# Toward More Effective Recognition and Management of Somatization Disorder

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Somatization disorder is a relatively new name for a very old clinical problem. This disorder describes patients with multiple unexplained medical symptoms. Work began in the early 1960s by Guze and colleagues[1,2] to characterize a disorder with diagnostic reliability, a characteristic course, and a familial pattern. The diagnosis was officially recognized by the American Psychiatric Association in 1980 as part of their official nomenclature. Since patients with somatization disorder perceive themselves to be medically ill, they are usually seen in general medical settings rather than psychiatric settings; therefore, the family physician is typically the physician who must diagnose and manage these difficult patients.

The article in this issue of The Journal by deGruy and colleagues[3] addresses very important clinical questions concerning patients with somatization disorder. Their study is the first report of the prevalence of somatization disorder in a general hospital. Even when their data are interpreted in the most conservative fashion, there were 19 of 623 patients admitted with the diagnosis of somatization disorder. These numbers translate to a prevalence estimate of 3 percent; three of every 100 admissions to a general hospital have somatization disorder. The best current estimates of prevalence in the general population range from 0.1 to 0.4 percent. Clearly patients with somatization disorder are overrepresented in the general hospital by at least a factor of 7.5. deGruy et al further report that 84 percent of their patients were women. It is noteworthy that 16 percent were men, which is similar to the proportion of men found in a previous study.[4] Contrary to earlier reports, this finding emphasizes that somatization disorder is not rare in men. The present study also documents the large number of negative workup results seen in patients with somatization disorder and the range of discharge diagnoses given to them. Not one of the 19 patients found with the disorder was given the diagnosis of somatization disorder.

One surprising finding was that no difference was found in either the length of hospitalization or the charges for hospitalization of patients with somatization disorder. This finding may be a result of the impact of diagnostic related groups (DRGs), since this study was undertaken during the DRG era, which has tended to shorten all hospitalizations. It is important to remember that to diagnose somatization disorder does not take five inpatient days, the mean length of stay in this study. Only a one-hour outpatient evaluation is required to make the diagnosis. It is appropriate for a certain number of patients with somatization disorder to be admitted to inpatient services. When such a patient is admitted, the diagnosis of somatization disorder should be made. Surprisingly, under the DRG system, this diagnosis is financially more beneficial to the hospital than are the nonspecific diagnoses frequently given to patients with somatization disorder. For example, at University Hospital in Little Rock, Arkansas, the DRG system reimburses $1,721 for nonspecific abdominal pain, $2,109 for nonspecific chest pain, and $2,367 for somatization disorder.

Our group has been involved in several studies of patients with somatization disorder with findings that parallel those of the present study.[4,5] We found that patients with somatization disorder average 7.6 days in the hospital per year, most of which is probably inappropriate, since these patients should be managed as outpatients. Furthermore, patients with somatization disorder report that their health keeps them in bed about seven days per month compared with the general population, which only reports a half-day per month. Finally, patients with somatization disorder consume an inordinate amount of health care, about nine times as much as the general population.[4] Treatment of these patients can be difficult at best. Our work indicates that primary care physicians are the appropriate physicians to manage patients with somatization disorder. This management may be assisted by a psychiatric consultation. Our experience has been that the astute primary care physician can eventually help the patient become "referral ready." The patient will often then be agreeable to psychiatric referral.

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There are important management principles for patients with somatization disorder.[5] The cornerstone of management is for the primary care physician to become the patient's main physician. After this relationship is accomplished, regularly scheduled brief appointments are helpful. These appointments, usually occurring every four to six weeks, should include a physical examination of the system of which the patient has symptoms. Regularly scheduled appointments allow the patient to see the physician without developing symptoms, which also tends to decrease the number of new symptoms developed. Physicians should look for signs of disease; in these patients the physician cannot rely on symptom development as the harbinger of new disease. Avoiding hospitalization, diagnostic procedures, surgery, and laboratory assessment is appropriate unless such services are clearly indicated. Finally, it is important not to tell the patient that it is "all in your head." These patients have very little insight and develop insignt only over months and years. The physician should tell the patient that nothing was found to be seriously wrong and that the patient will be followed at frequent intervals to watch for the development of serious disease.

In conclusion, deGruy and colleagues[6] have clearly outlined the problem of patients with somatization disorder in a general hospital. Their recent work in this journal concerning outpatients with somatization disorder clearly underscores the magnitude of the problem with these patients in a family medicine practice. Although more work needs to be done concerning these patients, the body of knowledge has progressed substantially to facilitate the recognition and more appropriate management of these difficult patients.

## References


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