Somatisation—Abnormal Illness Behaviour in Primary Care

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Case History

A 35-year-old woman, a new immigrant from mainland China for two years, presented with year-long history of headache and chest pain to a GP clinic. She had sought help from various doctors for these problems. A lot of examinations and investigations were done but no abnormality was found. Her pain got no relief despite she had been given different kinds of medication. These symptoms and her fear of having a serious illness distressed her. She also felt sad and suffered from insomnia. However, she rather attributed her low mood to the disturbing pain, and so she denied any psychological explanation for her symptoms.

On further assessment, she revealed that her 50-year-old husband, previously a construction site worker, injured his back at work and hence has been unemployed for years. She was very disappointed on arriving Hong Kong to see the living environment different from what she had originally expected.

Terminology

“Somatisation” is also a term to describe patients’ illness behaviour in which they have a tendency to experience and express physical symptoms for which they seek medical help, when they indeed have underlying psychological distress. This is not a diagnostic label. There are several similar disorders and terminology easily confusing non-psychiatric medical professionals. (Table)

Why do some patients tend to somatise? --- The relationship between psychological distress and somatisation

Some models are postulated. They are not mutually exclusive in explaining somatisation.

- Emotional distress prompts people to seek care for common somatic symptoms for which they would not seek medical advice in the absence of emotional distress.
- Some people, with the personality trait of amplifying perceptual style or as a result of abnormal neuropsychological information processing, have a lowered threshold for reporting physical symptoms.
- Physical symptoms may be an integral part of most psychiatric disorders. The somatising patient just focuses on these symptoms and attributes the psychological symptoms to the distress of having the physical symptoms. This is particularly common in patients suffering from panic disorder and masked depression.

Benefit of early intervention for somatisation --- GPs are particularly important in managing early somatisers

- Early detection will allow abnormal illness beliefs and attitudes to be modified more easily before becoming chronic and resistant.
- Psychiatric disorder can be managed earlier and hence better response to psychiatric treatment.
- The iatrogenic effects due to unnecessary investigations and inappropriate use of drugs, and "doctor shopping" can be avoided.
- Doctors’ frustration and negative reactions towards somatising patients’ inappropriate demands can be minimised, which is particularly important in the current medicolegal atmosphere.

This case vignette illustrates a common phenomenon in primary care, i.e. a patient presenting with persistent distressing physical symptoms despite normal medical findings, however psychosocial difficulties being denied by the patient as one of the aetiological factors. It was found in the West that this sort of problems accounted for 20% of all new consultations in primary care. In primary care, up to 80% of consultations for non-specific physical symptoms, like dizziness, chest pain and fatigue, are medically unexplained¹.

The process leading to this kind of inappropriate illness behaviour is termed “somatisation”. Somatising patients utilise a great amount of health care resources, for example, on unnecessary and repetitive investigations, drug dependence and “doctor shopping”. Despite substantial medical attention given, they still report high level of disability and suffering.

There are studies showing Asian patients and patients from developing countries, when they are emotionally distressed, reporting more somatic symptoms than Caucasian patients. Cultural factors and stigmatisation of mental illness in a society greatly influence the prevalence of somatisation². Perhaps, some Chinese people might be less inclined to express their anxiety and depression with words or terminology in psychological manner. Or, they tend to experience emotions in a different way.
Interview technique

- Somatising patients may have difficulty in putting their feelings into words, and may fear disclosing their psychosocial problems related to their feelings so that they may subsequently be labeled as "mad". They dislike being told their symptoms are "all in their mind", "unreal", "imaginary" or "psychological factor". If there were unsettled litigation issue with insurance, they would be afraid of being suspected of feigning illness. Therefore, to build up trust and to engage them in the therapeutic relationship are particularly important in treating this group of patients.
- No confrontation. Confrontation with the information that the somatic symptoms are psychological in origin is rarely helpful and generates an adversarial relationship.
- Pay more attention to a detailed history of somatic symptoms, i.e. the time course, whether more than one symptom present, a typical pain day, disability experienced. Such enquiry about somatic symptoms makes patients feel that their symptoms and the magnitude of distress are taken seriously.
- There is a need to be especially aware of verbal and non-verbal cues for psychosocial problems
- Empathic response to the account of symptoms. For example, as simple as a statement like "the pain must be very bad" may deepen the process of engagement and facilitate the exploration of mood state in the later stage.
- Don't give interpretative comment on the psychological cause of their somatic symptoms too early. It only becomes unconvincing, especially if it is given before a physical examination is done.

In the mental state examination, areas to be probed into:

- The patients’ illness beliefs or myth, which may also be shared by other family members.
- The range and depth of their emotional response, sometimes they may appear detached, bland and affectless.
- The use of vocabulary to describe their somatic symptoms which is often limited, e.g. "just pain over here and it hurts very much"
- The level of denial of psychological factors influencing their perception of discomfort.
- Any hostility towards doctors
- Any grudges towards their employers if compensation in association with occupational accident is pending.

General principles of management

- Arrange for regular follow-up to legitimate their sick role and to convey a message of continuation of care for them
- Treat underlying mood or anxiety disorders
- Present a clear rationale for the proposed management plan
- Draw up a list of psychosocial problems with the patient

- Recognise and control negative reactions and counter-transference in doctor’s side
- Minimise polypharmacy to prevent iatrogenic complications
- Aim at "coping" rather than "curing" the somatic discomfort

Specific approaches of management

Reattribute approach

It aims at helping somatising patients to see their symptoms in a different way during the first few interviews in a primary care setting. It is suitable for somatisers who have some psychological understanding, are not overtly hostile, and whose symptoms are relatively mild or of a shorter duration (facultative somatisers)

After the interview (with the points mentioned above emphasized) and physical examination, it is time to broaden the agenda of the consultation. Summarising the physical findings is a good start. It is important to acknowledge the reality of the physical discomfort. For example, a statement like “clearly your discomfort is real and also distressing to you, but fortunately you are not suffering from serious illness” may set a platform for a later psychological explanation. A discussion of previously elicited psychosocial factors and the onset of their symptoms should then follow.

The task is to help the patient link his/her somatic symptoms with psychosocial stressful factors in his/her life. The strategy is a 3-stage explanation rather than a haste explanation of just linking stress with physical symptoms. Some examples are: “when people are anxious they secrete more adrenaline in their blood, and this makes their hearts beat faster”; “when people are depressed it alters their pain threshold, and makes the pain from your arthritic joints much worse”; “your internal organs are mainly under the influence of autonomic nervous system which is directed by your ‘mood centers’ in your brain”. Practical demonstration is a good way to convince patients about muscular aches, which commonly occur in tense people. The patient is invited to hold heavy books with arm outstretched. They will quickly have to admit that tense muscles ache. The patient can also try hyperventilate briefly in front of doctor to feel the immediate dizziness and tingling sensation. But the doctor should immediately direct the patient to try deep slow breathing and relaxation technique to see the difference. Human body model can be used for vivid illustration. Other physiological mechanisms, like autonomic arousal, hyperventilation, physiological effect of inactivity, can also be used for explaining symptoms.

Directive approach

When some patients are hostile or strongly deny the possibility of psychological factors, the case doctor needs to present himself as expert in controlling pain or helping people to cope with symptoms. This avoids discussing psychological issue related to aetiology. However, patients are encouraged to ventilate their feelings of anger and frustration about previous
treatment. They are treated as if they have a physical problem. A programme of activities is discussed to improve their “strength” or “functioning”. The aim is for damage limitation. In the presence of obvious mood disorder, it would be appropriate to prescribe antidepressants. Antidepressants have been shown to have analgesic effect, which are independent of their antidepressant effect.

When to refer to psychiatrist?
- When the underlying psychiatric disorders are severe, with marked functional impairment, or the risk of suicide is high.
- When the somatisation is of long standing and resistant to change, long term psychotherapy (e.g., cognitive-behavioural or psychodynamic psychotherapy) is needed.
- It is important to prepare these patients well before referral because of their sensitivity towards their doctors and stigmatisation of mental illness as discussed above. It is sometimes more profitable to introduce psychiatrist as having expertise in “treating pain” or “rehabilitation”.

References

Table

| **Somatisation:** A psychiatric terminology to describe a tendency in some patients who experience and express somatic distress and symptoms unaccounted for by pathological findings, and attribute them to physical illness, therefore seeking medical help for them. It is often assumed that somatisation becomes manifest in response to psychosocial stress brought about by life events that are personally stressful to the individual. |
| **Somatoform disorder:** ICD-10 mental disorder. The presence of physical symptoms that suggest but which are not fully explained by a general medical condition, the direct effects of drugs or another mental disorder. The symptoms have caused clinically significant distress, or impairment in social, occupational or other areas of functioning. In contrast to factitious disorders and malingering, these medically unexplained symptoms are not intentional. |
| **Somatisation disorder:** ICD-10 mental disorder. A rare and extreme subtype of somatoform disorder where the patient over many years seeks medical attention for many physical symptoms with no evidence of organ pathology. The diagnosis of the disorder requires the presence of 14 of 37 potential physical symptoms for women and 12 for men. |
| **Hypochondriasis:** morbid fears of having serious illness despite repeated negative findings. The gist is the preoccupation with these fears. The preoccupation must last at least six months, persist despite appropriate medical evaluation and reassurance and cause clinically significant distress or impairment in social, occupational or other important areas of functioning. |
| **Factitious disorder:** The intentional production of false or grossly exaggerated symptoms for reasons that are not obvious (i.e. “unconsciously” in psychodynamic terms). It is presumed that there is a psychic need to assume the sick role and to receive care. Patients often present their history with flair or gross exaggeration, and receive multiple hospitalisations (Munchausen’s syndrome). When there are external incentives or clear motives for this illness behaviour (e.g., financial gain), this is malingering but not factitious disorder. |