

Somatisation is the expression in physical symptoms of psychological and social stress and includes functional illnesses as well as many organic illnesses.

Research shows:

1. About twenty-five percent of new patients presenting to general practice will have somatising illnesses with no identifiable organic pathology.¹ About a third of patients attending medical outpatient clinics (eg gastroenterology, neurology and cardiology) have somatising illnesses with no organic pathology and up to half of these will have an underlying anxiety disorder or depression.²
2. Most somatisers are ‘facultative somatisers’ and will readily accept psychosocial explanations if the doctor asks the appropriate questions and provides adequate explanation.³
3. Patients are frequently more willing to consider psychosocial aspects in evaluation of their symptoms than doctors are willing to enquire.⁴
4. Doctors commonly fail to express any empathy at all to patients with functional illness.⁵ Without sufficient empathy, patients easily believe the doctor has not adequately understood their experiences and they are much less likely to trust the doctor’s subsequent explanations about psychosocial factors causing physical symptoms.
5. Continuing collusion with the patient’s somatic focus tends to undermine patient respect for the doctor. i.e. a small group of patients may not particularly like the doctor’s suggestion that psychosocial factors are involved but they respect the doctor who raises the issues.⁶
6. Somatising patients in general do not want any more investigation than other patients.⁵
7. Despite some patients initially appearing resistant, they are challenged by the doctor’s suggestion that psychosocial factors are important, and frequently ruminate on this after the consultation.
8. Doctors usually have an exaggerated belief that assessing psychosocial factors takes more time than biomedically focussed consultations.⁷

Somatisation should not be a diagnosis of exclusion.⁸ Doctors should always first identify the commonest cause(s) of symptoms through pattern recognition, then exclude ‘red flags’ that need to be dealt with now, then institute management based on the most likely cause whether this includes somatisation or not. Review if not getting better and consider further investigation.

Patterns of functional illness

1. Worse with pressure, responsibility, relationship challenges, stress.
2. Often ‘triggered’ by a stressful event but symptoms may persist due to other more minor day to day pressures, responsibilities, stresses even though the emotional consequences of the initial event have been resolved. Sometimes these minor stresses may be nothing more than a thought crossing one’s mind e.g. “What am I going to do about that?” regarding a relatively minor

concern. This minor thought can be enough to generate moderate or even severe physical symptoms. Sometimes even thinking ‘how is my headache/‘gutache’/(etc) today’ is enough to generate the symptom in question.

3. Functional symptoms are usually absent during the night and first thing on waking, better during or straight after exercise, on weekends, holidays.
4. Functional symptoms often do not fit biomedical patterns; maybe highly atypical or unique.
5. Multiple symptoms in different organ systems. When one symptom is prominent others recede. E.g. when irritable bowel symptoms are prominent tension headaches are better or absent.

Four process skills

1. Empathise.⁶
2. Normalise: ‘We all get physical symptoms with stress...I get...’⁹
3. ‘Looking at possible connections between what’s going on in your life and your physical symptoms **does not mean you are not coping.**’ (exculpation)⁷
4. Explain

Four standard questions

1. ‘What was going on in your life around the time the (symptom) started?’ If the patient says, ‘Not much,’ say: ‘There may not have been much going on but can you tell me what was happening.’
2. ‘Are your (symptoms) ever related to pressure / responsibility/relationship challenges/stress?’
3. ‘Are there any times you don’t have (symptom) / when (symptom) seems to be better?’ e.g. at night, immediately on waking, weekends, holidays (when was the last holiday?), with exercise.
4. ‘Are there any times when you always / are very likely to get (symptom)?’

If patients are uncertain of the relation of their symptoms to the factors raised in questions 2-4 then they can do their own investigation and discover the connections for themselves.

Rarely, if these questions have not yielded helpful information then further exploration may be aided by asking patients to write the headlines of their life history including both ‘good’ and ‘bad’ events with more detail on the ‘bad’. Remember that the events with the most significance tend to rise to the top and you can trust what comes up.

Core issues

- Powerlessness
- Worthlessness
- Hopelessness
- Meaninglessness
- Abandonment
- Fragmentation
- Emptiness

There are five main emotions generated by core issues: MAD BAD GLAD SAD SCARED. Respond with empathy.

Explain

Patients want an explanation for their symptoms.¹⁰ Use any of these explanations to help patients understand the connections between mind and body.

- Clasped Hands: illustrates the intimate connections of mind and body.
- The Dam: ‘Sometimes nothing much has changed but the dam starts to crack,’ ‘sometimes a relatively small fall of rain is enough to overcome the dam when it’s under pressure’ etc.
- 20/80 Diagram: ‘The brain is wired to every other part of the body and what’s going on there can affect any other part of the body. 20% of our thinking is conscious; 80% is subconscious...’
- Emotional Organ: ‘The gut/skin/breathing/heart/nose/muscle etc is a very emotional organ’.
E.g. ‘most of us have had butterflies in the stomach’, ‘when we get embarrassed we go red or get a fright we go pale’, ‘when we cry we sob or when we get anxious we breath quicker’, ‘when we cry the nose blocks and runs’, etc.
- Common Mindbody Expressions: ‘pain in the neck’, ‘under my skin,’ ‘lump in my throat’, ‘makes me sick’, ‘right up my nose’, ‘my heart goes out’, ‘pain in the rear end’, etc.
- Multifactorial aetiology of illness: acknowledge physical psychological, social, environmental factors e.g. asthma. Often not one or the other i.e. physical or psychological but both.
- PNI (psychoneuroimmune network) useful especially for inflammatory conditions.
- The Four P’s
 - i) Predisposing factors: genetics/ difficult life events/accumulated stress.
 - ii) Precipitating (triggering) factors: infection, pregnancy, accident, stressful event...
 - iii) Perpetuating factors: demands of family, work...
 - iv) Protective factors: genes, personality strengths, other healthy relationships...
- Case illustrations from your previous experience.

Chronic somatisers with functional symptoms

(Remember that many chronic biomedical conditions are also affected by emotional factors!)

Helping chronic somatisers with multiple functional symptoms and entrenched convictions regarding as yet undiagnosed physical causes requires higher level communication skills and attention to the nuances of a more complex doctor-patient relationship. Creative tension needs to be maintained between the patient’s conviction that the illness has a physical cause and the doctor’s understanding that psychosocial factors are crucial. Colluding with the patient can result in fruitless expensive investigations and frustration for both doctor and patient. It is especially important to undergird these interactions with regular, authentic, accurate empathy regarding often-distressing symptoms, and it is often helpful to empathise with the patient’s frustration in having a doctor who views the illness somewhat differently! The ‘**fearful possibility**’ comment will need to be used with these patients. ‘There may be nothing there but if we don’t look we won’t know.’ It is essential to exclude underlying anxiety disorders and depression which are very common.

Facilitating the chronic somatiser’s gradual reframing of functional symptoms from a primarily physical focus to psychosocial causes may take a year or two and sometimes longer. An advantage of general practice is that there is time, and with adequate general practitioner skill, many chronic somatisers will increasingly recognise the importance of psychosocial factors in their illnesses. Many will have serious psychological injury or personality disorder in their backgrounds and will benefit from referral to a psychologist for cognitive behavioural therapy, or to a psychotherapist.

Chronic somatisers tend to be more desperate for symptom relief and consequently may be willing to try relaxation exercises or meditation. In my view there is little point starting unless the patient is willing to do the relaxation/meditation exercises for twenty minutes (including two lots of ten minutes)

six days/ week for six weeks. There seems to be a threshold around six weeks by which time most patients begin to notice improvement.¹¹

Management

1. Empathic listening is therapeutic in itself and sometimes, by itself, enables patients to move on.
2. Explanation helping patients make the connections between mind and body.
 - a) Reduces anxiety through being able to make sense of their symptoms.
 - b) Reassurance that there is no serious physical cause must address the patient's specific fear of a particular physical illness¹² and be combined with adequate explanation of the mind-body connection, otherwise somatic symptoms may be exacerbated.
 - c) Enables mobilization of patients' own resources.
3. Treat underlying anxiety, depression¹³ and hyperventilation.
4. Address lifestyle and emotional issues.
5. Consider 1-2 weeks benzodiazepine.
6. Writing and emotional health.¹⁴
7. Refer to clinical psychologist for CBT¹⁵, counsellor, mind-body psychotherapist, pain clinic.
8. Relaxation exercises or meditation. (*The Relaxation Response* or *Timeless Healing* - helpful books for patients by Prof Herbert Benson.)
9. SSRIs and tricyclic antidepressants have been shown to be useful for somatisation with or without associated mood disorders.¹⁶

Chronic hyperventilation syndrome

It is important for general practitioners to be familiar with disrupted breathing patterns (medically unexplained dyspnoea)¹⁷ and chronic hyperventilation syndrome which often complicates chronic functional illnesses. The following symptoms should alert the doctor to the possibility of this under-diagnosed problem and there should be a low threshold for enquiring about shallow breathing, holding one's breath, feeling one cannot get a deep enough breath, frequent sighing, yawning, dizziness, light-headedness, paraesthesiae, 'atypical' chest pain. When symptoms suggest that chronic hyperventilation may be a contributing factor it can be very useful to ask the patient to deliberately hyperventilate during the consultation, noting whether this exacerbates the same feeling of dizziness/light-headedness, pins and needles, shortness of breath or whether it causes a qualitatively different sensation. Simple explanation, perhaps with the suggestion to look up 'hyperventilation and breathing exercises' on the internet, may be sufficient, or the doctor can refer to an appropriate physiotherapist.

(I acknowledge the seminal work of Dr Brian Broom clinical immunologist and psychotherapist in developing an approach to somatising patients.)¹⁸

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