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SOMATIZING PEARLS

- Make sure people understand that you believe them and that their symptoms are seen as real, even if they are emotionally based. This is perhaps the key points of establishing a link up with people who somatize. This will certainly help forge an alliance for treatment.

- Make the mind/body link as soon as there is a reasonable suspicion of somatizing. This is usually apparent on the first visit when the overall presentation becomes somewhat atypical. Don't wait for all the organic work-up to return with negative results and then perhaps several months later bring up the psychological side of things. This will typically be seen by the patient as second rate. Open up both organic and psychological etiologic factors together, which gives them equal validity. You can do this on the very first visit. You may do this by saying "Mr. Smith, we are going to do a series of blood tests and a chest x-ray to look for the possible organic causes of the symptoms you are presenting with but it may be important to know that emotional factors or stress factors can also cause these symptoms. Were you aware of that, Mr. Smith?" This can then lead to a mind/body dialogue with the patient.

- If you are using a consultant, let the consultant know what you are thinking about the problem. This gives them the longitudinal view which the family doctor has, versus the cross sectional view which the specialist often has. One needn't worry that you will bias them. If the specialist finds something organic, they will certainly pursue this. I believe it is very helpful for them to have your longitudinal view including possible psychologic overlay.

- Almost all somatizing is unconscious. People are living their symptoms. They are <u>not</u> trying to fool you. They are doing something we all have done only more so. They do not have to feel like the "heart sink" patient (your heart sinks when you see their name on your list for the day!)

- I always rule out primary psychiatric illness that can present somatically such as depression, panic disorder (the great imitator), GAD, OCD, and delusional disorders. We have very good treatments for these entities, both psychopharmacological and psychotherapeutic.

- The majority of patients that somatize may not be all that psychologically minded. A useful technique is to see these people for 10-15 minutes perhaps once per month which can be very helpful. You can do supportive counseling and behavioural activation without calling it such. This once monthly meeting will preempt a lot of phone calls and office visits because this way the patients know they will have access to you on a monthly basis. You yourself may not feel as overrun by the situation as you may feel more in control of things.

- Psychotherapy treatments can be useful for somatizing patients who are psychologically minded.

- For chronic pain patients, Amitriptyline and Nortriptyline, 10-50 mg PO QHS have also been shown to be helpful. I prefer Nortriptyline due to its more benign side effect profile.

- As for many illnesses, judge progress by improvement in level of function. 'Cure' is unlikely. Allow for relapses.

- "Boy who cried wolf" syndrome. Remember, somatizers also get physically ill. Before you call something somatizing, you must rule out an organic cause with an appropriate workup. It doesn't always have to be the million dollar workup, but enough so you feel comfortable.