Crying Wolf

Renee P. Meyer, MD, and Dean Schuyler, MD

EDITOR'S NOTE

Through this column, we hope that practitioners in general medical settings will gain more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

Dr Schuyler is a psychiatrist with a part-time private practice and a part-time job on the Geriatric Unit at the Ralph H. Johnson Veterans Administration Medical Center, Charleston, South Carolina. **Dr Meyer** is an assistant professor of general internal medicine at the Medical University of South Carolina and medical director of Home Based Primary Care at the Ralph H. Johnson Veterans Administration Medical Center, Charleston, South Carolina.

Prim Care Companion CNS Disord 2011;13(6):doi:10.4088/PCC.11f01304

Published online: *December 08, 2011.*
Potential conflicts of interest: *None reported.*
Funding/support: *None reported.*
Disclaimer: *The views herein are those of the authors and do not necessarily reflect the views of the Veterans Administration.*
Corresponding author: *Dean Schuyler, MD, Geriatrics/Extended Care, Ralph H. Johnson Veterans Administration Medical Center, Charleston, SC 29401 (deans915@comcast.net).*

Patients who present urgently and frequently with medically unexplainable symptoms may have a somatization disorder. *Somatization* describes a cluster of psychiatric conditions in which patients demonstrate a preoccupation with symptoms with no medical explanation.[1] Pain disorder is one of these conditions in which pain from an initial medical or psychological stress becomes the focus of the patient's frequent visits and little or nothing is found to correlate with the patient's perceived pain severity. Extensive medical resource utilization, multiple laboratory tests, imaging, and specialty referral are often associated with the care of these patients. Patients diagnosed with a somatization disorder have a 50% higher use of office visits and a 9-fold higher overall health care cost compared to medically focused patients.[2] Somatization is highly associated with anxiety and depression, and increasing numbers of unexplained symptoms correlate linearly with the number of anxiety and depressive crises these patients experience.[3] Patients with a somatization disorder tend to have stormy family and marital relationships, as well as difficult encounters with health care providers.[4] Treatment recommendations include frequent office visits, reassurance, and an empathic environment of listening, therapy for anxiety and depression, and referral for psychiatric counseling, if the patient will permit it.

As patients with somatization disorders age, it is important for physicians to remain especially vigilant to recognize the appearance of new medical conditions. Illnesses commonly accompanying the aging process may be buried in the blur of presenting symptoms or missed due to a dismissive approach to the patient's continuing complaints. Vigilance is sometimes best achieved by repeated careful medical examinations, avoiding costly and invasive tests whenever possible.

CASE PRESENTATION (DR MEYER)

Ms A, a 70-year-old woman, was followed for several years in our Veterans Affairs geriatric clinic. She had a history of migraine headaches and a remote history of hysterectomy and partial colectomy for constipation. Her multiple somatic complaints during office visits included abdominal pain, constipation or diarrhea, pelvic pain, dyspareunia, dysuria, and dyspnea. Her clinic visits were dominated by detailed descriptions of her surgeries, her pain, her recent visits to outlying emergency departments, and her marital discord.

In the late spring of 2011, Ms A began describing more marital stress, her symptoms intensified, clinic and emergency department visits increased, and her speech seemed more pressured. In June 2011, Ms A presented to the emergency department with a new complaint: right eye burning and tearing after an accidental exposure to a chemical spray. She was referred to the ophthalmology department and was diagnosed with chemical conjunctivitis and was prescribed antibiotic ointment. In the following 2 weeks, Ms A placed multiple calls to the clinic and appeared in the emergency department 4 times, continuing to complain of severe eye pain and photophobia, diarrhea, abdominal pain, and the lack of attention she was receiving from her husband. During 1 emergency department visit, Ms A briefly consented to psychiatric hospitalization but signed out within hours of admission citing poor treatment and lack of attention to her needs.

At her follow-up appointment to the geriatric clinic, Ms A's right eye pain was noted to have persisted. The eye was carefully reexamined. The

previous conjunctival erythema appeared to be subsiding, but the pupil was irregular and sluggish. The ophthalmology department was reconsulted, and it was agreed that she now had uveitis. Several ophthalmology appointments later, Ms A had developed several vesicular lesions on her frontal scalp consistent with herpes zoster involving the right scalp and right eye. In the weeks that followed, Ms A's visits and calls lessened, and she reported improved relations with her husband.

This elderly woman experienced an atypical presentation of herpes zoster uveitis in which the skin rash appeared significantly later than the eye involvement. Her diagnosis was further obscured by the "white noise" of unrelated physical symptoms, multiple emergency department visits, her long scolding monologues about her husband, and her (seemingly) exaggerated and prolonged complaints of pain. The correct diagnosis was achieved by careful, repeated physical examinations, without relegating her complaints to psychiatric motives and without laboratory testing or imaging. Repeated physical examinations for the major complaints of aging patients with somatization disorders may build patient trust and help physicians avoid missing the illnesses awaiting these patients as they age.

PSYCHOTHERAPY (DR SCHUYLER)

I was asked by Ms A's internist (R.P.M.) to do a psychiatric evaluation of this 70-year-old woman, married for the third time for the past 30 years. Ms A had 2 adult sons and had served in the military for 3 years during her mid-20s. Surgically, Ms A previously had a cholecystectomy, a colectomy, and a hysterectomy. She also reported a "number of traumatic incidents" in the past that she told me about in great detail.

Ms A's emotionally impaired mother died at an advanced age. Her father had died earlier of kidney disease. A younger brother was tragically killed in an industrial accident. There was a lengthy medical history that documented multiple physical complaints to a succession of health care agents, as well as several unsuccessful referrals to mental health practitioners. The diagnosis of somatization disorder was clearly established, and Ms A's management in our clinic was undertaken by 1 physician (R.P.M.).

As a psychiatrist focused on adjustment, with a predilection for adaptation to medical illness, it was expected that I would treat Ms A, alongside her internist. My initial task was to establish a connection with Ms A. I have found that taking a careful medical and life history facilitates this goal. My initial contact with Ms A validated the ongoing prescription of clonazepam 1 mg taken 3 times a day for anxiety. In addition, initial contact established that I would contract to see her periodically as part of her treatment team.

At our second visit, Ms A spoke at length about her marriage and about her concern for her husband's health. Then, she discussed in detail an incident during which she may have inhaled a toxic spray. I carefully asked Ms A to describe the residual effects of this incident and then worked with her to problem solve and to determine the likelihood of her various conclusions and concerns.

At our third session, Ms A discussed her anxiety in detail, focusing on her concern with her husband's medical condition. She went on also to describe a fall that she attributed to the effect of clonazepam. We discussed whether this was likely to be a valid attribution. Ms A went on to implicate a variety of her medications for a range of "side effects" she had noticed. We carefully discussed the likelihood of each association mentioned.

By session 4, it was clear that Ms A expected to see me (her psychiatrist) along with her internist at each clinic visit. She felt that she had established 2 relationships to handle her medical needs during her visits to the clinic. On this occasion, Ms A focused on digestive problems and the symptom of pain. I listened to her presentation and then chose to focus on a seemingly random statement of hers that stressed the importance of the interpretation of events as opposed to the events themselves. I gently noted to her the applicability of this clever statement to an understanding of her panoply of medical complaints. Ms A appeared to be neither anxious nor depressed at this visit.

As part of our paired provision of care, Ms A's internist and I discussed her progress and our assessment of her (with her permission) after each clinic appointment. Our fifth visit together documented the progress she had made. Her circumstantial presentation was part anatomic related and part relationship related (with her husband) and ended with a question to me about how she was seen. I emphasized to Ms A that she could choose what to dwell on, rather than focus her concern on how others saw her. I acknowledged the value of an earlier (military) achievement that she had made.

SUMMARY

The management of Ms A's somatization disorder was ideal in several ways. Ms A's internist managed the basic relationship with her and remained continually focused and available. Her psychiatrist established his availability as well and committed himself to her continuing care. Each physician contributed to Ms A's overall management. Ms A accepted this arrangement by initially agreeing to present her complaints solely to these 2 health care professionals. The trusting relationships that were established allowed each of us to address some of Ms A's emotional complaints over time and to successfully tend to her physical needs.

REFERENCES

1. Schuyler D, Brownfield E. Somatization: a disorder about "nothing." *J S C Med Assoc*. 2002;98(1):21–24.
2. Oyama O, Paltoo C, Greengold J. Somatoform disorders. *Am Fam Physician*. 2007;76(9):1333–1338.
3. Katon WJ, Walker EA. Medically unexplained symptoms in primary care. *J Clin Psychiatry*. 1998;59(suppl 20):15–21.
4. Heinrich TW. Medically unexplained symptoms and the concept of somatization. *WMJ*. 2004;103(6):83–87.