
Hypochondriasis and Somatization Disorder: New Perspectives

23

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23.1 Introduction

The blurred boundaries between illnesses presenting with somatic symptoms confronts both psychiatrists and primary care physicians with one of the most challenging issues in patient care (Lipsitt 2000). On a typical day in a general physician's office, perhaps 50 % or more of the patients with physical complaints will have no definitive explanation for their ailment (Simon et al. 1996; Kroenke and Mangelsdorff 1989; Kroenke 2003; Baumeister and Harter 2007; Smith and Dwamena 2007). The patients present with distress from fatigue, chest pain, cough, back pain, shortness of breath, and a host of other painful or worrisome bodily concerns. For most, the physician's expression of interest, taking a thorough history, doing a physical examination, and offering reassurance, a modest intervention, or a pharmacologic prescription suffices to assuage the patient's pain, anxiety, and physical distress. But for some, these simple measures fall short of their expected result, marking the beginning of what may become a chronic search for relief, including frequent anxiety-filled visits to more than one physician, and in extreme cases even multiple hospitalizations and possibly surgery.

The longer and more persistently this pattern appears, the more likely it will generate referrals to specialists for expert consultation, potential iatrogenic illness, greater frustration in both the primary physician and the patient, and ultimately

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dysfunctional patient–physician relationships with inappropriate labeling of the patient as a “problem” or “difficult” patient, and perhaps even worse (Lipsitt 1970; McCahill 1999). This pattern of medical care seeking has been well documented for hundreds of years, accompanied by earnest attempts to understand and describe the phenomenon. Robert Burton’s (1621) *Anatomy of Melancholy* described the melancholic and hypochondriacal person. Crediting Hippocrates, Galen, and others, Burton described hypochondriasis (or “windy melancholy”) as an illness that “most commonly [begins with] fear, grief, and some sudden commotion, or perturbation of the mind in such bodies especially as are ill-disposed” (p. 249). The symptoms, he said, are “so ambiguous,” that “the most exquisite physicians cannot determine of the part affected” (p. 269). The challenge has changed little since Burton’s day.

This difficulty of diagnosis has been reflected through the ages, as one term has been supplanted by another (Wessely et al. 1999) in attempts to quell the discomfort of uncertainty that surrounds patients with multiple recurring physical symptoms; these terms include spinal irritation, hysteria, dissociation, neurasthenia, functional disorder, psychophysiological disorder, psychosocial complication, psychosomatic illness, somatization, and unexplained medical disorder (Shorter 1992). Most recently, the term “medically unexplained symptoms” (MUS) has supplanted most others as perhaps the most benign of these “explanatory” terms (Creed et al. 2010).

The term *somatization* had, for some time, become controversial (Martin 1999; Wessely et al. 1999; Mayou et al. 2005) in its broad application to patients whose physical symptoms motivate them to seek medical care and to take medications in hopes of finding relief from what distresses them (Lipowski 1988; Kravitz 2001; Walters et al. 2008; Taylor et al. 2012). An entire spectrum of somatizing (or somatoform) disorders had been enshrined in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association 1994), now superseded by a new, modified classification that has attempted to

address the issue of somatizing disorders (DSM-5, American Psychiatric Association 2013). For historical purposes, I will present a brief review of the concept of somatization and will address two of the more commonly confused somatoform disorders: hypochondriasis and somatization disorder, followed by their contemporary reclassification (Voigt et al. 2010).

23.2 The Concept of Somatization

Coined first, not, as conventionally thought, by the German psychoanalyst Wilhelm Stekel, but by his translator in 1925 (Marin and Carron 2002), who was searching for an approximation to the German *organsprache* (organ-speech), the word *somatization* at first was close to Freud’s concept of conversion. When Stekel (1943) later used the word in an English-language book on dreams, he defined it as the bodily representation of a deep-seated neurosis, the expression of mental conflict through organ language (Kellner 1991). Freud (1986) (1905) had called it “somatic compliance” in his early studies of hysteria, referring to the symbolic representation in particular organs of an otherwise insoluble emotional conflict.

Somatization achieved some popularity as a way to comprehend the variety of ways in which mind and body seemed to interact. The word was considered helpful to establish a bridge between such diverse conditions as hypochondriasis or conversion and, for example, irritable bowel syndrome or chronic fatigue syndrome. The term and concept were gradually almost universally disapproved if not abolished, giving rise to the movement to reconsider somatoform disorders in DSM-5 (Martin 1999; Dimsdale et al. 2007; Kroenke 2006).

Theories about somatization are scarce, although there is general agreement that it represents a process rather than a diagnosis, more appropriately acknowledged as merely a descriptive term, much as fever might be for a host of diseases (Kirmayer and Young 1998). At least one group of authors has attributed this process to abnormalities of attachment in early life (Waller et al. 2002; Pedrosa et al. 2008). A more

psychoanalytic explanation is provided by the Viennese psychoanalyst Max Schur (1955), who was also Freud's primary care doctor. Schur's theory provides a developmental model; the infant's undifferentiated somatic responsiveness to all stimuli gives way, with developing language and ego mastery, to a more desomatized state with normal emotional adaptation. In this theory, trauma or developmental failure causes normal adaptation to revert to a previous somatic state in which physical representation becomes the major response mode.

Given our common developmental heritage, we are all (including physicians)—in one sense or another and one time or another—somatizers. But it is only those individuals concerned about or distressed enough by their physical reactions to seek medical attention or take medications who are labeled "somatizers." Such individuals tend to attribute their somatic symptoms to signs of physical illness, even in the absence of pathologic medical findings, just as do physicians otherwise unable to make a definitive "organic" diagnosis. Consulting a primary care physician often marks the beginning of what, for many, becomes a lifelong quest for relief.

23.3 Classification

Classification is an earmark of science and especially medicine, wherein the recognition of similarities and differences permits manageable groupings for research, communication, and treatment with the greatest parsimony. Major contributions to medicine by the earliest physicians like Hippocrates and Galen addressed this problem in efforts to understand and treat the many symptoms they encountered in their patients. In time, progress is achieved through constantly evolving and, it is hoped, better classifications.

In mental illness, classification and "official" recognition of a uniform nomenclature of mental disease is a rather recent and elusive enterprise. Beginning with the collection of hospital statistics in 1917, classification gradually paid more attention to diagnosis and treatment, with the first DSM classification established after World War II.

23.3.1 From DSM-I to DSM-5

From the very earliest days of efforts to classify mental disorders, how to characterize somatization clearly presented a very sticky problem (Lipsitt 1996). In spite of attempts to clarify different somatizing disorders described as distinct entities, the spectrum of somatoform disorders is large, diffuse, and often defying of definitive diagnosis (Wessely et al. 1999). While sometimes distinguishable one from another, they all share the symptomatic representation of somatization.

Physicians, frustrated by the challenge of accurately diagnosing patients with medically uncertain syndromes, may pejoratively simply characterize such patients as "somatizers" in cases that in previous decades have called forth such utterances of frustration as "crock," "gomer," "turkey," or worse (Lipsitt 1970). Sometimes obsolete or undifferentiated diagnoses such as neurasthenia or chronic fatigue syndrome are resorted to. More recent references have been to "medically unexplained symptoms" (Creed et al. 2010). The Japanese literature refers to "unidentified clinical syndrome" or "vegetative syndrome" (Takii et al. 1994). All have been controversial or unacceptable.

Because most patients with unremitting physical symptoms of uncertain origin are more likely to consult a general physician than a psychiatrist, patients with somatoform disorders are seen infrequently in general psychiatric practice and more frequently by psychiatrists who work closely with nonpsychiatrist colleagues in medical or consultation-liaison settings. It often falls to the consultation-liaison psychiatrist to treat or manage these patients in the medical setting or to adopt a pedagogical relationship with primary care physicians to help them treat these patients.

In choosing the subclassification of psychophysiological autonomic and visceral disorders, the authors of the first edition of the DSM (DSM-I) wrote, "This term is used in preference to 'psychosomatic disorders,' since the latter term refers to a point of view on the discipline of medicine as a whole rather than to certain specified conditions. It is preferred to the term 'somatization reactions,' which term implies that these disorders are simply another form of psychoneurotic

reaction” (American Psychiatric Association 1950, p. 29). Thus, the place of somatization in the lexicon and theory of psychiatric disorder has had a long and controversial journey (Pilowsky 1969).

A large number of practicing psychiatrists and others, in attempts to lend some structure and common language to the vast field of “unexplainable” medical syndromes, finally located the unifying concept of somatization in a separate formal classification. Beginning in 1980, the third edition of the standardized nomenclature (DSM-III, American Psychiatric Association 1980) introduced the category of somatoform disorders and somatization, replacing the previous catalog of so-called psychophysiological disorders. The fourth edition (DSM-IV, American Psychiatric Association 1994) replaced the diagnosis of atypical somatoform disorder with undifferentiated somatoform disorder in an attempt to make diagnosis correspond more closely to actual clinical experience. It also reduced the number of symptoms for diagnosis of somatization disorder from 35 to 4 thematic areas of pain, gastrointestinal, sexual, and pseudoneurological. The authors of DSM-IV acknowledged that “Undifferentiated Somatoform Disorder was considered a candidate for possible deletion from DSM-IV [but] was retained only because of its familiarity and possible utility in primary care settings” (Frances et al. 1995, p. 280). DSM-5 has finally succumbed to the challenge of distinguishing various somatoform disorders by “lumping” them into one category of Complex Somatic Symptom Disorder.

A case history helps to elucidate the commonalities of somatizing patients, as well as the diagnostic and therapeutic challenges of sometimes confusing clinical presentations and their classification.

23.4 Case History (Part 1)

Melissa, an attractive, intelligent black college student, was referred to a psychiatrist at the age of 27 by her primary care physician (PCP) requesting help with “this complex and problematic young woman.” He had been seeing her for about a year for complaints of left-sided

abdominal as well as pelvic pain and urinary frequency. Having failed to obtain relief with over-the-counter medications, she urgently sought medical help and recommendations. Her physician, a highly skilled and competent young doctor, assiduously pursued an explanation for her symptoms, including referrals to a gastroenterologist, two urologists, and three gynecologists; they added equivocal diagnoses of gastroenteritis, esophageal reflux, irritable bowel syndrome, cervical inflammation, and diverticulosis to her medical history.

Because of a fear of cancer, she also underwent several cystoscopies with vaginal and urethral biopsies, with negative results. Her repeated thorough physical examinations and all laboratory and procedural studies were within normal limits. On verbal referral to the psychiatrist, Melissa’s doctor revealed that he was “concerned about the frequency of her visits to a hospital emergency room and to various physicians,” and also “about the increasing aggressiveness of the workups she was receiving despite essentially negative data.”

The consulting psychiatrist found Melissa to be a willing, if doubting, patient, eager for “anything that will help the pain” and “get my life back on track.” He learned that she had experienced a “painful belly” since around age 5, that her mother and father both had “drinking problems” and took her to doctors at a young age. Father was an advertising executive who had lost his job; mother worked as a secretary and battled a skin disorder for many years.

Melissa revealed little capacity, in spite of her obvious intelligence, for any psychological assessment of her distress or her relationships to family and others. She had been close to a grandfather who died of colon cancer, and she remembers thinking “catastrophic thoughts” when she first began to have crampy periods around age 12. Her grandmother had died of diabetes only a few years previously.

In spite of her long-standing struggle with vague pains, Melissa managed to do her college work reasonably well until she began a sexual relationship with a boyfriend. At that time, all of her pains escalated, with additional throbbing

sensations in her urethra, painful intercourse, and painful urinary frequency. As repeated referrals turned up no satisfactory explanation for her symptoms, she became more and more anxious and demanding in seeking medical care. She read the medical literature and raised questions about illnesses she thought she might have. Attempts at reassurance by her doctors had fallen on deaf ears. To her doctor, she was also beginning to seem depressed. She had begun to complain of additional symptoms including back and hip pain and constipation.

The psychiatrist recommended to Melissa's physician that he see her on a regular basis, but severely curtail further surgical and medical workups. Although she did not seem a candidate for psychotherapy, listening to her story and tolerating her complaints without an urge to "do something" might be of some help. Prescribing an antidepressant (beginning with small doses) could possibly ameliorate both pain and depression, but should not be administered with any optimistic promise of fast (or any) results. He suggested that a stable, continuous patient-physician relationship could potentially offer the greatest therapeutic benefit and that definite appointments should be made unrelated to occurrence or intensity of symptoms.

23.5 Diagnosis

23.5.1 Hypochondriasis

To qualify for a diagnosis of hypochondriasis in DSM-IV criteria, Melissa would have to fulfill the following: (1) a persisting preoccupation with having a serious disease based on misinterpretation of symptoms, despite normal findings on medical evaluation and reassurance; (2) the preoccupation is not of delusional intensity and is not confined to a circumscribed concern about appearance, as in body dysmorphic disorder; (3) the preoccupation causes significant distress or impairment of function; (4) the duration is at least 6 months; and (5) the preoccupation is not secondary to generalized anxiety disorder, obsessive-compulsive disorder, panic disorder,

major depressive episode, separation anxiety, or another somatoform disorder.

Melissa's intense anxiety and depressive accompaniment to her somatic concerns, with her increasing frustration, began to affect her relationships, at least with her recent boyfriend, but it is not clear which comes first—concern about pelvic distress worsening her sexual performance, or interpersonal tensions resulting in physical expression. She has not yet shown evidence of psychotic ideation, unreasonable preoccupation with bodily appearance, or significant impairment in her schoolwork. Cancer phobia does seem to have played a part in prompting physicians to repeatedly try to reassure her, with biopsies and other instrumentations, that she is not afflicted with this disease, although she does not feel reassured. And while her major symptoms do appear to be of recent onset, there is clear evidence of long-standing somatic preoccupation, at times even with "catastrophic" fears.

While we might be inclined to accept a diagnosis of hypochondriasis for Melissa, examining other dimensions of this disorder and comparing it later to another somatoform condition—somatization disorder—may provide more clarity.

23.5.1.1 Clinical Features and Patient Behavior

A physical complaint is the most common entrée to a medical care scenario. It is the "bread-and-butter," so to speak, of medical practice, and nothing is considered unusual when a patient first complains of a cough, a backache, fatigue, or dizziness. It is only when such symptoms resist remission with routine or simple measures and interventions that a physician's antennae become attuned for "more than meets the eye." Each physician's threshold for such alertness varies, and some may be tolerant of months or even years of chronic complaint without physical findings before acquiescing to a different view than a strictly biomedical one. Since somatizing patients themselves are not often inclined to use emotional language to describe their distress, their physicians may be dissuaded from exploring this dimension of the patient's experience. Increasing chronicity often leads to escalating frustration,

even restrained anger. Physicians become increasingly aggressive in pursuit of elusive physical etiologies and patients become more and more disappointed in the reports of specialists to whom they are referred for extensive and expensive evaluations. The pinnacle of such dynamics is often a series of dysfunctional patient–physician relationships, “doctor-shopping,” and resort to marginal remedies of often doubtful worth (Lipsitt 2001a). If psychiatric referral is regarded an “end-of-the-line” gesture, it is often made with distorted or inappropriate preparation by the physician and inadequate understanding and resentment by the patient. While this pattern of behavior by itself does not distinguish hypochondriasis from other somatoform disorders, it does begin to characterize the field in which patient and physician will engage one another.

23.5.1.2 Epidemiology and Prevalence

Many individuals manifest a hypochondriacal orientation toward life, a kind of health anxiety, while very few actually qualify for a bona fide diagnosis of hypochondriasis. Originally thought to be a disease only of men, it is now recognized as an equal opportunity illness, affecting men and women in similar numbers. Because good epidemiologic studies rely on valid measures of the disease, an illness with such a long, colorful, and changing history does not lend itself easily to such investigation. Recent studies, using such standardized scales as the Whitely Index, the Somatic Symptom Inventory (of the Minnesota Multiphasic Personality Inventory, MMPI), and the Illness Worry Scale, have suggested that hypochondriasis is a valid distinguishable disorder (Speckens 2001).

Prevalence rates, highly dependent on populations examined, have ranged from 1 to 25 %. A worldwide population study, involving 15 sites, established a prevalence rate of 2.2 % for hypochondriasis in general populations (Gureje et al. 1997). Making fine distinctions among illness phobia, illness fear, bodily preoccupation, and disease conviction is not easy and will alter prevalence rates considerably. It is this very difficulty of assessment that has led to reconsideration of classification in DSM-5 (Mayou et al.

2005; Dimsdale et al. 2007; Kroenke et al. 2007; Dimsdale and Creed 2009).

23.5.1.3 Diagnosis

An extremely broad and lengthy spectrum of somatizing primary and secondary disorders makes diagnosis more challenging. Some clinicians prefer simply to describe “hypochondriacal tendencies,” or “evidence of somatization” rather than use the specific designation of hypochondriasis, unless the condition almost reaches the threshold of somatic delusion. Of course, consultation and treatment that depend on a specific diagnosis to be eligible for reimbursement by insurance companies will be designated with that formal somatizing disorder that appears most salient in the patient’s history and presentation. Controversy prevails among clinicians as to when hypochondriacal behavior represents low-level “illness worry,” reasonable attentiveness to physical needs, a personality disorder, or a variant of obsessive-compulsive disorder (Tyrer et al. 1990).

23.5.1.4 Methods of Assessment

The clinician’s assessment of patients for hypochondriasis includes a careful review of prior history, considering all physical investigations and the course of the illness. A good current interview attends to how the patient relates to his or her body, the language used to describe symptoms, and the interactive nature of the encounter as engaged, avoidant, trusting, or doubtful. The past history of the patient–physician relationships sometimes predicts future relationships but should not be exclusively relied on. The patient’s capacity for collaborative exploration may define the level of opportunity (or absence) for developing a trusting alliance. A readiness to accept reassurance may anticipate the patient’s postexamination response to findings, supportive comments, and suggestions.

Observing patients’ reactions of fear, anxiety, or neutrality in discussion of symptoms or diseases, as well as distorted thinking and erroneous knowledge about them, can establish patients’ hypochondriacal attitudes toward their symptoms.

While somatizing patients referred for psychiatric assessment may become angry at their primary physician for implying that their physical

symptoms are not real, not important, a sign of “craziness,” or evidence of desperation in their physician, they may nonetheless be willing to comply with paper and pencil assessments, such as the Structured Diagnostic Interview for Hypochondriasis (SDIH) (Barsky et al. 1992); the Illness Behavior Questionnaire (IBQ) (Pilowsky et al. 1984); the Somatosensory Amplification Scale (SSAS) (Barsky et al. 1990); and the Whitely Index (WI) (Pilowsky 1967). Illness Attitude Scales (IAS) are available for more extensive assessment (Kellner et al. 1983–1984). Inclusion of an assessment of typical coping responses to ordinary (as well as extraordinary) life stresses sheds light on the patient’s illness behavior (Pilowsky 1969).

Of all the above-cited assessments, the Whitely Index is perhaps the most useful and easiest to administer with individual patients. It is available at http://www.uib.no/med/avd/med_a/gastro/wilhelms/whiteley.html. How the elicited data are utilized in either medical or psychiatric practice depends on each physician’s individual practice style.

23.5.1.5 Research

There has been increasing interest in researching the etiology, prevalence, and treatment of hypochondriasis (Fink et al. 2004). The search for pharmacologic agents that can bring relief to sufferers of hypochondriasis has been especially robust, with continuing need for random controlled trials that can promote the clinician’s confidence in everyday practice (Fallon 2001; Kroenke et al. 2006; Fallon et al. 2008; Schweitzer et al. 2011). To the extent that hypochondriasis is accompanied by depression, anxiety, or obsessive-compulsive disorder, there is good research evidence that drugs found effective in those conditions will bring some symptomatic relief to hypochondriacal patients without necessarily changing the basic disorder. Other studies have shown that thoughtful application of reassurance can be useful with patients not ordinarily considered amenable to this intervention (Starcevic 2001).

A growing interest in the relative efficacy of cognitive-behavioral treatment, both in groups

and individually, has fostered research that validates this approach (Warwick et al. 1996; Simon 2002; Lidbeck 2003; Barsky and Ahern 2004; Allen et al. 2006; Escobar et al. 2007; Greeven et al. 2007). Reports of the application of interpersonal psychotherapy based on attachment theory premises offers an unsubstantiated promise of effective intervention (Stuart and Noyes 2006; Pedrosa et al. 2008).

In post-Hippocratic days, hypochondriasis was acceptably attributed to disorders of various organs, such as the spleen, liver, stomach, and lungs, until evolving science was able to rule out such etiologies, rendering symptoms “unexplainable.” Now, science is also beginning to fill in the blanks of the “mysterious leap from mind to body” with potentially explanatory findings in neurocircuitry and molecular metabolites (Stein and Muller 2008; Brondino et al. 2008; Garcia-Campayoa et al. 2009; van den Heuvel et al. 2011). Imaging and neuroendocrinologic research, while exciting and promising, has not yet achieved transferability to the practicing psychiatrist or internist eager to treat somatizing patients.

23.5.1.6 Hypochondriasis and Primary Care

It is the primary care physician who is and will continue to be the mainstay of care for the millions of somatizing patients in the health care system (Smith et al. 2006, 2009), although their interest in treating somatizing patients is generally lacking (Salmon et al. 2007). Because physicians are trained primarily to detect physical rather than emotional illness (the biomedical approach), inordinate amounts of time can be squandered searching for physical explanations for “mysterious” presenting complaints (Salmon et al. 2004). The risks include delayed recognition, diagnosis and treatment, high and excessive utilization of medical resources, unreasonable and unnecessary costs, and prolonged suffering before the essential diagnosis and intervention are instituted. Such pitfalls can be avoided with the collaborative assistance of psychiatrists or other mental health professionals (Lipsitt 1996; Katon et al. 1999; Schaefert et al. 2013).

The presentation by the patient of a physical complaint does not automatically put the physician in mind of a somatoform disorder (Salmon et al. 2004). Nonetheless, with increasing chronicity and a lack of explanatory physical findings, the continuing presence of unexplained physical symptoms should place this category of disorders close to the top of a differential diagnosis list. The entire category of somatoform disorders offers a number of often overlapping options besides hypochondriasis: conversion disorder, pain disorder, somatization disorder, and undifferentiated somatoform disorder. Once symptoms are ruled out as due to a general medical condition, substance use/abuse, body dysmorphic disorder, other mental disorders, and malingering or factitious disorder, the primary care physician is faced with a perplexing choice. And for the PCP, unfamiliar with the nuances of the many subsyndromal somatized presentations, the somatizing patient presents a formidable and ultimately frustrating challenge. However, there is promise that reclassification of somatoform disorders will ease the PCP's task (Rosendal et al. 2005; Sumathipala 2007).

A frequent solution to the diagnostic dilemma is a "seat of the pants" maintenance approach that may either plateau to a tolerable truce or arrive at some critical nodal point where marked change is called for (Lipsitt 2009; olde Hartman et al. 2009b). However, if the predominant clinical picture is one of somatic expression of a fear of having a disease, the PCP might reasonably settle on the diagnosis of hypochondriasis and acceptably maintain the patient, employing recommended management principles (Lipsitt 1987; Bass and Benjamin 1993; Margo and Margo 2000; Servan-Schreiber et al. 2000a, b; Simon 2002; Avia and Ruiz 2005; Henningsen et al. 2007; Hatcher and Arroll 2008).

23.5.1.7 The Patient–Physician Relationship in Hypochondriasis

In those instances where a trusting working relationship is not established between the somatizing patient and his or her PCP, the resulting perturbations run the risk of creating a dysfunctional,

discordant, or ruptured relationship (Lipsitt 2001b; Hahn 2001). Mutual dissatisfaction, distrust, and frustration leading to anger can result in excessive referrals by the physician and futile "doctor-shopping" by the patient. The physician's capacity for empathy may be diminished in such a context, and the propensity for labeling the patient may be invoked (Margo and Margo 2000). Branding a patient a "problem patient" may unfortunately establish an unwarranted profile that adheres to the patient throughout his or her medical "career." This clinical hazard prevails whenever symptoms are "unexplainable" (Lipsitt 2001b), and being told of a "somatization disorder" may be experienced not only as unhelpful but also offensive to the patient.

23.5.1.8 Specific Aspects of Treatment

Management and treatment of hypochondriacal patients utilize principles applicable to all somatizing patients: respectful acceptance of the patient's complaints and symptoms; listening with patience to the (usually physical) narrative; thoughtful restraint about psychological interpretation, referral, or prescription; and emphasis on care rather than cure. The judicious use of medication (as yet insufficiently proven with good randomized controlled trials) for accompanying anxiety, depression, or obsessive-compulsive tendencies may produce some improvement but not sufficient to terminate treatment. Whether individual or in groups, supportive or cognitive-behavioral, all treatment rests on a platform of a trusting patient–physician relationship, and continuity of care with regular appointments at increasingly wider intervals according to the patient's tolerance and agreement.

If there is a distinguishing feature of treating patients with hypochondriasis, it probably resides in the challenging nature of complaints and persistent presentation of elusive and changing symptoms. This fluctuating pattern may severely test the clinician's tolerance more than disorders that show greater consistency in symptomatic expression. Acknowledging Melissa's diagnosis as a somatoform disorder, the next most likely possibility is somatization disorder, formerly known (pre-DSM) as Briquet's syndrome (Guze 1983).

23.5.2 Somatization Disorder

To qualify for a diagnosis of somatization disorder (SD) by DSM-IV criteria, Melissa would have to fulfill the following criteria: (1) a history of many physical complaints over a period of years, with onset before age 30, with significant impairment for which treatment is sought; (2) at any time during the course of the illness, there must have been (a) four pain symptoms in at least four different sites or functions such as during menstruation or urination; (b) at least two gastrointestinal symptoms; (c) at least one sexual symptom other than pain, e.g., irregular periods or erectile dysfunction; (d) at least one pseudo-neurologic symptom not limited to pain, e.g., weakness, blindness, seizures, amnesia; (e) for each of these symptoms, appropriate investigation either fails to reveal a medical disease or substance use that fully explains it, or, if a medical disease is found, the symptoms or functional impairment far exceed what might be expected from the disease; and (f) the symptoms are not intentionally produced or feigned, as in factitious disorder or malingering.

Before examining each of these criteria in Melissa's case, a general clinical profile is offered.

23.5.2.1 Clinical Features and Patient Behavior

Patients with SD are likely to attribute their distress to the symptoms themselves rather than, as in the case of hypochondriasis, to their meaning, and to more assertively seek symptom relief. Patients with SD are more likely to be women, often with histrionic coloring in their personality (compared to the more obsessional quality of hypochondriacal patients). They may also present themselves more dramatically in their help-seeking fervor, and rather than reject offers of help, show greater receptivity to whatever might be offered (or not). They may also reveal a stronger family history of personality disorder, alcoholism, or sociopathy. Physicians may be impressed with the multiplicity of prior symptoms, diagnoses, and surgeries beginning at an early age. When patients with suspected

SD are asked how long they have been sick, a common response is "all my life." The general picture is one of greater stability than that in hypochondriasis.

23.5.2.2 Epidemiology and Prevalence

Although the incidence of subsyndromal somatization as seen in primary care is quite high, SD in the general community is thought quite rare, according to the Epidemiologic Catchment Area (ECA) Study (Swartz et al. 1990), estimated at 0.13 %. A recent study of 119 primary care patients revealed a documented prevalence of only 1 % SD (Lynch et al. 1999). Patients referred for psychiatric evaluation from primary care resources have been estimated from 6 % (Katon et al. 1984) to 34 % (Smith 1995). It is precisely this marked variability that has prompted a desire for reclassification (Sharpe and Carson 2001).

23.5.2.3 Diagnosis

Having derived from an earlier diagnosis of Briquet's syndrome (or hysteria), SD is more likely than hypochondriasis to show a kinship with conversion disorder. Pierre Briquet, a French neurologist, was the first to free the definition of hysteria from its primitive notions of abnormalities of female reproductive organs, namely the "wandering uterus." In 1859, he described a dramatic syndrome with 59 different accompanying symptoms in women, many of which were of a sexual or painful nature. Briquet regarded this illness very seriously and attributed it to a brain defect in "that portion of the encephalon where affective functions are located" (Shorter 1992, p. 212). Perley and Guze (1962) established the validity and stability of the syndrome, which was subsequently renamed somatization syndrome (Bass 1990) in the DSM-III.

Because of the cumbersome diagnostic criteria, Briquet's 59 symptoms were reduced to 37, of which 13 were considered sufficient to establish the presence of SD. Even this degree of abbreviation was found unwieldy, heralding an abridged set of criteria showing consistency with DSM-III-R criteria (Smith 1995). The DSM-IV specifies a requirement of eight symptoms from the criteria as specified above. Escobar

and associates (1989) devised the Somatic Symptom Index (SSI), requiring only four symptoms for males and six for females to reach diagnostic significance and concordance with DSM criteria. Syndromes that do not fulfill SD criteria but show other characteristics of the disorder were ultimately classified as undifferentiated somatoform disorder, a diagnosis now subsumed under Complex Somatic Symptom Disorder in DSM-5 (Sykes 2012).

23.5.2.4 Methods of Assessment

In addition to the usual history, physical examination, and assessment of illness behavior, screening instruments are available (but probably seldom used) for use in primary practice (Othmer and DeSouza 1985; Swartz et al. 1986). A unique method of assessment and treatment has been developed by Wickramasekera (1989) using tests of hypnotizability and neuroticism to identify the tendency to somatize, then selectively used in a variant of biofeedback treatment; the complexity of this approach, while creative in its implementation, renders it unlikely as a method that can be integrated into primary care practice (Lipsitt 1998).

23.5.2.5 Research

To date, as with hypochondriasis, there is no definitive treatment for SD, although interest in the promise of cognitive-behavioral therapy (CBT) continues to grow (Kroenke and Swindle 2000; Allen et al. 2002; Simon 2002; Escobar et al. 2007; Kent and McMillan 2009). Reports indicate some variable success with noncontrolled educational approaches that help patients reattribute their physical symptoms to psychosocial stressors (Goldberg et al. 1989; Salmon et al. 2007). The ability of PCPs to effectively follow suggested management guidelines was impressively demonstrated in a randomized controlled study using only a consultation letter to assist physicians in the management of patients with SD (Smith et al. 1986). Patients were managed more effectively, with decreased utilization and a 49–53 % savings in cost of health care, although physical and emotional characteristics remained essentially unchanged. A replicated study was able to demonstrate emotional and physical

changes (Rost et al. 1994). Nevertheless (Cochrane Summary 2010) of such interventions suggests that benefits are too weak to be attributed to more than the therapist-patient relationship. Eight-session group therapy in a randomized controlled trial with 70 SD patients demonstrated lasting physical and emotional improvement 1-year poststudy (Kashner et al. 1995; Greeven et al. 2007). Regarding targeted pharmacotherapy, anecdotal and case series reports suggest potential benefit from paroxetine (Okugawa et al. 2002; Fallon et al. 2008), nefazodone (Menza et al. 2001), and other selective serotonin reuptake inhibitors (SSRIs) (Viswanathan and Paradis 1991; Fallon 2001; Stahl 2003), but controlled studies are largely lacking and current thinking is that benefits from psychopharmacologic agents are attributable to amelioration of affective components of illness (Cochrane Summary 2007, 2009a, b, 2012).

23.5.2.6 Somatization Disorder and Primary Care

Again, as with hypochondriasis, the primary care physician must often resort to “seat of the pants” approaches (Lipsitt 2009). The consultation-liaison and primary care literature offer empirical guidelines for the primary practitioner, but most general physicians are either too burdened by competing practice demands or lack the foundation skills and knowledge to support application of recommended interventions. Interest in treating the somatizing patients leans toward the biologic, drug-prescribing side of the interventional spectrum; results often compound the disappointment and frustration of managing SD patients in office practice. Untutored efforts at psychiatric referral may result in aborted attempts to procure specialist advice or care. Some early experience with team or collaborative approaches would appear to show some promise (Lipsitt 1996; Smith 1995; Katon et al. 1999; Schaefer et al. 2013).

23.5.2.7 The Patient–Physician Relationship in SD

Repeated failures at well-intentioned therapeutic efforts may generate either increasingly aggressive attempts at treatment or resignation and

withdrawal from the patient (olde Hartman et al. 2009a). Either vector is likely to escalate tension in the relationship, to the point of rupture. This end point adds to the patient's history of a succession of failed relationships with physicians; in the meantime, the patient's search goes on for someone who can listen without feeling overwhelmed, who is not impelled to act, and who can hold a middle ground that gives stability, confidence, and quiet reassurance to the patient.

23.5.2.8 Specific Aspects of Treatment and Management

Recommended approaches to treatment are cited in the above sections. But guidelines unfortunately are more general than specific (Kroenke 2007; Smith and Dwamena 2012). If there are differences in working with hypochondriacal patients as contrasted with SD patients, they may relate to a difference in entrenchment of patterns of illness behavior and relative time spent in the "sick role." The SD patients have usually had more of a "career" in unremitting illness, disappointment, frustration, and anger, while those with hypochondriasis are more often in the beginning stages of their illness and may even be able to apply a modicum of insight to their plight. In either situation, gratification for the dedicated physician comes slowly, but it is rewarding when some small change occurs. Group approaches, using cognitive behavioral techniques, have found favor partly because of a more economic method and a lower intensity of interaction with therapists (McLeod et al. 1997; Lidbeck 2003; Barsky and Ahern 2004).

23.6 Case History (Part 2)

At this point, can we really distinguish Melissa's diagnosis as either hypochondriasis or somatization disorder (olde Hartman et al. 2009a; Smith et al. 2005)? If we must make a choice for purposes of documentation or therapeutic selection, it is evident that uncertainty reigns. As far as presentation goes, Melissa does manifest multiple symptoms, strong concern that she could have cancer, difficulty being reassured about her negative

workups, a history of failed patient–physician relationships, multiple specialist referrals, operative explorations, and an early onset of physical concerns. There is a history of alcoholism in the family as well as an environment of physical illness and death. Possibility of personality disorder also exists.

The most salient features of hypochondriasis are perhaps the preoccupation with the idea of serious or fatal illness and the inability to be reassured. SD is more characterized by an early persisting history of multiple somatic symptoms. Melissa did complain of lifelong "digestive problems," as well as constipation and other physical problems from the age of 5, and she is not yet 30. She had pain on menstruation, hip and back pain, urethral pain, and a long history of "belly pain." Her nonpainful sexual or reproductive symptoms included urinary frequency and difficult intercourse. There is no evidence that her symptoms represent conversion and would thus cast doubt on a full diagnosis of SD.

We are left with the clinical picture of a woman who most certainly has a somatoform disorder, but clearly defining it as hypochondriasis, somatization disorder, undifferentiated somatoform disorder, or even pain disorder presents a perplexing clinical challenge. At this time in her clinical course, it may be less important to make a definitive diagnosis (other than somatoform disorder) than to apply the general principles of working with somatizing patients of all diagnostic types. Designation as Complex Somatic Symptom Disorder in DSM-5 offers pragmatic appeal.

Therefore, how might we be of assistance to Melissa and her concerned, diligent physician?

23.7 The Consultation-Liaison Psychiatrist's Role in Somatization

Because of consultation-liaison (CL) psychiatrists' immersion in medical settings and familiarity with comorbidities, they are well equipped to be of help to both the somatizing patient and the physicians who seek solutions to understanding and caring for them. Although their prevalence in

the general community is rather rare, they constitute a burdensome challenge to physicians as both inpatients and outpatients. Whether providing direct therapy or only consultative recommendations and support for the PCP, the CL psychiatrist employs and transmits to the referring physicians those principles of interviewing and management alluded to earlier. The CL psychiatrist is familiar with a biopsychosocial approach, psychodynamic concepts, stress theory, general medicine, and psychopharmacology, permitting a pragmatic, flexible approach.

The CL psychiatrist's ability to conduct a medical-psychiatric interview enables patients to give essential data in an empathic, respectful setting without feeling threatened or rejected, an experience that may seem rather rare for them. Knowing when to withhold or confront patients with psychological interpretations enables the CL psychiatrist to address the patient's worries and fears without puzzling or frightening the patient with emotional (rather than physical) language. The CL psychiatrist has learned to curb therapeutic zeal with these patients, and transmitting this attitude to the PCP has a powerful effect in reducing the PCP's guilt and frustration about poor results. Perhaps most useful of all, the CL psychiatrist can instruct the referring physician in how to create a supportive holding environment for the patient by reducing workups, referrals, and desperate interventions, and instead offering the patient regular (even if infrequent, but definite) appointments.

In the general hospital setting, when somatizing patients are admitted for medical care, the CL psychiatrist can help patients adapt to the sick role, and to endure or minimize pain, fear, and denial. He or she can serve as a "bridge" between the patient and the caregiving staff, who may need help in understanding the patient's illness behavior and minimizing negative countertransference reactions. Even brief engagement with the somatizing patient and hospital staff can have a profound psychotherapeutic effect (Lipsitt 2002).

Writing a jargon-free explanatory consultation note with clear recommendations for post-hospital management helps the primary care

physician maintain the discharged patient. An alliance established in the hospital may carry into the outpatient setting. In the outpatient setting, the CL psychiatrist can make himself or herself available for supportive collaborative assistance on an as-needed basis; this can sometimes be a prelude to easy future referral for more specific combined pharmacotherapy/psychotherapy. Depending on the patient's interest and receptivity, various treatment measures can be suggested, whether cognitive-behavioral therapy, individual, group, psychosocial, pharmacological, or others (Allen et al. 2002; Lipsitt and Starcevic 2006).

23.8 Conclusion

Melissa represents a population of patients relatively common in general medical practice. While somatization is nonspecific, it covers a wide spectrum of disorders. There is little definitive treatment and most effective interventions have derived from an abundance of clinical literature describing experience with these patients (Allen et al. 2002). The bedrock of any treatment is likely to be a trusting patient-physician relationship. A case can be made for Melissa's diagnosis bridging both hypochondriasis and somatization disorder, but diagnosis per se may be less important than recognizing the presence of the somatization process, its impact on the patient's behavior, and its influence on the nature of the patient-physician relationship (Creed 2006). Designating the clinical picture as Complex Somatic Symptom Disorder (with qualifying options) by DSM-5 criteria minimizes the need to make the difficult distinctions between somatoform disorders. The CL psychiatrist can work effectively with primary care clinicians to help many such patients adapt to a lifestyle that will optimize if not totally change their ability to experience satisfaction, pleasure, and gratifying relationships. Likewise, for the physician, there is also the likelihood of immeasurably improving his and her usual workday. Saving the excessive costs of inappropriate health care utilization is a welcome by-product (Lipsitt 1992).

References

- Allen, L. A., Woolfolk, R. L., Escobar, J. I., Gara, M. A., & Hamr, R. M. I. (2006). Cognitive behavioral therapy for somatization disorder: A randomized controlled trial. *Archives of Internal Medicine*, *166*, 1512–1518.
- Allen, L. A., Escobar, J. I., Lehrer, P. M., Gara, M. A., & Woolfolk, R. L. (2002). Psychosocial treatments for multiple unexplained physical symptoms: A review of the literature. *Psychosomatic Medicine*, *64*, 939–950.
- American Psychiatric Association. (1950). *Diagnostic and statistical manual of mental disorders (DSM-I)* (1st ed.). Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders (DSM-II)* (2nd ed.). Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders (DSM-III)* (3rd ed.). Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (DSM-IV)* (4th ed.). Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5)* (5th ed.). Washington, DC: American Psychiatric Association.
- Avia, M. D., & Ruiz, M. A. (2005). Recommendations for the treatment of hypochondriac patients. *Journal of Contemporary Psychotherapy*, *35*, 301–313.
- Barsky, A. J., & Ahern, D. K. (2004). Cognitive behavior therapy for hypochondriasis: a randomized controlled trial. *Journal of American Medical Association*, *291*, 1464–1470.
- Barsky, A. J., Cleary, P. D., Wyshak, G., Spitzer, R. L., Williams, J. B. W., & Klerman, G. L. (1992). A structured diagnostic interview for hypochondriasis: A proposed criterion standard. *The Journal of Nervous and Mental Disease*, *180*, 20–27.
- Barsky, A. J., Wyshak, G., & Klerman, G. L. (1990). The somatosensory amplification scale and its relationship to hypochondriasis. *Journal of Psychosomatic Research*, *24*, 323–334.
- Bass, C. (1990). *Somatization: Physical symptoms and psychological illness*. Oxford: Blackwell.
- Bass, C., & Benjamin, S. (1993). The management of chronic somatisation. *The British Journal of Psychiatry*, *162*, 472–480.
- Baumeister, H., & Harter, M. (2007). Prevalence of mental disorders based on general population surveys. *Social Psychiatry and Psychiatric Epidemiology*, *42*, 537–546.
- Brondino, N., Lnati, N., Barale, F., Martinelli, V., Politi, P., & Geroldi, D. (2008). Decreased NT-3 plasma levels and platelet serotonin content in patients with hypochondriasis. *Journal of Psychosomatic Research*, *65*, 435–439.
- Burton, R. (1621). *The anatomy of melancholy*. London: Thomas Tegg. Reprinted by Gryphon Editions, 1988.
- Cochrane Summary. Consultation letters for use by primary care physicians in their care of patients with physical symptoms for which no organic cause can be found. Retrieved 8 Dec 2010, from <http://summaries.cochrane.org/CD006524>
- Cochrane Summary. Enhanced care by generalists for functional somatic symptoms and disorders in primary care. Retrieved 7 Oct 2009a, from <http://summaries.cochrane.org/CD008142>
- Cochrane Summary. Improving outcomes for people with multiple chronic conditions. Retrieved 18 Apr 2012, from <http://summaries.cochrane.org/CD006560>
- Cochrane Summary. Psychosocial interventions delivered by GPs. Retrieved 15 Apr 2009b, from <http://summaries.cochrane.org/CD003494>. April 15, 2009b.
- Cochrane Summary. Psychotherapies for hypochondriasis (review). Retrieved 30 July 2007, from <http://summaries.cochrane.org/CD006520>
- Creed, F. (2006). Should general psychiatry ignore somatisation and hypochondriasis? *World Psychiatry*, *5*, 146–150.
- Creed, F., Guthrie, E., Fink, P., Henningsen, P., Rief, W., Sharpe, M., et al. (2010). Is there a better term than “medically unexplained symptoms”? *Journal of Psychosomatic Research*, *68*, 5–8.
- Dimsdale, J., Patel, V., Xin, Y., & Kleinman, A. (2007). Somatic presentations—A challenge for DSM-V. *Psychosomatic Medicine*, *69*, 829 [Editorial].
- Dimsdale, J., & Creed, F. (2009). The proposed diagnosis of somatic symptom disorders in DSM-V to replace somatoform disorders in DSM-IV—A preliminary report. *Journal of Psychosomatic Research*, *66*, 473–476.
- Escobar, J. I., Gara, M. A., Diaz-Martinez, A. M., Interian, A., Warman, M., Allen, L. A., et al. (2007). Effectiveness of a time-limited cognitive behavior therapy type intervention among primary care patients with medically unexplained symptoms. *Annals of Family Medicine*, *5*, 328–335.
- Escobar, J. I., Rubio-Stipec, M., Canino, G., & Karno, M. (1989). Somatic symptom index (SSI): A new and abridged somatization construct. Prevalence and epidemiological correlates in two large community samples. *The Journal of Nervous and Mental Disease*, *177*, 140–146.
- Fallon, B. A. (2001). Pharmacologic strategies for hypochondriasis. In V. Starcevic & D. R. Lipsitt (Eds.), *Hypochondriasis: New perspectives on an ancient Malady* (pp. 329–351). New York, NY: Oxford University Press.
- Fallon, B. A., Petkova, E., Skritskaya, N., Sanchez-Lacey, A., Schneier, F., Vermes, D., et al. (2008). A double-masked, placebo-controlled study of fluoxetine for hypochondriasis. *Journal of Clinical Psychopharmacology*, *2*, 638–645.

- Fink, P., Ombol, E., Toft, T., Sparle, K. C., Frostholm, L., & Olesen, F. (2004). A new empirically established hypochondriasis diagnosis. *The American Journal of Psychiatry*, *161*, 1680–1691.
- Frances, A., First, M. B., & Pincus, H. A. (1995). *DSM-IV guidebook*. Washington, DC: American Psychiatric Press.
- Freud, S. (1986). Fragment of an analysis of a case of hysteria (1905). In J. Strachey (Ed.), *The standard edition of the complete works of Sigmund Freud* (Vol. 7, pp. 7–63). London: Hogarth Press.
- Garcia-Campayoa, J., Fayed, N., Serrano-Blanco, A., & Roca, M. (2009). Brain dysfunction behind functional symptoms: Neuroimaging and somatoform, conver-sive, and dissociative disorders. *Current Opinion in Psychiatry*, *22*, 224–231.
- Goldberg, D., Gask, L., & O'Dowd, T. (1989). Treatment of somatization: Teaching techniques of reattribution. *Journal of Psychosomatic Research*, *33*, 689–695.
- Greeven, A., van Balkom, A. J., Visser, S., Merkelbach, J. W., van Rood, Y. R., van Dyck, R., et al. (2007). Cognitive behavior therapy and paroxetine in the treatment of hypochondriasis: A randomized controlled trial. *The American Journal of Psychiatry*, *164*, 91–99.
- Gureje, O., Utsun, T. B., & Simon, G. E. (1997). The syndrome of hypochondriasis: A cross-national study in primary care. *Psychological Medicine*, *27*, 1001–1010.
- Guze, S. B. (1983). Genetics of Briquet's syndrome and somatization disorder: A review of family, adoption, and twin studies. *Annals of Clinical Psychiatry*, *5*, 225–230.
- Hahn, S. (2001). Physical symptoms and physician-experienced difficulty in the physician-patient relationship. *Annals of Internal Medicine*, *134*, 897–904.
- Hatcher, S., & Arroll, B. (2008). Assessment and management of medically unexplained symptoms. *British Medical Journal*, *336*, 1124–1128.
- Henningsen, P., Zipfel, S., & Herzog, W. (2007). Management of functional somatic syndromes. *Lancet*, *369*, 946–955.
- Kashner, T. M., Rost, K., Cohen, B., Anderson, M., & Smith, G. R., Jr. (1995). Enhancing the health of somatization disorder patients. Effectiveness of short-term group therapy. *Psychosomatics*, *36*, 462–470.
- Katon, W., Kleinman, A., & Rosen, G. (1984). The prevalence of somatization in primary care. *Comprehensive Psychiatry*, *25*, 127–135.
- Katon, W., von Korff, M., Lin, E., Simon, G., Walker, E., Unutzer, J., et al. (1999). Stepped collaborative care for primary care patients with persistent symptoms of depression: A randomized trial. *Archives of General Psychiatry*, *56*, 1109–1115.
- Kellner, R. (1991). *Psychosomatic syndromes and somatic symptoms*. Washington, DC: American Psychiatric Press.
- Kellner, R., Abbott, P., Pathak, D., Winslow, W. W., & Umland, B. E. (1983–1984). Hypochondriacal beliefs and attitudes in family practice and psychiatric patients. *International Journal of Psychiatry in Medicine*, *13*, 127–139.
- Kent, C., & McMillan, G. (2009). A CBT-based approach to medically unexplained symptoms. *Advances in Psychiatric Treatment*, *15*, 146–151.
- Kirmayer, L. J., & Young, A. (1998). Culture and somatization: Clinical, epidemiological, and ethnographic perspectives. *Psychosomatic Medicine*, *60*, 420–430.
- Kravitz, R. L. (2001). Measuring patients' expectations and requests. *Annals of Internal Medicine*, *134*, 881–888.
- Kroenke, K. (2007). Efficacy of treatment for somatoform disorders: A review of randomized controlled trials. *Psychosomatic Medicine*, *69*, 881–888.
- Kroenke, K. (2003). Patients presenting with somatic complaints: Epidemiology, psychiatric comorbidity and management. *International Journal of Methods in Psychiatric Research*, *12*, 34–43.
- Kroenke, K. (2006). Physical symptom disorder. A simpler diagnostic category for somatisation-spectrum conditions. *Journal of Psychosomatic Research*, *60*, 335–339.
- Kroenke, K., & Mangelsdorff, D. (1989). Common symptoms in ambulatory care: Incidence, evaluation, therapy and outcome. *The American Journal of Medicine*, *86*, 262–266.
- Kroenke, K., Messina, N., III, Benattia, I., Graepel, J., & Musgnung, J. (2006). Venlafaxine extended release in the short-term treatment of depressed and anxious primary care patients with multisomatoform disorder. *Clinical Psychiatry*, *67*, 72–80.
- Kroenke, K., Sharpe, M., & Sykes, R. (2007). Revising the classification of somatoform disorders. Key questions and preliminary recommendations. *Psychosomatics*, *48*, 277–285.
- Kroenke, K., & Swindle, R. (2000). Cognitive-behavioral therapy for somatization and symptom syndromes: A critical review of controlled clinical trials. *Psychotherapy and Psychosomatics*, *69*, 205–215.
- Lidbeck, J. (2003). Group therapy for somatization disorders in primary care: Maintenance of treatment goals of short cognitive-behavioural treatment one-and-one-half-year follow-up. *Acta Psychiatrica Scandinavica*, *107*, 449–456.
- Lipowski, Z. J. (1988). Somatization: The concept and its clinical application. *The American Journal of Psychiatry*, *145*, 1358–1368.
- Lipsitt, D. R. (1970). Medical and psychological characteristics of "crocks". *Psychiatric Medicine*, *1*, 15–25.
- Lipsitt, D. R. (1987). The difficult doctor-patient relationship. In W. T. Branch Jr. (Ed.), *Office practice of medicine* (2nd ed., pp. 1348–1356). Philadelphia, PA: WB Saunders.
- Lipsitt, D. R. (1992). Challenges of somatization: Diagnostic, therapeutic and economic. *Psychiatric Medicine*, *10*, 1–12.
- Lipsitt, D. R. (1996). Primary care of the somatizing patient: A collaborative model. *Hospital Practice*, *31*, 77–88.
- Lipsitt, D. R. (1998). Commerce between the mind and the body. *Advances in Mind-Body Medicine*, *14*, 107–113.

- Lipsitt, D. R. (2001a). Psychodynamic perspectives on hypochondriasis. In V. Starcevic & D. R. Lipsitt (Eds.), *Hypochondriasis: Modern perspectives on an ancient Malady* (pp. 265–290). New York, NY: Oxford University Press.
- Lipsitt, D. R. (2001b). The physician-patient relationship in the treatment of hypochondriasis. In V. Starcevic & D. R. Lipsitt (Eds.), *Hypochondriasis: Modern perspectives on an ancient Malady* (pp. 183–201). New York, NY: Oxford University Press.
- Lipsitt, D. R. (2002). Psychotherapy. In M. G. Wise & J. R. Rundell (Eds.), *Textbook of consultation-liaison psychiatry* (2nd ed., pp. 1027–1051). Washington, DC: American Psychiatric Press.
- Lipsitt, D. R. (2009). *Results of a focus group. Workshop presentation, 162nd annual meeting*. San Francisco, CA: American Psychiatric Association.
- Lipsitt, D. R., & Starcevic, V. (2006). Psychotherapy and pharmacotherapy in the treatment of somatoform disorders. *Psychiatric Annals*, *36*, 341–346.
- Lynch, D. J., McGrady, A., Nagel, R., & Zsembik, C. (1999). Somatization in family practice: comparing 5 methods of classification. (*Primary Care Companion to The Journal of Clinical Psychiatry*, *1*, 85–89.
- Marin, C., & Carron, R. (2002). The origin of the concept of somatization [letter]. *Psychosomatics*, *43*, 249–250.
- Margo, K. L., & Margo, G. M. (2000). Early diagnosis and empathy in managing somatization. *American Family Physician*, *61*, 1282–1285.
- Martin, R. L. (1999). The somatoform conundrum: A question of nosological values. *General Hospital Psychiatry*, *19*, 177–186.
- Mayou, R., Kirmayer, L. J., Simon, G., Kroenke, K., & Sharpe, M. (2005). Somatoform disorders: Time for a new approach in DSM-V. *The American Journal of Psychiatry*, *162*, 847–855.
- McCahill, M. (1999). Labeling the somatically preoccupied. Have we gone too far? *American Family Physician*, *59*, 2980 [editorial].
- McLeod, C. C., Budd, M. A., & McClelland, D. C. (1997). Treatment of somatization in primary care. *General Hospital Psychiatry*, *19*, 251–258.
- Menza, M., Lauritano, M., Allen, L., Warman, M., Ostella, F., Hamer, R. M., et al. (2001). Treatment of somatization disorder with nefazodone: A prospective, open-label study. *Annals of Clinical Psychiatry*, *13*, 153–158.
- olde Hartman, T. C., Borghuis, M. S., Lucassen, P. L., van de Laar, F. A., Speckens, A. E., & van Weel, C. (2009a). Medically unexplained symptoms in somatization disorder and hypochondriasis: Course and prognosis. A systematic review. *Journal of Psychosomatic Research*, *66*, 363–377.
- olde Hartman, T. C., Hassink-Franke, L. J., Lucassen, P. L., van Spaendonck, K. P., & van Weel, C. (2009b). Explanation and relations: How do general practitioners deal with patients with persistent medically unexplained symptoms: A focus group study. *BMC Family Practice*, *10*, 68.
- Okugawa, G., Yagi, A., Kusaka, H., & Kinoshita, T. (2002). Paroxetine for treatment of somatization disorder. *The Journal of Neuropsychiatry and Clinical Neurosciences*, *14*, 464–465.
- Othmer, E., & DeSouza, C. (1985). A screening test for somatization disorder (hysteria). *The American Journal of Psychiatry*, *142*, 1146–1149.
- Pedrosa, G. F., Scheidt, C. E., Hoeger, D., & Nickel, M. (2008). Relationship between attachment style, parental bonding and alexithymia in adults with somatoform disorders. *International Journal of Psychiatry in Medicine*, *38*, 437–451.
- Perley, M. J., & Guze, S. B. (1962). Hysteria—The stability and usefulness of clinical criteria. A quantitative study based on a follow-up period of six to eight years in 39 patients. *The New England Journal of Medicine*, *266*, 421–426.
- Pilowsky, I. (1967). Dimensions of hypochondriasis. *The British Journal of Psychiatry*, *113*, 89–93.
- Pilowsky, I. (1969). Abnormal illness behavior. *The British Journal of Medical Psychology*, *42*, 347–351.
- Pilowsky, I., Spence, N., Cobb, J., & Katsikitis, M. (1984). The illness behavior questionnaire as an aid to clinical assessment. *General Hospital Psychiatry*, *6*, 123–130.
- Rosendal, M., Olesen, F., & Fink, P. (2005). Management of medically unexplained symptoms. *British Medical Journal*, *33*, 4–5.
- Rost, K., Kashner, T. M., & Smith, G. R. (1994). Effectiveness of psychiatric intervention with somatization disorder patients: Improved outcomes at reduced costs. *General Hospital Psychiatry*, *16*, 381–387.
- Salmon, P., Dowrick, C. F., Ring, A., & Humphris, G. M. (2004). Voiced but unheard agendas: Qualitative analysis of the psychosocial cues that patients with unexplained symptoms present to general practitioners. *The British Journal of General Practice*, *54*, 171–176.
- Salmon, P., Peters, S., Clifford, R., Iredale, W., Gask, L., Rogers, A., et al. (2007). Why do general practitioners decline training to improve management of medically unexplained symptoms? *Journal of General Internal Medicine*, *22*, 565–571.
- Schaefer, R., Kaufman, C., Wild, B., Schelberg, D., Boelter, R., Faber, R., et al. (2013). Specific collaborative group intervention for patients with medically unexplained symptoms in general practice: A cluster randomized controlled trial. *Psychotherapy and Psychosomatics*, *82*, 106–119.
- Schur, M. (1955). Comments on the metapsychology of somatization. *Psychoanalytic Study of the Child*, *10*, 119–164.
- Schweitzer, P. J., Zafar, U., Pavlicova, M., & Fallon, B. A. (2011). Long-term follow-up of hypochondriasis after selective serotonin reuptake inhibitor treatment. *Journal of Clinical Psychopharmacology*, *31*, 365–368.
- Servan-Schreiber, D., Kolb, N. R., & Tabas, G. (2000a). Somatizing patients: Part I. Practical diagnosis. *American Family Physician*, *61*, 1073–1078.
- Servan-Schreiber, D., Tabas, G., & Kolb, R. (2000b). Somatizing patients: Part II. Practical management. *American Family Physician*, *61*, 1423–1428.

- Sharpe, M., & Carson, A. (2001). "Unexplained" somatic symptoms, functional syndromes, and somatization: Do we need a paradigm shift? *Annals of Internal Medicine*, *134*, 926–930.
- Shorter, E. (1992). *From paralysis to fatigue: A history of psychosomatic illness in the modern era*. New York, NY: Free Press.
- Simon, G., Gater, R., Kisly, S., & Piccinelli, M. (1996). Somatic symptoms of distress: An international primary care study. *Psychosomatic Medicine*, *58*, 481–488.
- Simon, G. E. (2002). Treatment of somatoform and factitious disorders. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (pp. 408–422). New York, NY: Oxford University Press.
- Smith, G. R., Jr. (1995). Somatization disorder and undifferentiated somatoform disorder. In G. O. Gabbard (Ed.), *Treatments of psychiatric disorders, vol 2* (2nd ed., pp. 1716–1733). Washington, DC: American Psychiatric Press.
- Smith, G. R., Jr., Monson, R. A., & Kay, D. C. (1986). Psychiatric consultation in somatization disorder: A randomized controlled study. *The New England Journal of Medicine*, *314*, 1407–1413.
- Smith, R. C., & Dwamena, F. C. (2007). Classification and diagnosis of patients with medically unexplained symptoms. *Journal of General Internal Medicine*, *22*, 685–691.
- Smith, R. C., Gardiner, J. C., Luo, Z., Schooley, S., Lamerato, S., & Rost, K. (2009). Primary care physicians treat somatization. *Journal of General Internal Medicine*, *24*, 829–832.
- Smith RC, Dwamena FC. (2012). *Primary care management of medically unexplained symptoms*. UpToDate. www.uptodate.com
- Smith, R. C., Gardiner, J. C., Lyles, J. S., Sirbu, C., Dwamena, F. C., Hodges, A., et al. (2005). Exploration of DSM-IV criteria in primary care patients with medically unexplained symptoms. *Psychosomatic Medicine*, *67*, 123–129.
- Smith, R. C., Lyles, J. S., Gardiner, J. C., Sirbu, C., Hodges, A., Collins, C., et al. (2006). Primary care clinicians treat patients with medically unexplained symptoms: A randomized controlled trial. *Journal of General Internal Medicine*, *21*, 671–677.
- Speckens, A. E. M. (2001). Assessment of hypochondriasis. In V. Starcevic & D. R. Lipsitt (Eds.), *Hypochondriasis: Modern perspectives on an ancient Malady* (pp. 61–88). New York, NY: Oxford University Press.
- Stahl, S. M. (2003). Antidepressants and somatic symptoms: Therapeutic actions are expanding beyond affective spectrum disorders to functional somatic syndromes. *Journal of Clinical Psychiatry*, *65*, 745–746.
- Starcevic, V. (2001). Reassurance in the treatment of hypochondriasis. In V. Starcevic & D. R. Lipsitt (Eds.), *Hypochondriasis: New perspectives on an ancient Malady* (pp. 291–313). New York, NY: Oxford University Press.
- Stein, D. J., & Muller, J. (2008). Cognitive-affective neuroscience of somatization disorder and functional somatic syndromes: Reconceptualizing the triad of depression-anxiety-somatic symptoms. *CNS Spectrums*, *13*, 379–384.
- Stekel, W. (1943). *The interpretation of dreams*. New York, NY: Liveright.
- Stuart, S., & Noyes, R., Jr. (2006). Interpersonal psychotherapy for somatizing patients. *Psychotherapy and Psychosomatics*, *75*, 209–219.
- Sumathipala, A. (2007). What is the evidence for the efficacy of treatments for somatoform disorders? A critical review of previous intervention studies. *Psychosomatic Medicine*, *69*, 889–900.
- Swartz, M., Landerman, R., George, L., Blazer, D., & Escobar, J. (1990). Somatization disorder. In L. N. Robins & D. Regier (Eds.), *Psychiatric disorders in America: The epidemiologic catchment area study* (pp. 220–257). New York, NY: Free Press.
- Swartz, M. S., Hughes, D., George, L., Blazer, D., Landerman, R., & Bucholz, K. (1986). Developing a screening index for community studies of somatization disorder. *Journal of Psychiatric Research*, *20*, 335–343.
- Sykes, R. (2012). Somatoform disorder and the DSM-V Workgroup's interim proposals: Two central issues. *Psychosomatics*, *53*, 334–338.
- Takii, M., Muranaga, T., & Nozoe, S. (1994). A study of the clinical features of unidentified clinical syndrome (so-called vegetative syndrome). *Shin-shin Igaku*, *34*, 573–580 (English summary).
- Taylor, R. E., Marshall, T., Mann, A., & Goldberg, D. P. (2012). Insecure attachment and frequent attendance in primary care: A longitudinal cohort study of medically unexplained symptom presentations in ten UK general practices. *Psychological Medicine*, *42*, 855–864.
- Tyrer, P., Fowler-Dixon, R., Ferguson, B., & Keleman, A. (1990). A plea for the diagnosis of hypochondriacal personality disorder. *Journal of Psychosomatic Research*, *34*, 637–642.
- van den Heuvel, O. A., Mataix-Cols, D., Zwitser, G., Cath, D. C., van der Werf, Y. D., Groenewegen, H. J., et al. (2011). Common limbic and frontal-striatal disturbances in patients with obsessive-compulsive disorder, panic disorder and hypochondriasis. *Psychological Medicine*, *41*, 2399–2410.
- Viswanathan, R., & Paradis, C. (1991). Treatment of cancer phobia with fluoxetine. *The American Journal of Psychiatry*, *148*, 1090.
- Voigt, K., Nagel, A., Meyer, B., Langs, G., Braukhaus, C., & Lowe, B. (2010). Towards positive diagnostic criteria: A systematic review of somatoform disorder diagnoses and suggestions for future classification. *Journal of Psychosomatic Research*, *68*, 403–414.
- Waller, B., Scheidt, C. E., & Hartmann, A. (2002). Attachment representation and illness behavior in somatoform disorders. *The Journal of Nervous and Mental Disease*, *192*, 200–209.

- Walters, K., Buszewicz, M., Welch, S., & King, M. (2008). Help-seeking preferences for psychological distress in primary care: Effect of current mental state. *The British Journal of General Practice*, *58*, 694–698.
- Warwick, H. M., Clark, D. M., Cobb, A. M., & Salkovskis, P. (1996). A controlled trial of cognitive-behavioural treatment of hypochondriasis. *The British Journal of Psychiatry*, *169*, 189–195.
- Wessely, S., Nimnuan, C., & Sharpe, M. (1999). Functional somatic syndromes: One or many? *Lancet*, *354*, 936–939.
- Wickramasekera, I. (1989). Somatizers, the health care system, and collapsing the psychological distance that the somatizer has to travel for help. *Professional Psychology: Research and Practice*, *20*, 105–111.