

# Medically Unexplained Symptoms and the Concept of Somatization

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## ABSTRACT

Somatization, the physical expression of psychological distress, is a prevalent and important problem. It is seen in a wide variety of clinical settings and represents a significant evaluation and management dilemma. The burden to the patient—coupled with the consequential economic and social costs—can be substantial. As a result, the identification and appropriate management of these patients and their often-challenging symptoms is imperative. The following review attempts to summarize the significant body of work committed to the concept of somatization in the medical, surgical, and psychiatric literature. Articles were found through a Medline Search. The search was performed utilizing the terms “somatoform disorders,” “somatization,” “somatization disorder,” “alexithymia,” and “medically unexplained symptom” for January 1966 through May 2004. Appropriate referenced articles and text were also identified and incorporated.

## INTRODUCTION

The presentation of physical complaints suggestive of an organic pathology but that remain unexplained after appropriate evaluation represents one of the most frustrating and puzzling problems in clinical medicine. Medically unexplained symptoms are associated with significant distress, functional impairment, and increased health care utilization.<sup>1</sup> The motivation and etiology of these somatic complaints are varied, as are the potential clinical presentations. Conceptually, medically unexplained symptoms are best comprehended through a sound understanding of the theory of somatization. In this paper, the term somatization will be used descriptively for patients that experience and

communicate psychological distress with unexplained somatic complaints. Medically unexplained symptoms and somatization, descriptive terms that will be used interchangeably in this paper, need to be differentiated from the formal psychiatric diagnosis of somatization disorder. Somatization disorder is one of the somatoform disorders in DSM-IV TR and represents a specific diagnostic entity with precise diagnostic criteria that must be met in order to make the diagnosis.

## HISTORY

The concept of somatization has held various names throughout the centuries. Along with the multitude of names came a number of theories that attempted to explain the often diffuse and challenging physical complaints for which no corresponding disease-state could be found. The ancient Egyptians theorized that the uterus was displaced, thereby dislocating other bodily organs and causing diffuse physical symptoms. The Greeks also saw the wandering uterus as a source of these somatic complaints. This belief that the uterus was the source of medically unexplained symptoms, together with the assumption that this was a phenomenon of women only, held fast until the 17th century and the work of Thomas Sydenham. He recognized that somatization was a psychologic disturbance and that it may also occur in males. In the late 19th and early 20th centuries, Briquet, Freud, and Breuer also began to explore the phenomenology of medical unexplained somatic complaints and made further important contributions.<sup>2</sup>

Contemporary psychiatry places somatic complaints that are not adequately explained by a physical disease process under the diagnostic category of somatoform disorders in the DSM-IV TR.<sup>3</sup> The common feature of somatoform disorders is the presence of physical symptoms that suggest a medical condition but are not fully explained by the presence of an underlying medical condition. DSM-IV TR-defined somatoform disorders include conversion disorder, somatization disorder, hypochondriasis, body dysmorphic disorder,

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undifferentiated somatoform disorder, pain disorder, and somatoform disorder not otherwise specified. In addition, various medical and surgical specialties have developed their own nomenclature and diagnostic criteria to describe and classify these diverse complaints and symptom clusters, such as functional somatic syndromes<sup>4</sup> or multisomatoform disorder.<sup>5</sup>

#### PROCESS OF SOMATIZATION

The conceptualization of somatization begins with an understanding of the distinction between illness and disease.<sup>6</sup> Illnesses are subjective experiences made up of bodily symptoms individualized by the patient. Diseases, in modern medicine, are objective pathologic abnormalities in organ structure or function. Illness and disease are not synonymous entities, and if both are present the findings need not be proportionate. Problems commonly arise in the patient-physician relationship when the patient's subjective experience of illness does not correlate with the physician's objective findings of disease. This illness-disease mismatch is at the heart of the problems encountered in somatization.

Somatization may best be understood as a form of communication via somatic complaints rather than verbal or emotional interactions. Somatization has a wide variety of presentations and may not always represent a clinical problem. It only becomes pathological when associated with significant distress and social or occupational dysfunction. At times this disorder may be lifelong and almost characterologic in appearance and duration. However, the picture may also present more benignly as a transient and solitary clinical event at times of great stress.

The theory of alexithymia, literally "no words for mood," is another important concept in understanding somatization. Alexithymia was first described by Sifneos and refers to a specific disturbance in one's own emotional awareness or the capacity to verbalize affect.<sup>7</sup> Relationships between alexithymia and health care utilization, and with somatization in particular, have been established.<sup>8,9</sup> When one is unable to verbally express an emotional state, other means of declaration are often utilized. One common language used by alexithymic individuals is the somatic language of physical symptoms and complaints, which Stoudemire termed "somatothymia."<sup>10</sup>

#### PREVALENCE

Syndromes characterized by medically unexplained somatic symptoms are very common in all areas of clinical medicine. Medical explanations for common med-

ical complaints such as fatigue, dizziness, and abdominal pain are found in as few as 16% of medical outpatients despite diagnostic testing at the end of approximately 1 year of follow-up.<sup>11</sup> Medically unexplained symptoms are a common worldwide occurrence. One study of 15 primary care centers in 14 countries reported a prevalence of somatization approaching 20%.<sup>12</sup> A community sample in the United States revealed a rate of up to 20% of a subsyndromal form of somatization disorder.<sup>13</sup> Somatization is not limited to the ambulatory medicine population and is a common—and often unrecognized—occurrence in the general medical hospital.<sup>14</sup>

#### SIGNIFICANCE

Somatization, especially its persistent form, represents a substantial problem.<sup>15</sup> In addition to the physical distress experienced by patients there is significant occupational and social dysfunction. For example, patients who suffer from medically unexplained symptoms experience a lower level of life satisfaction.<sup>16</sup> Patients believe their health to be worse than the medically ill<sup>14</sup> and are at a greater risk for self-reported disease burden.<sup>12</sup> There is also a significant societal cost related to health-care utilization and the associated economic burden. Patients diagnosed with a somatization disorder have a 50% higher use of office visits and a 9-fold higher overall health care cost than nonsomatically focused patients.<sup>17,18</sup> In addition, physicians report low levels of professional satisfaction when dealing with patients experiencing medically unexplained symptoms.<sup>19</sup> A patient's somatic style of presentation may also impair the physician's ability to identify comorbid conditions such as anxiety or depression.<sup>20</sup>

#### ETIOLOGICAL FACTORS

Multiple potential etiologies of somatization have been proposed. Somatoform disorders may have a biological or genetic component.<sup>21</sup> Medically unexplained symptoms may represent bodily metaphors through which patients express emotional conflicts (classic conversion disorder). Early childhood exposure to models of illness behavior, such as an ill parent, increases the potential for developing somatization.<sup>22,23</sup> Trauma exposure, such as sexual or physical abuse, has also been reported to predispose individuals to the development of medically unexplained symptoms.<sup>24,25</sup> As mentioned earlier, a quantitative review of the alexithymia literature documented a relationship between the presence of alexithymia and somatization.<sup>9</sup> Society also stigmatizes psychiatric illness and places a premium on physical ill-

ness, as evidenced by unequal insurance reimbursement patterns. Insurance plans often cover physical problems but may lack parity with or even “carve-out” mental illness. As a result, individuals may feel that they can only seek care through the presence of physical complaints even though the primary problem is psychological. Thus, social and economic factors may induce a form of iatrogenic somatization. Although the relationship between gender and somatization is confusing and the studies flawed, it appears that women somatize more than men.<sup>26</sup> Most commonly in clinical practice the cause is multifactorial and involves a complex combination of multiple risk factors and incentives.

#### INITIAL EVALUATION

Clinicians must have a high degree of suspicion for somatization. Patients may have multiple non-specific complaints such as pain, sexual problems, fatigue, or gastrointestinal problems. They may also present with a specific complaint, such as chest pain, for which no organic etiology can be found. Individuals often present dramatically with extensive complicated past medical and surgical histories. Somatizing patients are often very persistent in their medical care, seeking multiple subspecialty referrals or engaging in “doctor shopping.” Despite this high utilization, patients often are dissatisfied with the attention they receive.

The underlying assumption is that no identifiable medical condition is present that explains the symptoms. Evaluation of a patient with medically unexplained symptoms starts with a thorough review of the medical records for appropriate medical evaluation and confirmed medical diagnoses. Patients who somatize also suffer from disease states, and appropriate medical assessment is vital. Collateral information regarding symptoms, functional disability, and prior evaluations or diagnoses should be obtained. Attention to the patient’s mental status for evidence of a mood or anxiety disorder is important. The patient’s attitude towards the somatic complaints should be assessed, along with a careful determination of the strength of the patient’s illness belief.<sup>27</sup>

#### DIFFERENTIAL DIAGNOSIS AND COMORBID CONDITIONS

Patients who somatically express psychologic disturbances may have a wide variety of psychiatric disorders and/or medical disease states. Some somatizing patients present with multiple unexplained physical complaints that are suggestive of somatization disorder. The diagnostic criteria for somatization disorder require that

the patient present with a variety of physical complaints that begin before age 30. These symptoms have resulted in treatment being sought and significant impairment in functioning. Symptom must include various pain, gastrointestinal, pseudoneurologic, and sexual complaints. Other patients may present with an excessive hypochondriacal worry about having a serious medical illness. Depression and anxiety may also be exhibited with multiple somatic complaints instead of the more easily recognized psychological complaints of subjective sadness or panic. Anxiety disorders and depressive disorders are very common in high utilizers of medical care.<sup>28</sup> The multitude of physical complaints has been shown to confuse the true psychiatric diagnosis and complicate appropriate treatment.<sup>29</sup> Personality disorders may also complicate the diagnostic evaluation of medically unexplained symptoms and are quite common in this patient population.<sup>30-32</sup>

As mentioned previously, patients with vague somatic complaints also develop true disease states. Medical disorders that present with vague and diffuse complaints, such as multiple sclerosis, lupus, or porphyrias, may be responsible for patient presentations that initially resemble somatization. A longitudinal study of conversion disorder provides an excellent example of this difficulty. The essential feature of conversion disorder is the presence of unconsciously produced symptoms that effect voluntary sensory or motor function, suggesting a medical or neurological disorder. A psychological conflict or stressor precedes the disorder and no medical etiology of deficit is found. The aforementioned study revealed that 13% of patients initially diagnosed as having conversion disorder later developed a medical disorder, which could have explained the initial “conversion” symptoms.<sup>33</sup> Medical disorders may coexist with medically unexplained symptoms, but the somatic complaints are either unexplained by the medical illness or out of proportion to the actual disease-state. As a result, an appropriate medical and psychiatric evaluation is imperative in patients who may exhibit characteristics of somatization.

#### COURSE

Somatization complaints vary over time with persistence of symptoms being a factor of the intensity of one’s health beliefs and the presence of comorbid psychiatric conditions.<sup>34</sup> Somatization disorder, by definition, is a chronic condition that starts before age 30. Nonetheless, medically unexplained symptoms may be situation-specific and transient with symptom exacerbation coinciding with periods of stress. Situation-spe-

cific somatization is often brief in duration and resolves with resolution of the precipitating stress. This form of somatization often only requires calming reassurance from the care provider. However, in some patients with recurrent frequent physical complaints, somatization may become so common as to appear as a way of life for the individual. This persistent chronic form of somatization should be differentiated from the more common transient somatization due to different management implications.

#### MANAGEMENT/TREATMENT

Individuals with medically unexplained symptoms, due to the nature of their complaints, are most often found in general medical clinics or hospitals rather than in psychiatric settings. Most management strategies have focused on the treatment of somatization disorder in particular, but generalizations can be made. The treatment of somatization disorder is fundamentally based on the understanding that the disorder is often chronic and unnecessary interventions are potentially harmful. There is little empiric evidence to support the use of psychotropic medications in the treatment of somatization disorder unless comorbid psychiatric conditions, such as depression or anxiety, are also present.<sup>35</sup> In addition, polypharmacy in an attempt to manage multiple somatic complaints places the patient at risk for iatrogenic harm. Do not treat what the patient does not have. As result, the treatment is primarily reassurance and conservative management.

Treatment begins with the physician attempting to establish an effective early treatment alliance. This alliance, at least initially, should be based on the concept of management rather than cure.<sup>36</sup> The foundation of the alliance is often built upon the physician's recognition of the somatic complaints and of the patient's suffering. This assures patients that the physician is taking them seriously. Confrontation is usually not helpful.<sup>37</sup> Regular follow-up is essential. Frequent appointments prevent the patient from developing a new complaint as a "ticket of admission" to another visit with the physician. The duration of appointments needs to be set with established specific treatment goals. Physician reassurance is one of the most important therapeutic interventions in the management of somatizers. Kathol suggested some steps that physicians may use to reassure patients: (1) question and examine the patient, (2) assure the patient that, based on the exam, a serious illness is not present, (3) suggest that the symptom will resolve and (4) follow the patient.<sup>38</sup>

Treatment of comorbid mood and anxiety disorders

is imperative. Untreated psychiatric disorders unnecessarily complicate the management of somatization and have significant morbidity in their own right. Patients with the tendency to somatize also develop independent medical and neurologic disorders. Appropriate physical examination and diagnostic tests may be indicated based on objective signs or a suspicious change in symptom presentation. However, the investigating clinician must place the new symptom in the context of the patient's history of somatization.

Caregivers must also recognize their own negative reactions to these often distressed patients and difficult management situations. In one study, physicians identified the use of empathy, tolerance, and non-judgmental listening as means of improving physician-patient relations and making potentially challenging patient encounters easier.<sup>39</sup>

Psychiatric referral may be sought in an attempt to augment the care of patients with medically unexplained symptoms. When the treating physician suggests psychiatric referrals, it is important that the patient not feel abandoned. The referring physician must ensure a continued presence with regularly scheduled and frequent appointments. Despite these measures, psychiatric referrals are often a source of contention between the treating physician and the patient. A careful explanation of the rationale for referral, often emphasizing the role of stress in physical illness, can be helpful in facilitating psychiatric referral. Despite the potential difficulties in initiating psychiatric consultation, patients with medically unexplained symptoms typically benefit from psychiatric consultation. Studies have shown that a letter to the primary care physician from a consulting psychiatrist has resulted in a net reduction of health care costs (21%-53%) and improved physical function in a group of highly impaired somatizing patients.<sup>40,41</sup> A randomized controlled clinical trial revealed the benefits of short-term group therapy in patients with somatization disorder. Patients who went to 8 sessions of group therapy reported better physical and mental wellbeing after 1 year, along with a net 52% reduction in health care charges.<sup>42</sup>

#### SUMMARY

The concept of somatization is the process through which one utilizes bodily symptoms for psychological purposes. It may present in a variety of ways and with varying degrees of severity. The clinician must be acutely aware of its presence and identify appropriate management plans and treatment goals. When not appropriately recognized by the clinician, somatization

may lead to frustration for the patient and clinician as well as unnecessary medical expenditures and risk of iatrogenic illness. These high costs, both personal and societal, make the study of medically unexplained symptoms important for both effective clinical care and financial reasons.

## REFERENCES

1. Hollifield M, Paine S, Tuttle L, et al. Hypochondriasis, somatization, and perceived health and utilization of health care services. *Psychosomatics*. 1999;40:380-386.
2. Smith GR Jr. *Somatization Disorder in the Medical Setting*. Washington DC: American Psychiatric Press; 1991:5-9.
3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th Ed. Washington DC: American Psychiatric Press; 2000:485-511.
4. Barsky AJ, Borus JF. Functional somatic syndromes. *Ann Intern Med*. 1999;130:910-921.
5. Kroenke K, Spitzer RL, deGruy FV, et al. Multisomatoform disorder. an alternative to undifferentiated somatoform disorder for the somatizing patient in primary care. *Arch Gen Psychiatry*. 1997;54(4):352-358.
6. Eisenberg L. Disease and illness. Distinctions between professional and popular ideas of sickness. *Cult Med Psychiatry*. 1977;1(1):9-23.
7. Sifneos PE. The prevalence of alexithymia characteristics in psychosomatic patients. *Psychother Psychosom*. 1973;22:255-263.
8. Joukamaa M, Karlsson H, Sholman B, et al. Alexithymia and psychosocial distress among frequent attendance patients in health care. *Psychother Psychosom*. 1996;65:199-202.
9. DeGucht V, Heiser W. Alexithymia and somatisation: a quantitative review of the literature. *J Psychosom Res*. 2003;54:425-434.
10. Stoudemire A. Somatothymia. *Psychosomatics*. 1991;32(4):365-381.
11. Kroenke K, Mangelsdorff AD. Common symptoms in ambulatory care: incidence, evaluation, therapy, and outcome. *Am J Med*. 1989;86(3):262-266.
12. Gureje O, Simon GE, Ustun TB, Goldberg DP. Somatization in cross-cultural perspective: a World Health Organization study in primary care. *Am J Psychiatry*. 1997;54(7):989-995.
13. Escobar JI, Rubio-Stipec M, Canino G, et al. Somatic symptom index (SSI): a new abridged somatization construct. Prevalence and epidemiological correlates in two large community samples. *J Nerv Ment Dis*. 1989;177(3):140-146.
14. deGruy F, Crider J, Hashimi DK, et al. Somatization disorder in a university hospital. *J Fam Pract*. 1987;25(6):579-584.
15. Fink P. The use of hospitalizations by persistent somatizing patients. *Psychol Med*. 1992;22(1):173-180.
16. Noyes R, Holt CS, Kathol RG. Somatization. diagnosis and management. *Arch Fam Med*. 1995;4(9):790-795.
17. DeGruy F, Columbia L, Dickinson P. Somatization disorder in a family practice. *J Fam Pract*. 1987;25(1):45-51.
18. Smith GR, Monson A, Ray D. Patients with multiple unexplained symptoms: their characteristics, functional health, and health care utilization. *Arch Intern Med*. 1986;1986:69-72.
19. Hartz AJ, Noyes R, Bentler SE, et al. Unexplained symptoms in primary care: perspectives of doctors and patients. *Gen Hosp Psychiatry*. 2000;22:144-152.
20. Kirmayer LJ, Robbins JM, Dworkind, et al. Somatization and the recognition of depression and anxiety in primary care. *Am J Psychiatry*. 1993;150(5):734-741.
21. Torgersen S. Genetics of somatoform disorders. *Arch Gen Psychiatry*. 1986;43(5):502-505.
22. Hotopf M, Wilson-Jones C, Mayou R. Childhood predictors of adult medically unexplained hospitalizations. Results from a national birth cohort study. *Br J Psychiatry*. 2000;176:273-280.
23. Hotopf M, Mayou R, Wadsworth M, et al. Childhood risk factors for adult medically unexplained symptoms: results from a national birth cohort study. *Am J Psychiatry*. 1999;156:1796-1800.
24. Lesserman J, Li Z, Drossman DA, et al. Selected symptoms associated with sexual and physical abuse history among female patients with gastrointestinal disorders: the impact on subsequent health care visits. *Psychol Med*. 1998;28(2):417-425.
25. Morrison J. Childhood sexual histories of women with somatization disorder. *Am J Psychiatry*. 1989;46(2):239-241.
26. Wool CA, Barsky AJ. Do women somatize more than men? gender differences in somatization. *Psychosomatics*. 1994;35(5):445-452.
27. Creed F, Guthrie E. Techniques for interviewing the somatizing patient. *Br J Psychiatry*. 1993;162:467-471.
28. Katon W, Von Korff M, Lin E, et al. Distressed high utilizers of medical care. DSM-III-R diagnoses and treatment needs. *Gen Hosp Psychiatry*. 1990;12(6):355-362.
29. Katon W. Panic disorder and somatization. *Am J Med*. 1984;77(1):101-106.
30. Rost KM, Akins RN, Brown FW, et al. The comorbidity of DSM-III-R personality disorders in somatization disorder. *Gen Hosp Psychiatry*. 1992;14(5):322-326.
31. Bass C, Murphy M. Somatoform and personality disorders: syndromal comorbidity and overlapping developmental pathways. *J Psychosom Res*. 1995;39(4):403-427.
32. Stern J, Murphy M, Bass C. Personality disorders in patients with somatization disorder. a controlled study. *Br J Psychiatry*. 1993;163:785-789.
33. Kent DA, Tomasson K, Coryell W. Course and outcome of conversion and somatization disorders. a four-year follow-up. *Psychosomatics*. 1995;36(2):138-144.
34. Gureje O, Simon GE. The natural history of somatization in primary care. *Psychol Med*. 1999;29:669-676.
35. Escobar JI. Pharmacological treatment of somatization/hypochondriasis. Overview of somatization: diagnosis, epidemiology, and management. *Psychopharmacol Bull*. 1996;32:589-596.
36. Bass C, Benjamin S. The management of chronic somatization. *Br J Psychiatry*. 1993;162:472-480.
37. Lazare A. Current concepts in psychiatry. conversion symptoms. *N Engl J Med*. 1981;305(13):745-748.
38. Kathol RG. Reassurance therapy: what to say to symptomatic patients with benign or non-existent medical disease. *Int J Psychiatry Med*. 1997;27:173-180.
39. Steinmetz D, Tabenkin H. The difficult patient as perceived by family physicians. *Fam Pract*. 2001;18(5):495-500.
40. Rost K, Kashner TM, Smith RG Jr. Effectiveness of psychiatric intervention with somatization disorder patients: improved outcomes at reduced costs. *Gen Hosp Psychiatry*. 1994;16(6):381-387.
41. Smith GR Jr, Monson RA, Ray DC. Psychiatric consultation in somatization disorder. a randomized controlled study. *N Eng J Med*. 1986;314(22):1407-1413.
42. Kashner TM, Rost K, Cohen B, et al. Enhancing the health of somatization disorder patients. effectiveness of short-term group therapy. *Psychosomatics*. 1995;36(5):462-470.