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Techniques for Interviewing the Somatising Patient

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Liaison psychiatrists need to interview somatising patients in a way which allows a full assessment of the problem. This can best be achieved if the psychiatrist has already discussed with the referring physician the reason for referral and what the patient has been told about it. The medical notes should always be reviewed in detail and independent data obtained from a relative or other informant. During the interview itself the psychiatrist must be prepared to use techniques which deepen rapport with the patient, who may be initially wary or hostile. The psychiatrist should attempt to establish early a treatment alliance. Special aspects of the mental state need to be noted, including the patient's attitude to his/her symptoms and the strength with which somatic beliefs are held. Different approaches may be used according to the nature of the problem and the therapeutic style of the doctor. An awareness of these interview techniques would greatly reduce the chances of fruitless interviews with a hostile patient who believes the symptoms are being dismissed as being 'all in the mind'.

Most psychiatrists who work in a district general hospital are referred from general physicians and surgeons' patients who complain of severe and chronic physical symptoms for which no organic cause can be found (Katon *et al*, 1984; Bridges & Goldberg, 1985). They have been categorised as patients with either "somatic presentation of psychological disorder" or "psychological reaction to physical illness" (Thomas, 1983; Sensky *et al*, 1985). Many of these patients never keep their appointment with the psychiatrist, and those who do may be hostile or defensive when they attend. It is common for the psychiatrist to determine that there is 'no overt psychiatric disorder' or 'no evidence of clinical depression' and to send the patient back to the referring doctor without providing advice and without helping the patient.

The first meeting with patients who somatise is, therefore, crucial. It may at one extreme be futile for both psychiatrist and patient, or, at the other, result in the development of a healthy therapeutic alliance with the prospect of treatment or some alleviation of the patient's suffering.

This paper represents a distillation of the ideas expressed by experienced liaison psychiatrists at a workshop based on videotapes of interviews with somatising patients. The workshop was held because this area of psychiatry is poorly developed and inadequately taught.

Preparation for the Interview

Preparatory work is always important for conducting any psychiatric interview, but especially so if the patient is reluctant to be interviewed. The following points should be considered.

(a) Collaboration with the referrer

The way the referral is made by the physician/surgeon can greatly influence the course of the first interview. As an example, some patients are not told by their doctor that they are going to refer them to a psychiatrist, with the result that they feel angry and duped when they receive a letter asking them to attend for an appointment at the department of psychiatry.

Satisfactory methods of referral depend upon the development of a good relationship between the psychiatrist and the physician. A joint meeting with physician, psychiatrist and patient is ideal, as the psychiatrist is then seen as a member of the medical/surgical team, and any ambiguities about the patient's diagnosis, treatment, or plans for further investigation can be discussed at the outset. This is not always feasible, but close liaison with the referring team is essential. It is important for the psychiatrist to discuss with the physician how best to explain to the patient the need for psychiatric referral. It may be appropriate for the physician to explain to some patients that they are depressed or anxious and that a psychiatrist may be able to help them feel better.

In most patients with somatisation disorders, however, the presence of psychological disorder may be less clear cut. In these situations, it is helpful if the physician has reassured the patient about the absence of serious organic pathology, invoked the possibility of psychological factors contributing in some way to the patient's symptoms, and introduced the idea of referral to a psychiatrist in a positive way.

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In some patients with certain conditions, such as myalgic encephalomyelitis (ME) or chronic pain, it can be counterproductive for physicians to offer a psychological explanation for the symptoms, and it may be more profitable for them to introduce the psychiatrist as having expertise in 'treating pain' or 'rehabilitation'. In this way, the scene can be set for engaging patients in a pain programme or an activities programme without the requirement to adopt a psychological view of their symptoms.

Good liaison psychiatry also involves going to departmental meetings, presenting case examples for discussion, and educating physicians about which patients are appropriate for referral, and how best to expedite the referral.

(b) Review of case notes

A thorough review of the patient's notes is necessary to be fully familiar with the patient's medical/surgical history. It is important to document the number, character, pattern, and frequency of the patient's complaints over the years, and also to document the medical response to them. This includes recording the number of investigations, medications and operations that have been ordered. In addition, comments made in medical correspondence can often reveal the patient's previous mental state and attitude to symptoms. It may indicate, for example, whether the patient has been importuning or has sabotaged treatment.

(c) Interviewing a relative

It can be particularly helpful if the psychiatrist or another member of the psychiatric team (e.g. social worker) can interview a close relative or friend. Further insight into the history of the symptoms may be obtained, and the relative will be able to describe the patient's illness behaviour and the family's response to it. It is important to assess the patient's current functioning and disability, and the relative should be asked in detail about the patient's ability to work, go out, do household chores, socialise, and perform general self-care.

Finally, with many patients who somatise, a good outcome depends upon engaging both the patients and their relatives in treatment; thus the first interview is an ideal opportunity to assess the co-operation the team is likely to receive from the relatives and begin the process of their engagement.

The interview

It is important to recognise at the outset that there are different types of somatisers, a variety of interview techniques, a number of mental state signs that should be noted, and a range of psychological approaches that can be used to engage the patient.

(a) Type of patient

Patients who present to doctors with somatic symptoms as an idiom of personal distress range from patients who will readily accept that somatic symptoms have an underlying emotional basis, to patients who cling firmly to the belief that their symptoms are the result of physical illness and are unable to countenance any notion of psychological causation. The former group have been termed 'facultative somatisers' and are frequently encountered in general practice (Goldberg & Bridges, 1988; Goldberg *et al*, 1989). The latter are often referred to as 'chronic somatisers' (Bass & Murphy, 1990).

The aims of the initial interview are different in each case. In the former case (facultative somatiser) the aim should be to elicit factual history, engage the patient, and begin treatment. In the latter case, the aim may be simply to try to gain the patient's willingness to complete an assessment.

(b) Interview techniques

Psychiatrists often experience particular difficulties with patients who somatise. Somatisers have difficulty in putting their feelings into words, and may fear disclosing certain information about feelings in case they are thought to be 'mad'. A subtle and empathic approach is therefore required, and the psychiatrist needs to be particularly aware of verbal and non-verbal cues. The psychiatrist can interact with the patient in three ways: ask questions, make empathic responses, and explain or interpret (term used loosely to imply making a link between psychological and somatic factors).

For the best results, it is important that the psychiatrist can move confidently and skilfully in and out of these different ways of relating. Table 1 illustrates the complexity of interaction between doctor and patient at any one point during the

Table 1
Grid representation of the interaction between different aims of the interview and techniques of patient interaction

Aims	Technique of interaction		
	Questions	Empathy	Interpretations
History	A	B	C
Engagement	D	E	F
Treatment	G	H	I

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interview, with any of the three modes being used to elicit one or more of the three aims.

A full and detailed history of the patient's physical symptoms is essential, and it will often be given by the patient, whether the doctor asks about it or not. It is important for the doctor to know the time course of the symptoms (acute, subacute, and chronic), whether there is one symptom or more, and the disability experienced by the patient. Enquiring about physical symptoms makes patients feel that their symptoms are being taken seriously, which increases trust and aids development of the doctor–patient relationship. Thus in Table 1, A and D are being invoked simultaneously.

An empathic response to a patient's account of the symptoms, such as 'You've had a bad time' or 'The pain's very bad', will often allow the patient to relax and confide. The patient begins to feel that the psychiatrist understands the problem, which deepens the process of engagement, and more information is spontaneously volunteered (B and E in Table 1).

An interpretative or linking comment such as 'I know your guts feel churned up . . . I wonder if you also feel a bit churned up inside', brings together the patient's physical and emotional state by using the same word ('churned') to describe both. At the same time it may allow the patient to be more forthcoming about emotional distress, and also make the patient feel understood (C, F and I in Table 1).

(c) Mental state signs

It is important to elicit as much information as possible, and it is a sad reflection on psychiatric training that many signs of abnormal mood or behaviour are often missed in these patients, because they do not appear overtly anxious or depressed. The following points are particularly important to assess.

(1) Is there any evidence of abnormal illness behaviour, such as constant return to the symptoms during conversation, repeated demonstrations of severe pain despite the patient appearing comfortable? It should also be noted when such behaviour becomes accentuated, for example when discussing a spouse's death.

(2) Assess the use of language – descriptive vocabulary is often limited. When asked to describe a symptom the patient may say, "It's just a pain, it hurts, I don't know what it's like, it just hurts.'

(3) What are the range and depth of emotional responses? The patient may seem detached, bland, and affectless.

(4) What is the level of denial? This can take two forms. 'Inappropriate lack of concern' refers to patients who may deny depression, claiming that they have 'nothing to be depressed about', even when the evidence suggests that continued suffering and failed medical treatment are ruining their lives. 'Denial of affect' refers to patients insisting that they are not upset even when appearing close to tears.

(5) What are the patient's beliefs about physical symptoms? This indicates how strongly patients believe they are due to a physical cause, despite evidence to the contrary. There may be overvalued ideas concerning their cause, and occasionally bizarre hypochondriacal beliefs, which, if challenged, may lead to hostility. The psychiatrist can test the conviction with which these are held when the patient suggests yet a further investigation 'to find the cause'. The patient can be asked, "If this investigation is performed and the result turns out to be normal, what will you think?"

(6) Is there any abnormal hostility expressed towards doctors who have previously treated the patient? Patients may complain that different doctors provided conflicting opinions or advice, and that some treatments have made them worse. The psychiatrist must be particularly careful when making a judgement regarding this matter. Many somatisers are not liked by physicians and surgeons, and in some cases may not have been treated with the same respect and care that other patients with 'physical problems' have received.

(d) Different approaches

Varying interviewing styles and approaches can be adopted depending upon the orientation of the psychiatrist (behavioural, cognitive or psychodynamic) and the nature of the patient's problems.

(1) Reattribution approach

This approach has been developed by Goldberg *et al* (1989) and involves getting patients to accept a psychological view of their symptoms during the first interview. It is suitable for somatisers who have some psychological understanding, are not overtly hostile, and whose symptoms are relatively mild or of a short duration (facultative somatisers). It has been designed particularly for use in general practice. A full symptom history is taken, including a physical examination. The doctor picks up verbal and non-verbal cues, and empathically responds to the patient's comments. The doctor enquires about psychological factors and screens for social/family factors and asks about health beliefs. The doctor then broadens the agenda by acknowledging the reality of the patient's symptoms, but also acknowledging

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the reality of psychological or stressful factors in the patient's life; for example, "I can see that your back pain is clearly a problem . . . you've also told me you're under a lot of pressure at work".

If the patient is responsive, the doctor can then go on to make more overt links between psychological and physical factors. The links can be made in a variety of ways: giving an explanation of how increased muscle tone can lead to pain, pointing out links between stressful life events and the development of symptoms in the patient's day, noticing whether the patient develops symptoms during the interview with the doctor, and pointing out any emotional antecedents, etc.

(2) Psychotherapeutic approach

This approach, developed by Guthrie (1991), concentrates on developing a close personal relationship with the patient, with the long-term aim of the patient gaining some psychological insight into the nature of the symptoms. It is a more subtle and intense style than the reattribution approach and is suitable for somatisers with long-standing symptoms who are resistant to change. Patients do not have to be particularly psychologically minded for this approach to work, but it is unsuitable for patients who are overtly hostile and refuse to allow any reference to psychological matters.

The psychiatrist uses the initial interview to establish a deep and trusting relationship with the patient. Any worries the patient may have about seeing a psychiatrist are openly confronted and discussed early in the interview. If this is not done, the patient will remain wary or sceptical of what the psychiatrist has to offer. The patient is then encouraged to talk about the physical symptoms in great depth. This increases rapport and, in addition, often provides valuable insight into the patient's emotional world.

Thus a patient could describe that he has a pain that pulls and twists inside, and that he is frightened of going out in case he messes his pants. This not only describes his physical symptoms but should alert the psychiatrist to the possibility that the patient may also feel emotionally torn inside and fears losing control or being humiliated. It is important that the psychiatrist is able to respond in a subtle way which acknowledges the patient's distress without leading to alienation or the patient losing face. Tentative links may be drawn between psychological and somatic factors, although the timing of such statements is crucial and often best left to subsequent meetings, after a strong treatment alliance has been established.

(3) Directive approach

Here, psychiatrists present themselves as experts in controlling pain or helping people to cope with symptoms (Benjamin, 1989). This avoids having to discuss psychological issues related to aetiology. It is suitable for all kinds of patients, but particularly those who are hostile or deny the possible importance of psychological factors. Patients are engaged by taking a full history of physical symptoms, and a detailed account of their involvement with previous physicians and surgeons. Somatisers often feel aggrieved or misunderstood by doctors, and allowing them to ventilate their feelings of anger and frustration about previous treatment is a good way of deepening the rapport and demonstrating that the psychiatrist is different and will listen to what they are saying. Patients are treated as if they have a physical problem, and a programme of activities is discussed to improve their 'strength' or 'functioning'. For example, patients with ME will be told that it is important to build up their strength, and that they can reduce tiredness by exercising (Wessely *et al*, 1989).

A physical examination often helps to reinforce the advice the psychiatrist is giving; simply commenting on the patient's pulse rate after being asked to perform a physical exercise can be an extremely powerful mechanism of engagement, as it reinforces the doctor's role as expert. Medication, for example an antidepressant for pain (Feinmann *et al*, 1985), can be another adjunct to engagement, requiring return appointments and further opportunities for developing a therapeutic relationship.

Ending the interview

There are several possible outcomes of the first interview. Firstly, the patient may accept a psychological explanation or that psychological factors have exacerbated an underlying physical condition. If so, a form of management can be agreed. Secondly, the psychiatrist may be genuinely unclear as to the cause of the patient's symptoms. In this case it is best to be honest and suggest a further discussion with the referring physician, followed by a subsequent psychiatric appointment if necessary. Thirdly, the psychiatrist may have a shrewd idea that somatic symptoms reflect an underlying psychological problem, but knows that the patient will reject such an explanation. In this situation, more sessions may be required before a treatment plan can be formulated, or if the psychiatrist has adopted the 'directive' approach a treatment plan can be discussed without invoking a psychological explanation.

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Conclusions

Patients who somatise are difficult to interview, and detailed preparatory work needs to be carried out. This involves close liaison with the referring physician/surgeon, a review of case notes, and an interview with a relative (where possible). During the interview, the psychiatrist needs to be particularly receptive to verbal and non-verbal cues, and interact with patients in such a way so as not to alienate them or damage their self-esteem by using inappropriate psychological interpretations. Many significant signs are often missed, as these patients do not overtly present with anxiety/depression. It must be remembered that an absence of affect is as important a sign as a change in affect. Different interview styles can be used to engage the patient. If the psychiatrist is going to try to help patients come to some psychological understanding of their physical symptoms, it is important to discuss early in the first interview any ambivalent feelings the patient has about seeing a psychiatrist. This is less important if the psychiatrist takes the role of an 'expert'.

Whatever the style of interview, it is always important to take a detailed history of the patient's physical symptoms. This makes patients feel understood, and suggests to patients that the psychiatrist believes that their symptoms are genuine. This is a powerful way of engaging someone in treatment.

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