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Somatisation: embodying the problem

The commonest way for psychiatric disorder to present

An emotionally distressed patient is more likely to consult a general practitioner with physical symptoms than to complain directly about psychological or social problems.[1] The term "somatisation" has recently secured a place in the psychiatric lexicon to denote such presentations. It is not a diagnosis, and it no longer means what it did to Stekel in 1908: a "deep seated" neurosis akin to the mental mechanism of conversion.[2] The term is now used to describe how patients come to seek medical help for bodily symptoms misattributed by them to organic disease.

In a study of British general practice attenders Goldberg and Bridges added two further criteria to define somatisation: psychiatric disorder shown by standardised interview and the likelihood that treatment of the disorder would reduce or eliminate the physical symptoms.[1] When applied to all new episodes of illness these criteria were fulfilled by almost a fifth of patients. In contrast, 5% consulted for psychological complaints.[3] Far from being atypical, as psychiatric reports often imply, somatisation is the most common way for psychiatric disorders to present.

Somatising patients do not lack psychological symptoms, but they are mainly or entirely concerned with their physical complaints and so less likely to report their psychological symptoms. They are also more hostile to mental illness, supporting Goldberg and Bridges' contention that somatisation allows those unsympathetic to emotional disturbance to none the less occupy the sick role.[1] Goldberg and Bridges have emphasised that somatisation helps patients avoid the blame for their unhappy predicament, which may lessen the pain of depression.

Medical anthropologists have reached similar conclusions. They observe that somatisation, defined as the expression of personal and social distress in the "idiom of bodily complaints," is the norm in most cultures, where it can be a socially adaptive strategy for dealing with potentially unacceptable or unwanted feelings, while avoiding the stigma of mental illness.[4] In some cultures healers may share the patient's explanatory model of somatic causation and diagnose a physical disorder rather than an emotional one.[5] Indeed, the concept of somatisation only makes sense in a dualist framework, which offers the possibility of "psychologisation."

Until recently psychiatrists' accounts of these somatic presentations were based on the experience of the small unrepresentative sample referred to them. A further problem is that traditional psychiatric categories and concepts, such as hysteria, hypochondriasis, and psychogenic pain, are often used loosely and pejoratively. This has led to alternative formulations of somatisation as learned illness behaviour reinforced by the advantages of the sick role.[6-9]

Efforts to define specific diagnostic entities have, however, continued. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (3rd edition, revised), offers a classification of "somatoform disorders," of which conversion disorder, somatisation disorder, and somatoform pain disorder are examples.[10]

Whereas conversion disorder corresponds to the "classic" picture of hysteria (short duration with abrupt onset and resolution) somatisation disorder describes patients with chronic, recurrent, multiple, and unexplained physical symptoms with an onset before the age of 30. To fulfil the diagnostic criteria a patient must have at least 13 symptoms that have led to medical consultation, disability, or treatment. Temporal stability,[11] reliability,[12] and validity[13] have been claimed for the diagnosis, which has been applied to 1-2% of women.[14]

British workers have been circumspect in accepting the validity of the diagnosis; they have questioned its usefulness and failed to detect such a high prevalence of the disorder in either primary care[15] or among hospital attenders.[16] This difference may reflect the ease with which patients in the United States gain direct access to various specialists and accumulate the criteria required for the diagnosis. The idea of this discrete diagnostic entity seems, therefore, inappropriately restrictive for research into chronic somatisation in Britain. It also obscures doctors' contribution to the process of somatisation.

Chronic somatisers have often embarked on a career of hospital attendances, admissions, and investigations to exclude diseases that might account for their symptoms. How this process begins and is maintained therefore depends also on doctors. Some general practitioners produce more somatisation than others,[1] but patients may control the behaviour of their general practitioner by the timing, order, and nature of the symptoms they present.[17]

Once in specialist care many patients are reluctant to return to their general practitioner without a physical diagnosis. For many patients (and some health workers) the suggestion that a symptom is psychological implies that it is not "real" and that they must be lying or "imagining" it. A potentially acri-

monious and embarrassing confrontation is often avoided by further investigations and specialist referrals. Despite the antipathy doctors often express towards chronic somatisers medical care may become a valued source of social support; when it does the patient is often not seeking relief of physical symptoms but using them instead to gain the interest and empathy of the doctor.[18 19]

The recent theoretical shift towards viewing somatisation as a process rather than a category has led to greater optimism in prevention and treatment. [1 9 20] Kaiser-Permanente, an American health maintenance organisation has claimed, however, that the "over utilisation of primary care physicians by somatising patients" could bankrupt the "health care financing system."[19] There is evidence that such patients can be helped, while at the same time reducing health costs.[20] The National Health Service could benefit greatly from a modest programme of clinical and operational research in this neglected area.

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Approaches to somatisation

Issues of time, consultation style, and practice organisation

Treating somatisation has become a topical issue: the Society for Psychosomatic Research recently devoted a conference to it, and last year the Royal College of General Practitioners published the third edition of *To Heal or to Harm: The Prevention of Somatic Fixation in General Practice*.[1] This journal has also devoted space to the closely related topics of "heartsink" and "difficult" patients[2 3] and to "unrecognised depression" in patients consulting general practitioners.[4]

Identifying the true cause of presenting complaints in patients who may be anything from mildly anxious to seriously depressed is difficult but important—drug treatment, which may be appropriate for severely depressed patients, is less useful in managing patients responding to economic, environmental, or personal stressors. General practitioners often feel unable to do much to help patients change these stressors and may lack the skills and time for counselling. Treatment with drugs, therefore, becomes a practical action rather than the preferred option.

What can be done to help doctors deal successfully with patients who "somatise" their lives? Recently, doctors have been encouraged to take a balanced approach to the physical, social, and psychological components of consultations. [5-9] The value of these developments, however, is difficult to assess, and there is little point in training young doctors to work to such a model when the financing and organisation of British general practice does not encourage doctors to take time to listen to patients. Proposals contained in the new white paper, *Working for Patients*, may make this worse.[10]

At present many doctors work with appointment or "open" surgery systems, which do not allow them time to identify and explore psychosocial problems. Inevitably they find it difficult and stressful to deal adequately with complicated interactions between psyche and soma in the time available. Some doctors feel that they have little enough time to deal with patients' perceived needs without delving into their unacknowledged psychological problems. Some may question their role in dealing with illness other than somatic illness. This approach may appeal particularly to patients who resist making a connection between their presenting a physical problem and any underlying psychosocial component, who resent a doctor steering the consultation away from the somatic towards the psychosocial. In larger practices somatising patients can usually change doctor until they find one who views their complaints as physical and responds by arranging investigations. The current medical climate encourages this: doctors are trained to minimise uncertainty and exclude physical causes for symptoms by ever more tests.

Apart from these problems of incentives, time management, and doctors' style there are issues of records, computers, and team care. General practitioners' notes in patients' records, particularly on psychological topics, depend more on the doctor than on the patient's illness and may convey different meanings to successive readers.[11 12] The distinctive pattern of individual and family consultations described by Huygen[13 14] is often unavailable to the doctor, either because family members are registered in several practices or their notes are filed separately. Concerted action by general practitioners can change the consultation behaviour of whole families, small numbers of whom can create a large proportion of doctors' workload.[2 15]

Given the ever expanding remit of general practice—for example, community care and health promotion—it is difficult to see how general practitioners can provide holistic care for 2000 patients. One way forward would be a reduction in list size without a loss in income, matched by a commitment from doctors to devote this "new" time to their patients. The attachment of appropriately experienced counsellors to the primary care team is another possibility. A third might be the use of standardised psychiatric, psychosocial, and health screening questionnaires,[16-22] to help identify people with