be recognized by careful historical data as elucidated by Smith and others[6]:

1. Developmental histories of gross neglect, child abuse, and sexual abuse
2. Unstable adult relationships characterized by multiple divorces and often physical violence
3. Past family histories of alcoholism
4. A past history of alcohol abuse prior to the start of somatization
5. Past history of substance abuse
6. A positive review of systems on medical history
7. A polysurgical history
8. A history of litigious relationships with authority figures
9. Past history of psychiatric illness
10. Modeling of pain behavior in their families as ways of solving problems and coping with intimate relationships

Epidemiologic research both in defining the psychological and social problems associated with somatization and in designing specific interventions is at an early stage. This research should be designed in the primary care clinic, and family physicians with their marriage to the biopsychosocial training model should be at the forefront. In these days of government concern about rising medical costs, research aimed at more accurate recognition and effective treatment of somatizing patients who are high utilizers of medical care should be a high priority. The National Institute of Mental Health has a study section this fall with representatives from family medicine and psychiatry-liaison physicians working in primary care that will attempt to define the methodologic issues and problems in this type of primary care research. More important than saving medical costs, however, is to decrease patient suffering; the lack of accurate diagnosis and treatment for somatizing patients leads to not only unnecessary physician visits, surgery, and medical testing but also to prolonging chronic psychological pain.

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