Is Pain a Somatic Symptom?

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The grouping of symptoms into “somatic” or “physical” on the one hand and “mental”, “somatoform” or “psychological” on the other are vestiges of an era in medicine when it seemed useful to divide all the phenomena of disease into two groups – one related to the soma and other to the psyche. Today, this division is becoming obsolete and is harmful. Obsolete, because we are discovering changes in the tissues or in biochemical and immunological functions of the body in people with mental disorders, and because psychological complaints are frequent in all physical illnesses. Harmful, because the labels “psychological”, “psychogenic”, or “somatoform” are so loaded with connotations of being simulations or complaints about nothing that patients are unlikely to receive the help they need.

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Findings from the examination of a patient’s body, eg, the enlargement of the liver established by palpation, are physical findings and can be called symptoms if the physician who has carried out the examination thinks that they might be an indication of a disease. All other complaints (which might be labeled as symptoms, if they are seen as signs of a disease) are psychological. Doctors are inclined to call physical pain that patients frequently describe – ie, the report about pain related to a swollen joint – a physical symptom. But they are wrong: whatever a patient reports is the result of that patient’s interpretation of an experience that is accessible only to him or her who experiences it; to all others the experience is understandable at best by analogy – the doctor compares patient’s feelings to his own in similar situations (ie, “I would feel pain, if my knee was so swollen”).

In practice, when patients talk about an experience or complain about a deranged body function, physicians look for a physical finding. If they establish that there is a change in the tissues of the body or a measurable abnormality of function, they label the patient’s report a “physical symptom”. When they find no physical abnormality, they label the complaint “somatic”, “somatoform”, “hysterical”, “mental”, or “psychological”.

In addition to its use to describe “medically” unexplained symptoms, the label “psychological” is also used to describe patient’s complaints about (unpleasant or strange) contents of thought, unusual emotional experiences, loss of memory, and the like. When employed in this way, the use of the term “psychological” is similar to the use of the term such as “cardiovascular” by which we describe complaints about disorders related to the functioning of the cardiovascular system: if this were the only way in which the term was used, there would be no confusion of terms nor would it be so easy to dismiss some of patients’ complaints as being unreal and of no importance.

The grouping of symptoms into “somatic” or “physical” on the one hand and “mental”, “somatoform” or “psychological” on the other are vestiges of an era in medicine, when it seemed useful to reduce the complexity of human experience and the human organism by dividing all the phenomena of disease into two groups, one related to the soma and the other to the psyche. This division is becoming obsolete and is harmful.

Obsolete, because more powerful methods of investigation that we have at our disposal are increasingly discovering changes in the tissues or in the biochemical and immunological functions of people with mental disorders (eg, depression), and systematic studies of symptoms of “physical” diseases, such as thyrotoxicosis, show that psychological complaints, such as anxiety and tension, are frequent in all physical illnesses. The basis for the division of diseases and symptoms into the two groups makes less and less sense. It is becoming generally accepted that both “mental” and “physical” disorders involve most of the body systems and that the divi-
sion of diseases into mental and physical can no longer be scientifically justified.

Harmful, because the labels “psychological”, “psychogenic”, “somatoform”, and the like are so loaded with connotations of being simulations, complaints about nothing, signs of excessive sensitivity, and so on, that patients do not accept them and go “doctor shopping” until they find a practitioner who says that there is a change of tissue. By that, the complaint is “legitimized”. These tissue changes are not necessarily the cause of the complaint but, in such situations, the patients and the doctors are usually ready to accept their causative role without further questioning. Similar reasons are at work when a mental disorder (eg, depression) is co-existent with a physical disorder. In such instances, physicians and patients often enter into a tacit collusion to disregard the mental disorder (at least until the “physical”, “real” disorder is sorted out), although both are often aware of its presence.

Patients’ complaints, however, do not depend only on what they experience. The doctors’ attitudes and the way in which the doctors’ interest is perceived play an important role in patients’ deciding to which out of a variety of problems they should give priority in their presentation. If patients know that the doctor will pay no attention to complaints couched in psychological terms, they will not express themselves in that way.

The different ways in which doctors talk to patients and cultural factors (eg, acceptability of talking about one’s feelings) are probably among the reasons for the differences in the presentation of mental and physical diseases in different settings. Recent studies show that the percentage of people who complain mainly or exclusively about somatic experiences when they suffer from a mental disorder varies to a considerable degree among services and cultures (1). During the earlier decades of this century psychiatrists believed that people in developing countries had a greater tendency to speak about their diseases in somatic terms than people in industrialized countries who were believed to speak about their mental disorders in psychological terms. More recent work demonstrates that the situation is even more complex and that the presentation of one’s disease depends on numerous factors, including social class, culture, doctors’ education, orientation and attitudes, and previous illness experiences (1). Recent work has also shown that "medically" unexplained somatic symptoms are frequent in general practice attenders and that people who suffer from such somatoform syndromes are using health services more than other groups in the population (2). A study from the Netherlands showed that as many as 40% of patients frequently attending health services have a somatoform disorder (3). The symptoms that these patients have vary in intensity, nature, and quantity: sometimes a single symptom, such as persistent pain or lasting excessive fatigue, will dominate the clinical picture or be the only symptom; in other instances, a variety of symptoms related to various body systems are brought forward. The terms employed to describe these patients (eg, “frequent attender”, “chronic complainer”, “high service user”) witness the uncertainty about the nature of these disorders: there is, however, general agreement that these patients are seen frequently and that their management represents considerable difficulty (4).

The exploration of the nature and frequency of “somatic” symptoms – in the framework of depressive disorders or other mental and physical diseases – is useful, because it might help us to resolve a number of important questions. The first one is whether somatoform symptoms are an idiom of distress or an independent clinical syndrome, which can coincide with other syndromes, mental or physical, or appear independently from those. If the former were the case, we could stop the search for specific treatments for somatoform syndromes and concentrate on the treatment of the underlying condition. If the latter were true, we would have to intensify our search for the cause, pathogenesis, and appropriate treatments of the somatoform syndrome. The current arrangement of having a category for somatization in the international classification of diseases does not give an answer to this question. Since the classification is based on descriptive (rather than etiological) criteria and serves administrative as well as scientific purposes, the existence of the category mainly responds to the need to count the people who suffer from this syndrome and often visit a doctor and seek help.

We also need an answer to the question of whether a somatoform syndrome is the expression of a separate disease for epidemiological investigations. If the syndrome composed of somatic complaints, for which we find no organic basis, is a separate disorder, it will be necessary to establish its frequency and the disability that it produces in order to plan services that will help such people.

Should it turn out that somatoform syndromes are a separate entity, the practical question of professional responsibility also emerges – who should treat people who have such syndromes? If these syndromes are the expression of a specific disease, it will be necessary to decide whether those who suffer from it should be seen by psychiatrists, psychologists, internists, general practitioners, or some special subgroup of doctors that will have specialized in the management of these conditions.

While searching for an answer to the question of independence of somatoform syndrome and somatization disorders, it will, however, be necessary to develop specific treatment guidelines that will help health care workers – psychiatrists or others – to deal with people who come forward and complain about the malfunction of their body, a malfunction that we can not ascribe to a physical or mental disease for which we have a specific treatment. The urgency of producing appropriate guidelines is considerable: the number of people with “medically unexplained” somatic symptoms who come to health services is large and general practitioners as well as other medical personnel are very uncertain about action they should take. The guidelines should address the identification and treatment of the people who present such symptoms in the framework of other psychiatric or non-psychiatric diseases and of those in whom there is no reason to make any other diagnosis.
References


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