Somatization as illness behavior

John F. Kihlstrom and Lucy Canter Kihlstrom

John F. Kihlstrom PhD is in the Department of Psychology, and Lucy Canter Kihlstrom PhD is in the Institute for Personality and Social Research, at the University of California, Berkeley. Both are also members of the Institute for the Study of Healthcare Organizations & Transactions.

Somatization disorder, in which a patient complains of physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms, has been characterized as "medicine's unsolved problem" (Lipowski 1987). Certainly it is a problem: the per capita expenditure for health care of somatizing patients is up to nine times the average (Smith et al. 1986), including repeated consultations with primary-care physicians, unnecessary hospitalizations, and loss of work time. These patients resist referrals to mental health practitioners, and also appear to use complementary and alternative medicine at a relatively high rate—perhaps because of more frequent consultations and improved provider–patient relationships offered by complementary and alternative practitioners (Garcia-Campayo & Sanz-Carrillo 2000).

Although the National Institute of Mental Health Epidemiologic Catchment Area study reported a rate for somatization disorder of only 0.1% in the general population (Robins et al. 1984), the syndrome's prevalence is much higher among patients seen in primary-care clinics, specialty clinics, and psychiatric consultation/liaison services (for example, Kellner 1990). Although generally considered a disorder of middle-aged women, a recent survey found that almost 11% of undergraduates at a major American public university, including almost 15% of women and almost 7% of men, reported enough somatic complaints to cross the *Diagnostic and Statistical Manual of Mental Disorders IIIR* threshold for somatization disorder (Canter Kihlstrom et al. 1998: see also Kihlstrom & Canter Kihlstrom 1999).

Somatization disorder, like conversion disorder and other "somatoform" disorders recognized by *DSM-IV*, has often been construed as an illustration of the "mind–body" interaction—as the translation of emotional distress into somatic symptoms, in contrast with psychologization (for example, Kirmayer & Robbins 1991). Perhaps the increased interest in complementary, alternative, and integrative medicine will revive medical interest in psychosomatic medicine and other aspects of mind–body interaction. On the other hand, the psychosomatic disorders are currently in bad repute. Classic psychosomatic syndromes like ulcers are now attributed wholly to physiological processes that have nothing to do with emotion (for example, Hyman 1994; but see Overmier & Murison 1997). Both *DSM-1*, published in 1952, and *DSM-II* (1968) contained a major category of psychophysiological autonomic and visceral disorders, further classified according to the organ system involved. In *DSM-III* (1980) and *DSM-IIIR* (1989), the psychosomatic and psychophysiologic disorders were listed as "psychological disorders affecting physical condition." But *DSM-IV* contains no such category: it is open to "mental disorders due to a general medical condition" (Code 293.83), but "psychological factors affecting medical condition" are relegated to the back of the book. "Psychosomatic" has gone the way of "neurosis" and "psychosis."

McWhinney and his colleagues seem to applaud this trend in their target article. In their view, the very notion of psychosomatic illness reflects an outmoded Cartesian dualism between mind and body, a stance that has been rendered obsolete by the advances of modern medicine and neuroscience (McWhinney et al. 1997). If the mind is what the brain does, and the brain controls the body, then there is nothing "abnormal" about the translation of mental states into physical states: Emotion is embodied, along with cognition and motivation, and that's all there is to it. Or, at least, there's no point in trying to figure out how the mind affects the body because mind and body are the same thing.

 © John E. Fetzer Institute 2001

Such a rejection of psychosomatic concepts is in line with reductionist trends within psychology, but it may be a mistake to include somatization disorder in its sweep. This is because somatization does not involve somatic symptoms that can be confirmed and explained by physical examination or laboratory test but rather somatic complaints. The patient may complain of cardiovascular or gastrointestinal symptoms, but physical examination and laboratory testing reveals no evidence of tachycardia or gastric lesions. In this respect, somatization disorder is similar to body dysmorphic disorder and hypochondriasis, some factitious and eating disorders, and malingering. All represent "illness without disease," in the words of the *Harvard Mental Health Letter* (1999a,b) and it is the inability of the healthcare provider to confirm the patient's physical complaints that makes them so frustrating for all concerned. By contrast, in the conversion disorders, and in what used to be called the psychosomatic and psychophysiological disorders, the physician can confirm the patient's complaints—even if their causes remain mysterious.

Put another way: While the psychosomatic syndromes may be properly construed as physical illnesses with psychosomatic causes, it seems likely that somatization is better construed as illness behavior (Mechanic 1962)—behavior that, like all behavior, must be understood in terms of the patient's personal experiences and life circumstances. The somatizing patient may be anxious or sad, angry or resentful, unhappy in marriage, or frustrated at school or work, or have any of a host of problems in living. This is what the complaints are really about, not the heart or the gut, and these are the problems that have to be addressed. Nothing is embodied in somatization at all. Behavioral neuroscience, psychoneuroendocrinology, and psychoneuroimmunology may help us understand the psychosomatic disorders, but they cannot help us to understand somatization, for the simple reason that the body is not involved in the phenomenon except in the trivial sense that the body is involved in all behavior. The symptomatic complaints of the somatizing patient *may well be bodily expressions of emotional* distress, and attempts to use one's body as a vehicle for social control, but that is not the same thing as saying that they are physical embodiments of that distress. In some sense, somatization is an aspect of personal identity: Somatizing patients identify themselves as sick people, just as patients with body dysmorphic disorder identify themselves as ugly people (Kihlstrom & Canter Kihlstrom 1999) and behave accordingly.

To propose that somatization can be understood only by examining the person in a social context (a point on which we agree with McWhinney et al.) is not to revive an old-fashioned psychodynamic view that symptoms must be interpreted to reveal the patient's unconscious conflicts. In fact, much of the basis for somatization probably lies outside the individual patients, in the social context in which their behavior takes place. Just as cultural factors affect the individual's experience and presentation of physical symptoms, so some cultures may prefer somatization over psychologization as the means for the individual's behavioral expression of distress. In fact, some medical anthropologists have argued that psychologization is something of a Western invention, and somatization more the norm in the rest of the world (for example, Kirmayer 1984, Kleinman & Kleinman 1985). If somatization is to some extent a culture-specific disorder, abnormal only in the industrialized West, there is no point in adding bio to psychosocial: Cultures may differ, but bodies are everywhere alike.

Even within a culture, social factors, from the interpersonal to the institutional, may affect the degree to which somatization occurs. In our society, for example, mental patients remain stigmatized to a considerable degree, with the benefits of the sick role accruing to physical rather than mental illness. Someone with heart palpitations can be excused from attending a family function, but someone with lingering resentment will be expected to overcome it for purposes of maintaining harmony. In addition, while somatizers are generally considered to be "difficult" patients, difficult *patients can also be labeled as somatizers. A recent* study of medical practice found that physicians

were more likely to diagnose symptoms as medically unexplained (the core of somatization) if they perceived their interactions with the patient as negative rather than positive (Nimnuan et al. 2000). Because medically unexplained symptoms lie at the core of somatization, to some extent somatization may reside in the physician not the patient.

In addition, changing diagnostic standards may affect how the patient is labeled. In *DSM-III* and *DSM-IIIR*, somatization disorder was considered if the patient presented a high number of symptomatic complaints, without restriction on their distribution. However, *DSM-IV* requires that at least one of these symptoms come from the sexual and reproductive sphere. Such complaints come almost wholly from women, and in fact some of the relevant symptoms, such as irregular menses and vomiting throughout pregnancy, can be reported only by women. In a study of symptomatic complaints among college students (Canter Kihlstrom et al. 1998), application of the *DSM-IV* criterion for somatization not only reduced the percentage of subjects crossing the threshold of somatization from almost 11% to just over 8%, but it also greatly increased the ratio of women to men, from 2:1 to 7:1. In other words, *DSM-IV* effectively redefined somatization as a "female" disorder. Boys and men with multiple unexplained medical symptoms are now less likely than before to be classified as somatizers.

The very structure of the healthcare system may be an important factor in somatization. Medical procedures for diagnosis and treatment naturally focus on anatomy and physiology, and may encourage somatic rather than psychosocial attributions for distress. Attempts to manage somatization within primary care, by performing regular physical examinations and foregoing special diagnostic tests or hospitalization, may control costs and improve patient satisfaction over the short run (Morriss et al. 1999; Smith et al. 1986), but may fail over the longer term (Kashner et al. 1992). Referral to a psychiatrist or other mental-health professional fails because it clearly communicates to patients that their problems are in their minds, or their social relationships, rather than in their bodies—which is probably true, but not what they want to hear.

In fact, medical specialization itself may play an important role in supporting somatization. A patient with presenting complaints that cannot be verified or explained by an internist is likely to be referred to a specialist, who will spend even more time, and perform even more expensive tests, trying to find something wrong with the patient's body. The availability of such specialists in a modern healthcare system provides a ready escape route for both patients and general practitioners, and may effectively delay both the recognition of somatization and its treatment.

Specialization may even play a role in creating new forms of somatization disorder. The classic presentation of somatization disorder, patterned on Briquet's syndrome (Mai & Merskey 1981), is a patient with multiple unexplained symptoms. However, somatizing patients can also present single symptoms, or multiple symptoms within only a single bodily system. In fact, it has been argued that the tendency of specialists to focus only on that part of the body that lies within their expertise has led to the proliferation of functional somatic syndromes within each medical specialty: irritable bowel syndrome for gastroenterologists, fibromyalgia for rheumatologists, tension headache for neurologists, multiple chemical sensitivity for allergists, and so on. Nevertheless, there appears to be substantial overlap among these functional somatic syndromes in terms of diagnostic features, response to (psychosocial) treatment, and other characteristics, suggesting that they are more alike than different (Wessely et al. 1999).

We are not suggesting that somatization, in whatever form it takes, is "all in the mind" of either patients or physicians. Some patients really do suffer from irritable bowels or tension headaches (and in some cases, the patients' problems may be genuinely "psychosomatic" in nature). These symptoms are a source of discomfort to them and an object of frustration for their caregivers, but they also provide patients with entrée into the sick role and its benefits. However, we are suggesting that somatization may be the wrong place to look for a resolution to the mind–body problem, whether by reinforcing

 © John E. Fetzer Institute 2001

Cartesian interactive dualism, in which the body responds to emotional states, or by abandoning dualism in favor of a unified conception of psyche and soma in which emotion is embodied in bodily processes. This is because at least some somatizing patients' problems do not lie anywhere in their bodies. Rather, they are using their bodies, the language and culture of medicine, and the institutions and processes of the healthcare system to express and manage their personal and interpersonal difficulties in a way that would otherwise be difficult or impossible. Somatization may, for some individuals, be an acceptable way of interacting with others in a medicalized world. From this point of view, understanding somatization requires not that we look into the patient's body but rather into the patient's life and the world in which he or she lives.

Authors Notes: The point of view expressed in this paper is based on research supported in part by Grant MH-35856 from the National Institute of Mental Health. *E-mail John F. Kihlstrom at Kihlstrm@socrates.berkeley.edu or Lucy Canter Kihlstrom at lucyck@uclink4.berkeley.edu.* *Further information on somatization and other aspects of health and illness behavior is available at www.institute-shot.com.*

References

Canter Kihlstrom L. Marsh KF, Kihlstrom JF 1998 Multiple somatic symptoms among young adults. Available: www.institute-shot.com/illness_behavior.htm.

Garcia-Campayo J, Sanz-Carrillo C 2000 The use of alternative medicines by somatoform disorder patients in Spain. British Journal of Medical Practice 50:487–488

Hyman SE 1994 Another one bites the dust: An infectious origin for peptic ulcers. Harvard Review of Psychiatry 1:294–295

Harvard Mental Health Letter 1999a illness without disease-Part1 (Somatoform disorders) 16, 3:1–4

Harvard Mental Health Letter 1999b illness without disease-Part 2 (Somato form disorders) 16, 4:1–4

Kashner TM, Rost KM, Smith GR, Lewis S 1992 The impact of a psychiatric consultation letter on the expenditures and outcomes of care for patients with somatization disorder. Medical Care 30:811–821

Kellner R 1990 Somatization: Theories and research. Journal of Nervous & Mental Disease 178:150–160

Kihlstrom JF, Canter Kihlstrom L 1999 Self, sickness, somatization, and systems of care. In: Contrada RJ & Ashmore RD, eds. Self, Social Identity, and Physical Health: Interdisciplinary Explorations, Vol 2. New York: Oxford University Press

Kirmayer LJ 1984 Culture, affect, and somatization: I & II. Transcultural Psychiatric Research Review 21:159–188; 237–262

Kirmayer LJ, Robbins JM 1991 Current Concepts of Somatization: Research and Clinical Perspectives. Washington, DC: American Psychiatric Press

Kleinman A, Kleinman J 1985 Somatization: The interconnections among culture, depressive experiences, and the meanings of pain. A study in Chinese society. In: Kleinman A & Good B, eds. Culture and Depression. Berkeley, CA: University of California Press, pp 132–167

Lipowski ZJ 1988 Somatization: the concept and its clinical application. American Journal of Psychiatry 145(11): 1358–1368

Mai FM, Merskey H 1981 Briquet's concept of hysteria: An historical perspective. Canadian Journal of Psychiatry 26: 57–63

McWhinney IR, Epstein RM, Freeman TR 1997 Rethinking somatization. Annals of Internal Medicine 126:747–750. Reprinted in Advances in Mind–Body Medicine, 2001

Mechanic D 1962 The concept of illness behavior. Journal of Chronic Diseases 15:189–194

Morriss RK, Gask L, Ronalds C, Downes-Grainger E, Thompson H, Goldberg DP 1999 Clinical and patient satisfaction outcomes of a new treatment for somatized mental disorder taught to general practitioners. British Journal of General Practice 49:263–267

Nimnuan C, Hotopf M, Wessely S 2000 Medically unexplained symptoms: How often and why are they missed? Quarterly Journal of Medicine 93(1):21–28

Overmier JB, Murison R 1997 Animal models reveal the "psych" in the psychosomatics of peptic ulcers. Current Directions in Psychological Science 6:180–184

Robins LN, Helzer JE, Weissman MM et al. 1984 Lifetime prevalence of specific psychiatric disorders in three sites. Archives of General Psychiatry 41:949–958

Smith GR, Monson RA, Ray DC 1986 Psychiatric consultation in somatization disorder. New England Journal of Medicine 314:1407–1413

Wessely S, Nimnuan CS, Sharpe M 1999 Functional somatic syndromes: One or many? Lancet 354:936–939

© John E. Fetzer Institute 2001