Rethinking Somatization: A Review

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"A diagnosis of a somatoform disorder will become a non-psychiatric diagnosis once the symptomatology is adequately explained by disordered physiology".

This quotation is to be found in a recent paper by Robert Bennett (*ref: The Scientific Basis for Understanding Pain in Fibromyalgia. ImmuneSupport.com, 28th August 2002)* and the reference from which is comes is a paper called "Rethinking Somatization" published in the Annals of Internal Medicine in May 1997 by Ian McWhinney et al (*ref: Rethinking Somatization. McWhinney IR, Epstein RM, Freeman TR: Ann Intern Med 1997:126:747-750).*

The paper may be of interest to the ME community; it makes the following points:

The authors believe that their stance takes a position on the concept of somatization which has not so far entered the discussion, namely that the concept of somatization, and the language in which it is expressed, should be abandoned.

They believe that such a radical step is necessary because the concept of somatization and the language in which is it cloaked are so fundamentally flawed that the field can only be reconstructed from new fundamentals, and that such reconstruction needs to change some of the most elementary theoretical generalisations on which the concept is currently based.

One of the generalisations is the mind/body dualism which is so deeply embodied in modern medicine: in medical education, doctors learn a language that is expressive of the mind/body dualism, with terms like organic, psychosocial, and psychosomatic. Even the term "biopsychosocial", as Engel himself acknowledged, is open to interpretation that a patient's illness can be compartmentalised in such ways.

The authors' position is clear: dualism runs like a fault line through medicine, with each side having its own textbooks, clinical methods and nosology. For physicians educated in this way, bodily symptoms without bodily signs, or chronic illness without demonstrable organ pathology, are a source of confusion and frustration. The logical inference from the structure of medical knowledge is "If it isn't organic, it must be psychiatric", and the term "functional" becomes synonymous with "psychogenic".

Current medical education makes it difficult for doctors to believe in the reality of an illness without demonstrable organ pathology. A doctor's statement "I don't believe in chronic fatigue syndrome" may become "I don't believe you are really ill", and there are a hundred ways of saying to a patient "I don't believe you".

The concept of somatization rests on the (assumed) translation of repressed emotion and psychological conflicts into bodily symptoms. The authors refer to Wickramesekera, who states that the somatoform patient keeps secrets from the mind but not from the body *(ref: Secrets kept form the mind but not from the body or behaviour. Wickramesekera I. Advances in Mind-Body Medicine 1998:14:2:81-132*) The authors here state, however, that for a person to disclose a secret to the body which is kept from the mind is not possible in a unitary being which is both body and mind ie. the body is not separable from the mind.

To treat such separate abstractions as concrete realities is to fall into what Whitehead called "the fallacy of misplaced concreteness" (*ref: Science and the Modern World. Whitehead AN. Cambridge University Press, 1926)*

The authors note the need for medicine to **heal** and they note the need for "a healer who has the self-knowledge to be aware of his or her own biases" in order to achieve the restoration of wholeness to a sick person.

The authors state that dualism can be replaced only by a unitary theory of the person, with mind and body viewed as two sides of the same coin, and that such a unitary theory is able to deal with complex disorders.

To expand the definition of somatization to include a disabling illness with the hallmarks of an immunological response to infection (the authors here cite chronic fatigue syndrome) is, say the authors, a category error.

The absence of demonstrable organ pathology, even in patients with extreme prostration, seems a contradiction to modern physicians because they focus their attention on the organs instead of on the whole person, and thus fail to focus on higher level functions of the neuro-endocrime-immunological axis, for which there is empirical evidence for malfunction in disorders such as chronic fatigue (syndrome).

The authors believe that physicians should revert to diagnosing the patient rather than the disease, because in the so-called somatoform disorders, physicians are indeed dealing with disease of the whole person.

They note that Wessely is critical of the tendency for patients with what he calls somatoform or "functional disorders" to be referred to system specialists such as rheumatologists or gastroeneterologists, arguing for the return of the general physician who, he asserts, should be aided by psychiatrists and psychologists (*ref: Functional somatic syndromes: one or many? Wessely S, Nimnuan C, Sharpe M, Lancet*

1999:354:936-939). McWhinney et al are unequivocal that such proposals would perpetuate the existing dualism on the basis that the clinical method taught in medical schools still requires the physician to be entrenched on one side or other of the dualism fault line.

Their view is that integration has to start in the hearts and minds of clinicians.

Nowhere is this more urgently necessary than in ME/ ICD-CFS.