

Somatization Disorder: Clinical Presentation and Treatment in Primary Care

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Somatization disorder, also termed *Briquet's syndrome*, is a distinct clinical and epidemiological condition that lies in the borderland between clinical medicine and psychiatry.¹ Primary care providers may intuitively recognize patients with somatization disorder and may earnestly wish to refer them to other physicians because of the overwhelming feelings of dread that these patients evoke with their multiple medical complaints.²

Patients with somatization disorder usually present with numerous symptoms, such as headaches, back pain, persistent lack of sleep, stomach upset, and chronic tiredness, all without demonstrable medical causes.³ Patients with somatization disorder have a persistent conviction of being ill, despite repeated negative results on laboratory tests, diagnostic tests, consultations with specialists, and recurrent hospitalizations. Patients with somatization disorder continue to seek medical care, take several medications, and submit to needless diagnostic and surgical procedures. By the time these patients reach middle age, they may have undergone an average of 10 operations and acquired several volumes of medical records.¹⁻³

Because patients with somatization disorder feel ill most of their lives and complain of multiple body ailments, these patients consume nearly half of their physician's time.³ With the mounting pressure to contain health care costs, primary care providers need a comprehensive approach to guide their clinical management of patients with somatization disorder. This article reviews the epidemiology, clinical features, diagnostic evaluation, and treatment of somatization disorder in the primary care setting.



EPIDEMIOLOGY

The lifetime prevalence of somatization disorder ranges from 0.2% to 2% among women and is less than 0.2% in men.⁴ The disorder usually begins in the teenage and young adulthood years. Onset after the age of 30 years is extremely rare.⁵ Somatization disorder seems to be more common in less educated and lower socioeconomic groups.⁶ The disorder is observed in 10% to 20% of female first-degree relatives of

women with the disorder.^{4,7} The male relatives of women with somatization disorder have an increased risk of antisocial personality, substance abuse disorders, and somatization disorder.^{4,5} A biologic or adoptive parent with antisocial personality, substance abuse disorders, or somatization disorder also increases the related patient's risk of developing any or all of these disorders,⁴ thus suggesting that the combination of both environmental and genetic factors contributes to the risk of developing these conditions.^{4,5}

An estimated 25% to 75% of patients presenting with somatization disorder to primary care providers may have this disorder resulting from psychological distress.⁸ Compared with patients without the disorder, patients with somatization disorder are found to have a six-times higher rate of hospital expenses, a 14-times higher rate of ambulatory care visits, and a nine-times

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higher rate of total health care costs.^{7,9} A typical patient with somatization disorder spends an average of 7 days per month sick in bed compared to 0.48 day for a patient without the disorder.^{2,5,9}

CLINICAL FEATURES

Patients with somatization disorder have the tendency to react to psychosocial distress and environmental stressors with physical bodily symptoms.^{8,10} Their complaints are usually centered on cardiovascular, gastrointestinal, respiratory, skin, and other organ systems that have a strong autonomic nervous system mediation.^{10,11} **Table 1** summarizes the common symptoms associated with somatization disorder.¹⁰

Patients with somatization disorder can be vague and dramatic in reporting their medical history.¹⁰ These patients frequently move abruptly from complaining of one symptom to another symptom and subsequently complicate the task of isolating one medical problem at a time, rendering the office visit an arduous and frustrating task for the physician.^{5,6} Often, the only reliable conclusion that is reached during the initial assessment of a patient with somatization disorder is that, objectively, the review of systems is grossly and diffusely normal.^{1,10} Physical examination may reveal some skin lesions or scars that resulted from previously performed surgeries; however, these minor abnormalities do not account for the magnitude of the patient's complaints.¹¹

For a patient with somatization disorder, the demand for attention extends beyond the medical setting to the patient's family life and professional career; as a result of this demand, personal relationships are sacrificed and vocational occupations are relinquished.^{5,10} Somatization disorder affects the patient's perception of wellness, and the patient begins to believe that she or he is physically disabled and unable to work. Even if a suitable job is found, frequent sick leaves lead to an eventual loss of employment. The crippling burden of medical expenses and the possible complications of unnecessary surgical and diagnostic procedures may further magnify the psychosocial distress and reinforce the feelings of discomfort and disability, thus prolonging the course of somatization disorder and leading to a more chronic and refractory condition.^{10,12}

Patients with somatization disorder tend to obtain care from multiple providers, to fail to keep scheduled appointments, and to use medical services in maladaptive and inefficient ways.¹¹ Convinced that their illnesses are medically based, patients with somatization disorder characteristically deny the influences of psychosocial distress in producing the symptoms of their disorder and resist psychiatric referral.^{11,12} These patients are

Table 1. Common Symptoms Associated with Somatization Disorder

Generalized symptoms

Abdominal pain that is vague and nonfocal
Arthralgia
Backache
Chest pain that is nonspecific
Chronic tiredness
Headache

Gastrointestinal symptoms

Chronic bloating
Constipation
Diarrhea
Food intolerance to multiple foods
Nausea
Rectal pain
Vomiting

Genitourinary symptoms

Erectile dysfunction, ejaculatory disturbance, and impotence
Decreased libido
Dyspareunia
Dysuria
Menses that is painful, irregular, and heavy
Vomiting that is prolonged or frequent during pregnancy

Data from Cassem NH, Barsky AJ: Functional somatic symptoms and somatoform disorder. In *Handbook of General Hospital Psychiatry*. Cassem NH, ed. St. Louis: Mosby-Year Book, 1991:131-157, and Moore DP, Jefferson JW: *Handbook of Medical Psychiatry*. St. Louis: Mosby-Year Book, 1996:198-200.

often refractory to conservative, palliative, and supportive management.^{12,13}

Outcome of the Office Visit

Patients with somatization disorder do not feel relieved by hearing a physician's statements such as "Nothing is wrong" or "You are fine and healthy." To the contrary, these patients may become resentful, disappointed, and frustrated when told by physicians that they are not clinically ill. Some patients may even express anger and dissatisfaction with the physician's medical assessment and may demand further diagnostic procedures, ranging from routine laboratory tests, radiographic studies, and electrocardiographic studies to computed tomography, magnetic resonance imaging, endoscopy, and exploratory surgery.^{5,10} Unconvinced by

Table 2. Diagnostic Criteria for Somatization Disorder

- A. History of physical complaints lasting for several years and beginning before age 30 years, resulting in the request for treatment or leading to a significant impairment in social, occupational, and other types of functioning
- B. The following four criteria must be met, with individual symptoms occurring at any time
1. History of pain related to at least four sites or functions
 2. History of at least two gastrointestinal symptoms other than pain
 3. History of at least one sexual or reproductive symptom other than pain
 4. History of at least one symptom or deficit suggesting a neurologic condition not related to pain
- C. One of the two following criteria must be met
1. Symptoms in B cannot be explained by a medical condition, the effects of medication, or substance abuse
 2. In the case of the presence of a medical condition, the physical complaint or the resulting social or occupational impairment is in excess of what would be expected from the history, physical examination, or laboratory findings
- D. Somatization symptoms are not intentionally produced or feigned

Adapted with permission from American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*. Washington, DC: American Psychiatric Association, 1994.

the negative findings of these tests, patients with somatization disorder eventually “fire” the exasperated physician and then move on to another physician.^{3,10} The difficult and challenging clinical features of somatization disorder require appropriate diagnosis and management if the patient, the primary care provider, and the health care delivery system are to benefit.^{5,11,13,14}

DIAGNOSIS AND ASSESSMENT

The diagnosis of somatization disorder can be established using the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* diagnostic criteria.⁴ Some of these criteria are summarized in **Table 2**. The mnemonic “Somatization Disorder Besets Ladies And Vexes Physicians,” as outlined in **Table 3**, can be used as an adjunctive screening tool.

The diagnosis of somatization disorder may influence the response of primary care providers to patients with the disorder; therefore, it is important for physicians to exclude other medical and psychiatric conditions when

Table 3. Mnemonic for Use as a Screening Test for Somatization*

Somatization Disorder Besets Ladies And Vexes Physicians

Somatization Disorder	Shortness of breath during rest
Besets	Dysmenorrhea
Ladies	Burning pain in sexual organs or rectum unrelated to sexual intercourse
And	Lump in throat
Vexes	Amnesia
Physicians	Vomiting
	Pain in extremities

* A positive response to two or more symptoms suggests a need for a complete review of systems.

Adapted with permission from Othmer E, DeSouza C: A screening test for somatization disorder (hysteria). *Am J Psychiatry* 1985;142: 1146-1149.

the patient presents with a new complaint.^{4,5,11} The features that suggest the diagnosis of somatization disorder rather than a general medical condition include the involvement of multiple organ systems, the early onset of disease with a chronic course of illness in the absence of physical signs or structural abnormalities, and the absence of laboratory abnormalities that characterize the suggested general medical condition.⁴

Differential Diagnosis

General medical conditions. The physician must rule out general medical conditions such as systemic lupus erythematosus, multiple sclerosis, sarcoidosis, and several other medical disorders that may all produce many physical symptoms.¹⁴ Thus, a thorough medical examination with scheduled follow-up appointments is always indicated in establishing the differential diagnosis in somatization disorder.^{5,10}

Hypochondriasis. Somatization disorder differs from hypochondriasis by the fact that the patients with hypochondriasis are not extremely concerned with their illness and associated symptoms, but instead are concerned with the implications of such illnesses.^{4,10} Patients with hypochondriasis interpret their symptoms as manifestation of a terrible and as yet undiagnosed disease, and these patients will “doctor shop” until an aggressive diagnostician is found.¹⁰ In contrast, patients with somatization disorder are usually content with the primary care providers who forego diagnostic measures in favor of numerous symptomatic treatments.^{10,12}

Conversion disorder and malingering. A patient with conversion disorder presents with a relatively small number of symptoms that generally originate from one organ system, typically the central nervous system.¹⁰ Other disorders not to be confused with somatization disorder are malingering and factitious disorders, which involve the conscious simulation of illness in order to consciously manipulate or control others. The patient with somatization disorder is truthfully reporting her or his bodily experience and is not consciously manipulating or controlling others.¹¹

Psychiatric illnesses. Psychiatric illnesses included in the differential diagnosis for somatization disorder are schizophrenia, panic disorder, generalized anxiety disorder, and depressive disorders.

Schizophrenia with multiple somatic delusions. Schizophrenia with multiple somatic delusions must be differentiated from the non-delusional symptoms of somatization disorder. In rare cases, somatization disorder and schizophrenia may coexist.

Panic disorder. Although it is difficult to distinguish multiple somatic symptoms associated with panic disorder from symptoms of somatization disorder, usually the symptoms associated with panic disorder occur during an episode of panic attack. If somatic symptoms occur in the absence of a panic attack, this finding could suggest comorbid panic disorder and somatization disorder.

Generalized anxiety disorder. In the case of somatic symptoms associated with a generalized anxiety disorder, the patient's symptoms include excessive worry and anxiety that are not just limited to the physical complaints of the patient.⁴

Depressive disorders. Although depressive disorders may coexist with somatization disorder, the somatic complaints of depressive disorders are usually associated with the episodes of depressed mood. In somatization disorder, the physical complaints persist even in the absence of an underlying depressed mood.⁴

Sequelae of surgery. In patients with somatization disorder who have had multiple surgeries, primary care physicians must identify new symptoms that develop as a result of surgery. These symptoms must be differentiated from complaints of somatization disorder.^{10,14}

Comprehensive Assessment

A comprehensive assessment of the patient is an essential component of the diagnostic evaluation of somatization disorder. Such an assessment should be conducted on an ongoing basis and involves a careful evaluation of the somatic symptoms in the context of the patient's psychosocial and cultural concerns.^{1,2} Evaluating family relationships may reveal the role that the patient's

various somatic complaints play among family members in gaining attention, seeking avoidance of responsibility, and coping with losses. Patients with somatization disorder often have a history of inadequate coping with painful interpersonal relationships and frequent but unsatisfying encounters with health care providers.¹⁵⁻¹⁷ History of physical, sexual, and substance abuse must be assessed to determine the impact of these conditions on the initial clinical presentation of somatization.¹⁵ The possible areas of stress in the patient's life must be assessed despite the absence of such a complaint. For example, a recent death, a loss, or a major social change may all contribute to the symptoms of somatization despite the patient's denial of concern about such stressful events.¹⁶ Exploration of the social, cultural, and spiritual beliefs of patients and their families must also be included in the assessment of somatization disorder.^{4,17} Such an assessment may determine the extent of how somatic complaints are rewarded, neglected, or criticized within the patient's sociocultural and spiritual context.¹⁷

MANAGEMENT AND TREATMENT

Somatization disorder is a lifelong condition; thus, the management of patients with this disorder may be an arduous clinical endeavor.¹¹ Most studies have determined that the management of patients with somatization disorder is best handled by primary care physicians rather than psychiatrists.^{1,9,13,18} Examination of the medical records of patients with somatization disorder reveals that these patients resist psychiatric evaluation and resent psychiatric referral by primary care providers.^{1,2,9,13}

A conservative treatment plan that primary care physicians can implement includes the following steps:

- 1) Establishing and developing a trusting patient-physician relationship with the same primary care physician²
- 2) Scheduling regular "check-ups" every 4 to 6 weeks, even if the patient is doing well^{2,19}
- 3) Conducting regular physical examinations during the regularly scheduled appointments and providing support with empathy^{2,5}
- 4) Avoiding further diagnostic evaluations or aggressive treatments unless physical examination reveals new objective evidence of disease^{2,14}
- 5) Gradually shifting the emphasis from listening to complaints of somatization to eliciting and listening to information about psychosocial stressors^{1,2,5}
- 6) Avoiding statements such as "It's all in your head" or "There is nothing physically wrong with you"^{2,5,10}

In a randomized controlled clinical trial, the implementation of these management strategies and treatment plan reduced the quarterly health costs of patients with somatization disorder by 53% without adversely affecting patient satisfaction with their health care.^{2,11,19}

The essential goal of managing somatization disorder is to assist patients in coping with their symptoms rather than attempting to eliminate the symptoms with aggressive treatments.¹⁶⁻¹⁸ Prescribing psychotropic medications or analgesic agents can be helpful unless underlying, clearly diagnosed, comorbid medical and/or psychiatric conditions are present.² If a comorbid major depressive disorder is present, antidepressant medication may be indicated; however, care must be exercised to choose an antidepressant with few side effects to prevent the exacerbation of more somatic complaints.^{10,16} When treating a patient with somatization disorder and comorbid panic disorder or generalized anxiety disorder, potentially addicting medications should be avoided if the patient also has a substance abuse disorder.^{5,10,14}

Individual psychotherapy does not appear to be effective in treating somatization disorder unless the illness coexists with other psychiatric disorders such as depressive disorders, panic disorder, and anxiety disorders.^{2,5} Psychotherapy aimed at uncovering hidden or unidentified emotional conflicts is likely to be counterproductive.¹⁰ Consistent supportive inquiry into the areas of stress in the patient's life and family life could also provide an avenue to monitor the patient's contact with other medical providers. Such a monitoring could prevent the unnecessary diagnostic procedures and prescription medications from other physicians whom the patient may contact.^{2,19}

A supportive, practical, and common sense treatment approach by primary care physicians that focuses on palliative care rather than outright medical care can slowly move patients from their somatic preoccupation toward the more rewarding attention to their multiple psychosocial and personal problems.¹⁰

CONCLUSION

Although no definite cure has been found for somatization disorder, a careful and comprehensive assessment of the patient's complaint(s) is an essential component of the evaluation process. Primary care providers can play a key role in identifying patients with somatization disorder and helping them avoid extensive diagnostic evaluations and unnecessary treatments. Knowledge of the epidemiology, clinical features, diagnostic evaluation, and management of patients with somatization disorder enables primary care providers to clinically inter-

vene in a timely manner. Consultation with psychiatrists may be considered in complicated cases with comorbid psychiatric disorders. **HP**

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ACKNOWLEDGMENT

The authors wish to thank Paul E. Emery, MD, for his helpful suggestions and Nancy J. Donnelly, MS, RN, CNS, for her literature search, Veteran's Administration Medical Center, Department of Mental Health, Manchester, NH.

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