DAVID SERVAN-SCHREIBER, M.D., PH.D.,
N. RANDALL KOLB, M.D., and
GARY TABAS, M.D.
University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

The phenomenon of somatization, which results in unexplained physical complaints, is ubiquitous in primary care settings although it often goes unrecognized. Medical training emphasizes the identification and treatment of organic problems and may leave physicians unprepared to recognize and address somatoform complaints. As a process, somatization ranges from mild stress-related symptoms to severe debilitation. Patients at the low end of the spectrum often respond to simple reassurance, but patients who are more impaired require interventions specifically designed to avoid unnecessary exposure to dangerous, costly and frustrating diagnostic procedures and treatments. (Am Fam Physician 2000;61:1073-8.)

In patients with somatoform disorders, emotional distress or difficult life situations are experienced as physical symptoms. Patients who somatize present with persistent physical complaints for which a physiologic explanation cannot be found. Failure to recognize this condition and manage it appropriately may lead to frustrating, costly and potentially dangerous interventions that generally fail to identify occult disease and do not reduce suffering.

Somatization is common.1,2 In one study, no organic cause was found in more than 80 percent of primary care visits scheduled for evaluation of common symptoms such as dizziness, chest pain or fatigue.1 In addition, somatizing patients use inordinate amounts of health care resources. One study4 estimated that patients with somatization disorder (the most severe form of the condition) generated medical costs nine times greater than those of the average medical patient. Despite substantial amounts of medical attention, somatizing patients report high levels of disability and suffering.5 Finally, physicians report that somatizing patients are frustrating to
Physicians lack a sense of effectiveness when multiple complaints do not fit into usual diagnostic categories or patients do not fit into a typical office schedule.

Traditional medical training is focused on the identification and treatment of organic disorders and leaves most physicians ill prepared for recognizing and managing patients who somatize. This first part of a two-part article provides an approach to diagnosing and understanding the process of somatization that may lead to more effective and satisfying relationships with these often-difficult patients.

**Diagnosis of Somatization**

Somatization is too often a diagnosis of exclusion. This is a costly and frustrating approach in patients with multiple and chronic complaints. It is much more effective to pursue a positive diagnosis of somatization when the patient presents with typical features. The *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (DSM-IV) defines several different somatoform disorders. However, somatization is not a specific disease but rather a process with a spectrum of expression. Once the process of somatization is identified, management of the different somatoform disorders is based on similar principles.

The low end of the somatization spectrum includes stress-related exaggeration of common symptoms, such as headache, lightheadedness or low back pain in the context of, for example, a divorce, new family member or new job. At the high end, it includes unrelenting problems that can leave patients completely disabled and withdrawn from most aspects of personal and occupational functioning. The primary care physician's emotional response to a patient can serve as an early cue to pursue a somatization diagnosis. A feeling of frustration or anger at the number and complexity of symptoms and the time required to evaluate them in an apparently well person, or a sense of being overwhelmed by a patient who has had numerous evaluations by other physicians, may be a signal to the clinician to consider somatization in the differential diagnosis early in the patient's evaluation. In addition, identifying the physician's emotional reaction to somatizing patients may help prevent deterioration of the physician-patient relationship.

Because the features of somatoform disorders are so variable, establishing specific diagnostic criteria, such as those listed in DSM-IV, can be difficult and may not be very useful. Clinical experience and existing research on diagnostic criteria for the more severe forms of somatization suggest that only two features are necessary to establish a positive diagnosis of somatization in patients in primary care settings: (1) several (more than three) vague or exaggerated symptoms in, often, different organ systems, and (2) a chronic course (i.e., a history of such symptoms for more than two years).

The two features necessary for a diagnosis of somatization are the presence of more than three vague or exaggerated symptoms in, often, different organ systems and a chronic course lasting over two years.

*Table 1* lists many of the symptoms and syndromes affecting patients with somatoform disorders. Most of these symptoms also occur in patients with organic pathology. As isolated symptoms, they would require a full medical work-up. However, somatizing patients have too many symptoms, in too many...
organ systems, that last too long. The intensity of the symptoms often strikes the physician as being out of proportion to the healthy appearance of the patient. The syndromes listed in Table 1 may be legitimate in many patients but are typically impossible to verify in somatizing patients.

### Table 1

<table>
<thead>
<tr>
<th>Gastrointestinal symptoms</th>
<th>Pseudoneurologic symptoms</th>
<th>Syndromes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vomiting</td>
<td>Annesia</td>
<td>Vague “food allergies”</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>Difficulty swallowing</td>
<td>Atypical chest pain</td>
</tr>
<tr>
<td>Nausea</td>
<td>Loss of voice</td>
<td>Temporomandibular joint syndrome</td>
</tr>
<tr>
<td>Bloating and excessive gas</td>
<td>Deafness</td>
<td>“Hypoglycemia”</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Double or blurred vision</td>
<td>Chronic fatigue syndrome</td>
</tr>
<tr>
<td>Food intolerances</td>
<td>Blindness</td>
<td>Fibromyalgia</td>
</tr>
<tr>
<td><strong>Pain symptoms</strong></td>
<td>Fainting</td>
<td>Vague “vitamin deficiency”</td>
</tr>
<tr>
<td>Diffuse pain (i.e., “I hurt all over.”)</td>
<td>Difficulty walking</td>
<td>Premenstrual syndrome</td>
</tr>
<tr>
<td>Pain in extremities</td>
<td>Seizures (pseudoseizures)</td>
<td>Multiple chemical sensitivity</td>
</tr>
<tr>
<td>Back pain</td>
<td>Muscle weakness</td>
<td></td>
</tr>
<tr>
<td>Joint pain</td>
<td>Difficulty urinating</td>
<td></td>
</tr>
<tr>
<td>Pain during urination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cardiopulmonary symptoms</strong></td>
<td><strong>Reproductive organ symptoms</strong></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath at rest</td>
<td>Burning sensations in sexual organs</td>
<td></td>
</tr>
<tr>
<td>Palpitations</td>
<td>Dyspareunia</td>
<td></td>
</tr>
<tr>
<td>Chest pain</td>
<td>Painful menstruation</td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td>Irregular menstrual cycles</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Excessive menstrual bleeding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vomiting throughout pregnancy</td>
<td></td>
</tr>
</tbody>
</table>


Psychiatric and psychosocial disorders have a strong association with somatoform disorders. Finding evidence of a psychiatric condition does not rule somatization in or out; rather, it can be a clue to diagnosis. There is considerable evidence that patients with common psychiatric conditions such as depression and anxiety disorders may present to primary care physicians with nonspecific somatic symptoms, including fatigue, aches and pains, palpitations, dizziness and nausea. In one large family practice sample, multiple somatic complaints provided the best indicator of depression.

Second, patients with somatization disorder commonly have coexisting depression (up to 60 percent), anxiety disorders such as panic or obsessive-compulsive disorder (up to 50 percent), personality disorders (up to 60 percent), or a substance abuse disorder. In fact, the risk for a psychiatric disorder in a primary care patient increases linearly with the number of physical...
Finally, several studies have suggested an association between somatization and a history of sexual or physical abuse in a significant proportion of patients.\textsuperscript{17,21} Table 2 summarizes the typical diagnostic features of somatization. Perhaps the greatest challenge in making the diagnosis is that the presence of somatization does not exclude the presence of an organic medical condition. Therefore, medical conditions must constantly be considered, even in patients with somatization. Patients with chronic debilitating medical conditions often have features similar to those associated with somatoform disorders. However, when the symptoms appear to be in excess of the medical condition and other features of somatization are present, the physician's approach should be adjusted to address somatization in addition to appropriate work-up and treatment of the medical condition. At this point, a colleague's second opinion may be helpful in confirming the diagnosis of somatization and its relationship to the existing organic pathology.

To optimize care and limit frustration for patients and physicians, the investigation of patients with multiple vague somatic complaints should follow a standard process (Table 3). After performing an initial medical evaluation, reviewing medical records and evaluating the patient for common psychiatric conditions, the presence of the typical features of somatization (Table 2) may be sufficient to allow a firm diagnosis of somatization. Although achieving this diagnosis may require more than a single office visit, over the long run this systematic process will prevent many unnecessary acute office visits, evaluations in the emergency department, telephone calls and frustrating arguments.

**Pathophysiology**

No one fully understands the pathophysiology of somatization. However, four psychologic mechanisms are frequently discussed. Understanding them can help physicians develop empathy with patients and direct care more effectively. The mechanisms tend to be independent, and individual patients may show evidence of a single mechanism or any combination of the four mechanisms.

**Amplification of Body Sensations**

Worries about physical disease can focus the patient's attention on common

**Evaluation of Somatization in Primary Care**

---

**Diagnostic Features Suggesting Somatization**

- Multiple symptoms, often occurring in different organ systems
- Symptoms that are vague or that exceed objective findings
- Chronic course
- Presence of a psychiatric disorder
- History of extensive diagnostic testing
- Rejection of previous physicians

---

**Step 1. Evaluate for organic medical conditions.**

**Step 2. Evaluate for psychiatric conditions associated with**
variations in bodily sensations to the degree that they become disturbing and unpleasant. At the least, they provide the patient with "confirmatory evidence" for the suspected presence of pathology. The perception of such altered sensations then seems to exacerbate the patient's concerns, which further increases anxiety and amplifies the sensations. This mechanism is well established in the pathophysiology of panic attacks and has also been documented in the pathophysiology of somatization.22,23

The Identified Patient
When a family system is under stress, identifying one person as a patient may provide a focus that stabilizes the family system and alleviates feelings of anxiety within the family. Members know how to interact with each other in the context of the illness. The patterns of behavior may become recurrent, and family rules about how each member should act are formed. The patterns may become dysfunctional when one member takes on the role of being weak and defective. The physician may reinforce this troublesome dynamic by focusing medical attention on the somatizing patient's disability and illness. The family system often has a powerful tendency to resist change, even though changes, such as the improved health or function of the identified patient, may be desired.

The 'Need to Be Sick'
In somatizing patients, complaints wax and wane in response to stressful life situations.24 In fact, somatization has often been considered the expression of "psychic pain" in the form of bodily complaints in persons who do not have the vocabulary to present their distress in any other way.25

Viewed from an individual perspective, the somatizing patient seems to seek the sick role, which affords relief from stressful or impossible interpersonal expectations ("primary gain") and, in most societies, provides attention, caring and sometimes even monetary reward ("secondary gain"). This is not malingering (consciously "faking" the symptoms), because the patient is not aware of the process through which the symptoms arise, cannot will them away and genuinely suffers from the symptoms. The physician should remember this subconscious need when experiencing the urge to try yet another empiric treatment. In the words of Barsky, "There is no pill that can cure, and no surgery that can excise, the need to be sick."26

Dissociation
Dissociation corresponds to the mind's ability, as displayed in hypnosis, to have complete and detailed sensory experiences in the absence of actual sensory stimulation. For example, in a hypnotic state, a person may report that a hand is "freezing," "burning" or "anesthetized," depending on the suggestions made by the therapist. The subjective experiences are "real" to the extent that the person behaves as if the hand were actually in that state (for example, they may allow the "anesthetized" hand to be pierced by a needle without flinching).

Neuroimaging studies of dissociative experiences such as dreams and flashbacks (experiencing a past event as if it were recurring in the present) suggest that the same sensory areas of the central nervous system that are activated by external events may also be activated by such internal experiences.27,28
Patients with somatization report having dissociative symptoms much more commonly than patients with other psychiatric conditions. Examples of such symptoms include flashbacks, out-of-body experiences (observing one's body from the outside, as if by a third person) and depersonalization (feeling as if one is not oneself). It is therefore likely that some somatized symptoms also result from dissociation (activation of somatic representations of pain or of other physical sensations in the central nervous system in the absence of actual physical stimulation). The phenomenon may be analogous to phantom limb pain: although there is no observable tissue damage in the area of the reported pain, the central nervous system behaves "as if" tissue damage were present.

Final Comment

Somatization is the experience of physical symptoms in relation to emotional distress. It is common, costly and frustrating to patients as well as to physicians, who are trained to focus on organic etiologies. Our simple and effective approach to making a positive diagnosis of somatization in primary care settings relies on only two essential criteria: (1) several nonspecific symptoms in different organ systems and (2) a chronic course. Mechanisms commonly thought to explain somatization in primary care patients include amplification of normal body sensations, the expression of emotional distress constrained by cultural and familial rules, and dissociation. Understanding these mechanisms facilitates the development of empathy, which is essential to an effective physician-patient relationship.

This article exemplifies the AAFP 2000 Annual Clinical Focus on mental health.

This is part I of a two-part article on somatization. Part II, "Practical Management," will appear in the next issue.

This two-part article is partially based on a previously published paper written by the first author: Servan-Schreiber D. Coping effectively with patients who somatize. Women's Health Primary Care 1998;1:435-47.

The Authors

DAVID SERVAN-SCHREIBER, M.D., PH.D., is chief of the Division of Psychiatry, director of the behavioral sciences curriculum for the residency programs in Family Medicine and Internal Medicine, and director of the Center for Complementary Medicine at University of Pittsburgh Medical Center Shadyside. He completed his medical degree at Laval University in Canada, completed a residency in psychiatry at the University of Pittsburgh School of Medicine, and received a Ph.D. in cognitive neuroscience at Carnegie Mellon University, Pittsburgh.

N. RANDALL KOLB, M.D., is an associate clinical professor in the departments of Family Medicine and Clinical Epidemiology at the University of Pittsburgh School of Medicine and medical director of the Family Health Center at UPMC Shadyside. He received his medical degree from the University of Pittsburgh School of Medicine and completed a family practice residency at Shadyside Hospital.

GARY TABAS, M.D., is clinical assistant professor of medicine at the University of Pittsburgh and director of Ambulatory Medical Education at UPMC Shadyside. He completed
his medical degree at the University of Pennsylvania School of Medicine, Philadelphia, and completed residency training in internal medicine at the University of Pittsburgh School of Medicine.

Address correspondence to David Servan-Schreiber, M.D., Ph.D., Center for Complementary Medicine, UPMC-Shadyside, 5230 Centre Ave., Pittsburgh, PA 15232. Reprints are not available from the authors.

REFERENCES


Copyright Â© 2000 by the American Academy of Family Physicians. This content is owned by the AAFP. A person viewing it online may make one printout of the material and may use that printout only for his or her personal, non-commercial reference. This material may not otherwise be downloaded, copied, printed, stored, transmitted or reproduced in any medium, whether now known or later invented, except as authorized in writing by the AAFP. Contact afpserv@aafp.org for copyright questions and/or permission requests.

February 15, 2000 Contents | AFP Home Page | AAFP Home | Search
Somatization is the experiencing of physical symptoms in response to emotional distress. It is a common and costly disorder that is frustrating to patients and physicians. Successful treatment of somatization requires giving an acceptable explanation of the symptoms to the patient, avoiding unwarranted interventions and arranging brief but regular office visits so that the patient does not need to develop new symptoms in order to receive medical attention. Antidepressants may be helpful in many patients, as well as cognitive psychotherapy when patients are willing to participate in it. Typical problems in managing such patients can be addressed by relying on the continuity established through regular visits to the same primary care physician. (Am Fam Physician 2000;61:1423-8,1431-2.)

Patients with somatization experience emotional distress or difficult life situations as physical symptoms. This common and costly disorder is frustrating to patients and physicians.¹

This article reviews management strategies (some of which have received empiric support through controlled studies) recommended by clinicians experienced in dealing with such patients.

The first principle of effective management is to understand the patient’s suffering and develop a concerned attitude. From the standpoint of the physician, the symptoms may seem exaggerated and the worries irrational, but the patient’s suffering is always real. Even in the clearest cases of organic pathology, suffering is poorly correlated with the extent of tissue damage.² Suffering is always a subjective phenomenon. Patients may amplify normal body sensations and be locked into a role as the identified patient, unconsciously seeking to be treated as a sick person, but they still suffer from pain and limitation of functioning. Failure to acknowledge this suffering and disability
may be interpreted by patients as trivializing, and it impairs the physician-patient alliance.

Successful approaches to somatization rely on providing an acceptable explanation of the symptoms to the patient, establishing reasonable treatment goals and arranging for brief but regularly scheduled office visits that help make it unnecessary for the patient to develop new symptoms in order to see a physician.

**Discussing the Diagnosis**

The first opportunity to discuss the diagnosis occurs when the initial work-up has failed to identify organic pathology. This is a defining moment in the physician-patient relationship. The first challenge is describing the condition to the patient in a manner that avoids any reference to the ineffective "It's all in your head" idiom. In order to achieve this goal, physicians must understand that the concept of somatization is well beyond the grasp of the patient's rational mind and, for that matter, beyond medicine's usual way of understanding disease. With this in mind, physicians should be comfortable making a statement such as: "The results of my examination and of the tests we conducted show that you do not have a life-threatening illness. However, you do have a serious and impairing medical condition, which I see often but which is not completely understood. Although no treatment is available that can cure it completely, there are a number of interventions that can help you deal with the symptoms better than you have so far."

This statement acknowledges the patient's suffering and experience of disability. It provides reassurance by emphasizing that this is not a rare condition, yet acknowledges the limitations of treatment from the outset. Finally, it avoids rejection and, instead, emphasizes that the physician will be actively engaged in helping the patient function more effectively.

If the patient insists on receiving a name for the condition, it is often best to say that there are many names for the condition, none of which is completely satisfactory. Patients might be told that the terms "pain disorder" and "somatoform disorder" are sometimes used to refer to the condition but that the labels only hide our ignorance.

Patients often seem reassured when a specific name is given to the condition, such as "fibromyalgia," "chronic fatigue syndrome" or "irritable bowel syndrome." Such labels help them identify with the traditional disease model of their symptoms and reassures them that the physician is not thinking that it is "all in their head." To the extent that labels facilitate the physician-patient relationship and help focus the patient's efforts toward functioning better, there is no harm in using them. In one study, 90 percent of patients with chronic fatigue reported that receiving the diagnosis was the most important factor in their treatment course. Even when patients do not meet the diagnostic criteria that have been proposed for these different conditions, the labels can sometimes be used nonspecifically. For example, a patient can be told "you have a variant of fibromyalgia" if the main complaints are related to pain and fatigue.

**Scheduling Regular Visits**

Treatment consists of regular, brief office visits that allow patients to receive some of the attention they need without having to develop new complaints to obtain it.
After this introduction, the treatment plan can be discussed. It consists of regularly scheduled, brief office visits (e.g., 15 minutes once a month). These visits allow patients to receive some of the attention they need without having to develop new symptoms to obtain it. The physician can stress the importance of following the patient closely to help deal with current symptoms and make sure that no new, life-threatening condition is developing.

The frequency of visits may be adjusted according to the severity of the patient's somatization. One goal is to progressively diminish and then stop emergency visits and telephone calls altogether as patients learn to rely more on the regularly scheduled visits. The typical frequency of visits for patients with disabling symptoms is every three to four weeks. Some patients require even shorter intervals. Such regular visits have been shown to significantly reduce the cost and chaos of caring for patients with somatization disorder without affecting patient satisfaction with their care.4

During these brief visits, the physician listens for any new symptoms, conducts a brief physical examination that helps rule out any new or worrisome condition and provides the patient with the important benefits of "laying on of hands." The physician also begins to shift the focus away from the patient's physical symptoms to the psychosocial context that may be most affecting them. A time-honored opening that is comfortable for physician and patient is: "How have your symptoms interfered with your everyday life?"

It is important to ask open-ended questions rather than questions that can be answered with "yes," "no" or another single word. Somatizing patients are always ready to discuss the way their symptoms are affecting their life. This question avoids the threatening suggestion that stress or other psychologic factors may be causing the symptoms. Yet it may lead to important information that links life circumstances with symptoms, especially when it is followed by gentle prompts such as: "Tell me more about your (boss, husband, children, girlfriend, etc.)."

The BATHE technique5,6 provides an excellent framework for exploration of psychosocial stressors (Table 1). This entire interaction may last less than five minutes and still provide useful information for the physician, as well as meaningful support to the patient. The same structure can often be used during subsequent visits. Variations develop naturally as the patient and physician become more comfortable with each other and with this aspect of their relationship.

Other useful interventions during these regular visits include recommendations for antidepressant medications, stress-management programs, lifestyle changes and benign medical treatments, as described below.

---

The BATHE Technique

**Background:** "What is going on in your life?"

**Affect:** "How do you feel about it?"

**Trouble:** "What troubles you the most about that situation?"

**Handle:** "What helps you handle that?"

**Empathy:** "This is a tough situation to be in. Anybody would feel (down, stressed, etc.). Your reaction makes sense to me ..."

---

Adapted with permission from Stuart MR, Lieberman JA. The fifteen minute hour: applied psychotherapy for the primary care physician. 2d ed. Westport, Conn.: Praeger, 1993.
The psychiatric disorders associated with somatization, specifically anxiety and depression, respond well to pharmacologic treatment. However, especially with antidepressants, it is important to start with low dosages and to increase the dosage progressively to avoid side effects that may be present at the beginning of treatment and discourage the patient from continued use of the medication.

Although pharmacotherapy is often beneficial, it does not address the essential mechanisms of symptom amplification and the "need to be sick" that is associated with somatization. For this reason, pharmacotherapy can be thought of only as an adjunct to regular visits with the primary care physician.

**Psychoeducation and Psychotherapy**

Approaches derived from cognitive psychotherapy have been shown to reduce the intensity and frequency of somatic complaints and to improve functioning in many somatizing patients. This type of treatment starts with the mutual agreement that whatever the patient has been thinking and doing about the condition has not been successful. It then proceeds to challenge the patient's beliefs and maladaptive behaviors in a gentle and caring manner.

Some centers have established brief group therapy programs (eight to 16 sessions) specifically for treatment of somatizing patients that have been shown to be remarkably effective in improving function and reducing distress. The sessions combine general advice such as stress management, problem solving and social skills training with specific interventions targeted at the amplification and need-to-be-sick features of somatization.

Patients should be gently encouraged to pursue this type of treatment, individually or in a group format. To avoid the stigma often associated with mental health referrals, these treatment programs may be referred to as "stress management for patients with chronic illness."

**Lifestyle Recommendations**

Interventions directed at reducing specific sources of stress are most helpful. Such interventions may include psychoeducational advice about dealing with marital conflict or more effective ways to handle relationships with children. Family system interventions that reinforce healthy family alliances may also help.

Some physical exercise is important, even in patients who believe themselves to be physically impaired. It prevents deconditioning, enhances self-esteem and provides an opportunity for patients to take a break from oppressive duties or unpleasant situations. A minimum of three 20-minute exercise sessions per week is desirable.

In general, physicians should emphasize the importance of pleasurable private time. Beyond exercise, this may include yoga classes or meditation, bowling or nature walks, which, under the general title of "stress management," can be presented as necessary medical treatments.

**Benign Treatments**
A number of benign interventions may be helpful in patients with somatoform disorders without causing possible iatrogenic complications (Table 2). Benign interventions include hot and cold packs, bandages, canes, lotions, vitamins and nutritional supplements. In addition, complementary medicine approaches such as acupuncture, chiropractic massage therapy, biofeedback or homeopathy may have highly positive effects. These approaches do not challenge the patient’s view of himself or herself as ill but provide a framework within which the patient learns to take responsibility for his or her own health. Even though there is no evidence to support the use of benign interventions in patients with somatization, these modalities are generally much safer than the diagnostic and surgical procedures that are often offered by conventional medicine with little rationale.

**Problems in Management**

Several common problems can derail the course of treatment.

**Setting Unrealistic Goals**

In severe cases of somatoform disorder, symptoms are unlikely to resolve completely. If the unspoken goal of the treatment plan is to relieve the patient’s illness, the physician and patient soon become frustrated and tempted to engage in a new flurry of diagnostic tests and invasive procedures. In fact, attempts to "take away the symptom" may cause the patient to substitute another symptom as a result of the need-to-be-sick phenomenon.

A more appropriate goal is to help the patient succeed in coping with the symptoms. The physician can help the patient tolerate uncertainty by demonstrating the ability to continue caring for the patient without finding a clear etiology for the symptoms. Treatment is successful if it keeps the patient out of the hospital and the emergency department, and if it reduces exposure to iatrogenic complications.

**Presence of Comorbid Medical Conditions**

Somatizing patients also develop organic diseases, especially common disorders such as osteoarthritis, coronary artery disease and cancer. Thus, preventive health measures and regular screenings must be integrated into the overall treatment plan. When organic pathology is identified, the patient’s concerns or suffering may still seem exaggerated in relation to the degree of objective pathology. The principles of treatment outlined above should remain the mainstay of the physician-patient relationship while the organic pathology is addressed. Because subjective complaints remain unreliable in somatizing patients, treatment of the organic problem should be guided primarily by

**Treatment of Somatizing Patients**

**Do:**

- Use one designated physician.
- Schedule frequent, brief, regular visits not contingent on new complaints.
- Allow "sick role," focus on function rather than symptoms.
- Explore psychosocial issues.
- Prescribe benign treatments and enjoyment time.

**Don’t:**

- Suggest "It’s all in your head."
- Pursue invasive diagnostic tests, medications or surgical interventions without good indications.
- Refer excessively to specialists.
- Focus on the symptoms themselves.

Treatment may be derailed by unrealistic goals, comorbid conditions, patient requests for diagnostic studies or opiate analgesics and frequent telephone calls.
Requests for Diagnostic Studies
Patients may challenge the physician's reassurance that no life-threatening condition is present. They may say, "How do you know that I don't have a brain tumor? You haven't done a brain scan." Reminding patients that they will be followed with frequent and regular visits often reassures them that any problems will be identified early. Sometimes, performing laboratory tests becomes a "negotiating" process designed to give the patient some control over what test is performed and to enhance the trust level between the physician and patient.

Requests for Opiate Analgesics
Although patients with pain may request opiate analgesics, it is best to emphasize the benign treatments mentioned previously. Acetaminophen (Tylenol) or nonsteroidal anti-inflammatory drugs (NSAIDs) may be helpful if they are not contraindicated. Opiates have significant side effects such as constipation, sedation and impaired cognition. Addiction may also develop. Opiates will not cure the need to be sick that is often associated with somatization. In patients who require use of opiates for pain management, preparations with a slow onset of action and long half-lives should be used and preferably for short intervals. These preparations, such as the continuous-release forms of morphine sulfate or oxycodone, are less likely to be abused and have a lower street value.

Frequent Telephone Calls
Excessively frequent telephone calls may threaten the physician-patient relationship. To address this problem, the physician can emphasize his or her own feelings and needs (which cannot be challenged) rather than set limits on the patient's behavior (which may be perceived as arbitrary rules). A typical statement may be: "It is hard for me to give you the proper care and attention that you deserve when I find myself spending so much time on the telephone with so few positive results for you."

It may then be appropriate to propose more frequent regular visits or to set an explicit limit on the number and length of calls, such as "I understand that there may be times when you feel you cannot wait for your next office visit. Maybe this means that we should increase the frequency of the visits," or "I am comfortable with us having one or two 10-minute telephone calls between visits, but I am concerned when it gets beyond that. Can we agree on that limit?"

Frequent Visits to the Emergency Department
Visits to the emergency department often result in inconsistent care and mixed messages from physicians who are seeing the patient for the first time and may be alarmed by the patient's presentation. New iatrogenic complications may also be induced from unnecessary procedures or inappropriate admissions to the hospital. The understandable concern of emergency department physicians for undiagnosed organic pathology also reinforces the patient's impression that a life-threatening medical condition is present and can seriously impair the outpatient treatment plan.

Emergency department staff should agree to avoid repeating tests and inpatient admissions unless the patient presents with new objective findings. At the same time, the patient should be reminded that the regular ambulatory clinic visits are meant to take care of all medical needs. A shorter interval between visits can be negotiated, but it should be noted that the ambulatory clinic visits are expected to help avoid emergency department visits.
Unfortunately, because of the current nature of emergency department staffing, these goals may be difficult to achieve unless continuity and communication can be established between the emergency department and the outpatient office.

This article exemplifies the AAFP 2000 Annual Clinical Focus on mental health.

This is part II of a two-part article on somatization. Part I, "Practical Diagnosis," appeared in the February 15 issue (Am Fam Physician 2000; 61:1073-8).

This article is based in part on a paper written by the first author and previously published as Servan-Schreiber D. Coping effectively with patients who somatize. Women's Health in Primary Care 1998;1: 435-47.

REFERENCES
