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Direct reprint requests to:

Dr. T. Kitamura, F.R.C. Psych.
Department of Sociocultural Environmental Research
NIMH, 1-7-3 Konodai
Ichikawa, Chiba 272, Japan

THE SOMATIZING PATIENT IN GENERAL PRACTICE

P. F. M. VERHAAK
M. A. R. TIJHUIS

Netherlands Institute of Primary Health Care

ABSTRACT

Objective: The exploratory study described in this article followed two groups of patients over a twelve-month period. Subjects were drawn from a pool of patients who had consulted their general practitioner during the three-month selection period. One group consisted of patients who had consulted their general practitioner at least once about a physical complaint that the GP regarded as predominantly psychosocial; these patients did not articulate complaints of an explicitly mental or social nature. The second group was characterized by the fact that its members voiced precisely such mental or social complaints. **Method:** The study investigated the extent to which the two groups (which were comparable in the severity of their complaints) differ with respect to patient characteristics such as the severity of their possible psychological problems, the frequency with which they visited their GPs, and the types of complaints—e.g. mental, psychosomatic and purely physical—they presented. **Results:** It was found that patients in the first group, whose somatic complaints were seen to have a psychosocial basis, are not the dependent types generally mentioned in theories about somatization. In fact, they adopt a more independent attitude to the GP than do patients voicing mental complaints. There are indications that for "somatizing" patients, underlying mental problems are less important than for "psychologizing" patients. **Conclusions:** Both the somatizing patients and the psychologizing patients continued very frequent visits to their GP during the 12-month research period, although chiefly to address physical complaints that the GP also assessed as such.

(*Int'l. J. Psychiatry in Medicine* 24:157-177, 1994)

Key Words: somatizing, psychosomatic, primary care, psychosocial problems

INTRODUCTION

Persons diagnosed as having some form of mental disturbance, as well as those who believe that they have problems of a mental or social nature, make disproportionately greater use of medical facilities, with general practitioners bearing the brunt of this [1]. Estimates of the percentages of mental disturbances among visitors to general practice physicians (from 22% to 35%) [2-5] are significantly higher than the 8 to 15 percent of the general population estimated to have some form of mental disturbance [6-9].

Most patients with mental problems come to their GP with an explicitly physical complaint [8-11]. Often the GP agrees that the request for help concerns a purely physical matter, but GPs also consider some physical complaints to be psychosocial in nature. Such a judgment need not result from a single consultation, but may be based on a lengthier history of interaction with the patient. For example, the number or the intensity of the complaints may be disproportional to demonstrable somatic dysfunctions. The judgment that a complaint is psychosocial is then based on the absence of evidence for a physical explanation, and is consistent with Lipowski's definition of somatization as "a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness and to seek medical help for them" [12]. "Somatizing" is thus a purely descriptive concept.

Somatizing is often linked to mental problems [13, 14], in which case it is interpreted as "the articulation of emotional problems and psychosocial stress by way of physical symptomatology" [14]. According to Katon et al. "somatization is a metaphor for personal distress. It as an idiom to obtain help from care-givers and a universally powerful mechanism of obtaining social support and manipulating relationships." In many cases somatizing is also equated with the psychiatric DSM-III diagnosis "somatization disorder" [15]. A distinction is made between "acute somatization" lasting some days or weeks, "subacute somatization" for a period of months, and "chronic somatization" over much longer periods. This distinction is important because in primary care settings somatization disorder—identified as a form of chronic somatization—is much more rare than is the patient who presents with one or two symptoms that are not accounted for by pathological findings. We stress that this study reports on the latter type of patients, few of whom are likely to have a somatization disorder as defined by DSM-III criteria.

Although GPs often suspect a psychosomatic basis in patients whose complaints are difficult to explain physically, they do not always treat the presumed mental component of such cases. While 90 percent of those patients who describe their problems as mental or social receive some form of psychosocial treatment, only 50 percent of patients who arrive with physical complaints that appear to have mental causes receive such attention [16, 17]. Thus many patients who are emotionally disturbed do not express these feelings to their doctors, and present

with physical symptoms that appear to have no physical basis. GPs often do not discuss the probable emotional background of such symptoms with either type of patient. Those who argue that physical complaints for which no explanation can be found are in general an expression of emotional distress advocate a "retribution process:" the GP must try to give the patient insight into the psychosocial factors that cause or aggravate the symptoms [18]. There are indications that recognized mental complaints have a better prognosis than unrecognized complaints and that GPs must be better trained in recognizing possible mental problems, and in broaching these with the patients, even if the patient does not raise them [16, 19-22].

On the other hand, notably in the world of general practice, psychosocial causes need not always be sought. Thus Huygen has remarked that many complaints—including psychosomatic ones—fade of their own accord, and that the physician who seeks psychosocial causes unasked may prompt undesired side-effects [23]. This does not imply that physicians must proceed narrowly on the basis of patient-described physical complaints and neglect the mental component, only that a reserved attitude is desirable [24].

The present study investigated the prognosis of patients with physical symptoms for which medical explanations are lacking. A group of somatizing¹ patients has been followed for one year. The group has been compared with a group of patients who presented explicitly mental complaints and with a control group of average patients.

The following questions have been put forward:

1. *What characterizes somatizing patients and in what respects do they differ from patients who present explicitly mental complaints (psychologizers) and from average patients?*
The degree of mental disturbance and psychosocial problems experienced by somatizing and non-somatizing patients and average patients is compared. The extent to which the demographic and personality characteristics of somatizing patients may be distinguished from those of non-somatizing and average patients has also been investigated. It has been assumed that somatizing patients will tend to be older, less well educated and more dependent on their GPs than patients who explicitly discuss their mental problems [13, 14].
2. *What trends can be distinguished in the medical histories of somatizers and psychologizers over a one-year period?*

¹ By somatizing we mean the presenting of physical complaints that the GP considers to be mainly of a psychosocial nature. Physical complaints that the GP considers to be of a psychosocial nature are designated as "psychosomatic complaints." Somatizing patients are patients whose GPs judge their physical complaints to be mainly psychological ones, non-somatizing patients are patients who bring forward explicitly psychological complaints. We shall address them in this article as "somatizers" and "psychologizers" respectively.

The number of consultations during the year after selection and the kind of complaints presented by somatizing and non-somatizing patients are compared. A distinction is made between complaints explicitly formulated as psychosocial; complaints without sufficient evidence which are, according to the GP, somatically formulated (psychosomatic complaints); and somatically formulated complaints the GP agrees are mainly somatic.

To allow a valid comparison, cohorts have initial complaints of the same severity, based on the GP's assessment of the life-threatening or incapacitating impact of the symptoms presented during the selection period. The degree of possible mental illness was evaluated by means of the General Health Questionnaire (GHQ-30) completed by all patients.

We assume that failure to recognize the psychosocial basis of psychosomatic complaints during the selection period will be identifiable by the more frequent presentation of psychosomatic and mental complaints in the follow-up year in comparison with "non-somatizers," assuming that there are no differences in the treatment of the two groups. Therefore, the treatment histories of the follow-up year will be taken into account.

DATA AND METHOD

The patients and practices selected all participated in the Dutch National Study into Morbidity and Services in General Practice [25]. This larger study registered all contacts ($n = 335,000$) between 103 practices and their registered patients over a three month period. On the basis of this registration, somatizing patients and patients with explicitly mental complaints were selected from nine practices involving sixteen GPs. For an additional nine-month period the number of contacts with the GP's office and the complaints presented there by the two groups were recorded; the patients also completed questionnaires twice during the study period.

The complaints, registered during the registration period were coded with the aid of ICPC.² A somatized mental complaint is defined as a somatic complaint (neither P nor Z) that the physician assessed as predominantly psychosocial (scoring 4 or 5 on a five-point scale from somatic to psychosocial). The group of psychologists explicitly described mental complaints at least once during the selection period. Somatizing patients presented only somatic complaints, which, at least once (during the selection period) were assessed by the GP as psychosocial. Based on a three-month registration six percent of all visitors could be defined as somatizers and twelve percent as psychologists.

The following data was registered for contacts with each patient during the twelve-month period:

1. All complaints presented:
 - ICPC-code;
 - (differential) diagnosis by the GP (coded in ICPC);
 - five-point scale assessment by the GP of the possible psychosocial character of the complaint;
 - five-point scale assessment by the GP of the life-threatening character of the complaint;
 - five-point scale assessment by the GP of the disabling character of the complaint;
2. Treatment:
 - counselling;
 - referral;
 - consultation of specialist;
 - duration of the consultation.

The patients completed questionnaires in the fourth month and during the final quarter of the registration year. The final study sample was compiled on the basis of the response to these questionnaires. Full records are available on 397 patients with explicitly mental complaints and 411 somatizing patients.

Questionnaires recorded demographic data (age, sex, marital status, education), and included the following attitude lists and screening questions:

- a list used to measure the patient's dependence on the GP (on a scale of 12 to 60). Higher scores indicate less dependent attitudes;
- a Dutch adaptation of the list originally developed by Rotter [26] to measure "Health Locus of Control" (specifically, the scale measuring the orientation of internal control);
- a screening list, the General Health Questionnaire (GHQ-30), [27] was used to trace psychosocial problems and to assess the likelihood that a patient suffered from severe psychosocial problems are involved (GHQ scores range from 0 to 30; usually 4 or 5 is used as cut-off), with scores higher than 4 considered to indicate possible psychopathology; and:
- a list aiming to quantify the specific psychosocial problems that patients have faced [28]. Scores can range from zero (no psychosocial problems, no burden) to twenty-two (high burden).

The aforementioned national study, which includes data derived from interviews with some 13,000 respondents, served as a base reference. These respondents answered the same questionnaires used in the present study. Because the data from the contact registration of these respondents are available, it is possible to make two kinds of comparisons: each group may be compared with an average

² This well-known classification system for general practice (Lamberts and Wood, 1987) places each complaint in one of 17 main categories; for example, P = psychic complaints; Z = social complaints.

practice population (all respondents to the national survey) and with the profile of the average person who visited a GP in a comparable three-month period. Data from the first three months, during which the individuals were selected, can be readily compared with the national survey data, because by definition all respondents visited their GP during the period. This data is less useful for comparison with later periods, for which data on the total population (including non-visitors) is more relevant, given that patients need not have visited their GPs in each successive quarter of the study period. Differences between the groups have been statistically tested by means of a unilateral *t*-test or, in the case of nominal variables (for example marital status) using Pearson's Chi-square. Following the recent recommendations of the editorial board of this journal [29], effect sizes are reported, using Cohen's *d* as a measure for effect size. Following Cohen's recommendations, a value of .20 is considered a small effect, .50 indicates a moderate effect and .80 a large effect [30].

RESULTS

Demographic and Personality Characteristics of Somatizing, Psychologizing, and Average Patients

Table 1 lists the demographic and personality characteristics of somatizing patients, patients who explicitly indicated the existence of psychosocial problems and an average group of visitors to GPs.

Somatizing patients are younger and (therefore) less frequently divorced or widowed ($p < 0.05$). Somatizers are less dependent on their GP than are psychologizers. However, somatizing and psychologizing patients could not be distinguished on the basis of gender or control orientation, nor did their educational level differ. Although the reported differences reach the level of significance, the effect size is rather moderate, Cohen's *d* not exceeding .26.

Compared to the average patient in the national study, patients with concealed or unconcealed mental problems are more often between twenty-five and forty-five years old and more frequently divorced; they also have a lower internal control orientation than the average GP visitor, although the effect size in this respect is rather low (Cohen's $d = .12$ respectively .07). Somatizing patients are less dependent on their GP than average visitors ($d = .21$).

Severity of Symptoms of Somatizers and Psychologizers

Comparisons of the course of complaints of somatizing and psychologizing patients requires that the severity of the complaints be comparable. To determine the extent to which the selected patients have complaints that are of similar severity, the life-threatening or disabling potential of their complaints was assessed by their GPs (see Table 2).

Table 1. Demographic and Personality Characteristics of Somatizers and Psychologizers, Both Divided according to GHQ-Scores

	Somatizers	Psychologizers	Average Consulters
N	411	397	4042
Sex			
Male	39	42	43
Female	61	58	57
Marital Status			
Married	67	64	65
Divorced	7	9	4
Widowed	3	7	7
Never married	23 ^{a,b}	20 ^{a,b}	23 ^b
Education			
Higher	13	13	11
Secondary	20	20	21
Primary	54	51	47
Unknown	12	16	21
Age (years)			
16-25	14	11	18
25-45	58	49	43
45-65	24	33	29
65 and over	5	7	10
Mean Age	39 ^{a,b}	42 ^a	42 ^b
Mean Scores for Dependency	39.4 ^{a,b}	37.6 ^{a,b}	36.3 ^b
Internal Locus of Control	18.4 ^b	18.8 ^b	19.3 ^b

^aStatistically significant difference between somatizers and psychologizers.

^bStatistically significant difference between average consultants and somatizers or psychologizers.

People who explicitly raise psychosocial concerns during their consultation with their GPs visit their GP more often in the quarter in which they first report such complaints ($p < 0.05$; $d = .30$). Similar findings were reported in the UK by Wright, who also divided patients with "clinically significant psychiatric disturbance" into patients with mental symptoms and patients with somatic symptoms without a physical explanation [31].

The "severity" of the complaints, indicated by the GP as life-threatening or disabling potential, is the same for both somatizing and non-somatizing patients. For a number of types of complaints, namely involving the gastrointestinal tract,

Table 2. Average Severity of Symptoms Presented Within the First Three Months of Registration

	Somatizers	Psychologizers
<i>N</i>		
Patients	411	397
Consultations	2.1	2.6 ^a
All Complaints		
Life threatening	4.93	4.90
Incapacitating	4.78	4.75
Mental Complaints		
Life threatening	—	4.90
Incapacitating	—	4.76
Psychosomatic Complaints		
Life threatening	4.94	4.87
Incapacitating	4.80	4.71
Somatic Complaints		
Life threatening	4.93	4.91
Incapacitating	4.77	4.74

^aStatistically significant difference between somatizers and psychologizers ($p < 0.05$; $d = .30$)

nervous system, muscular system and with reference to pregnancy, somatizers consulted their GPs more frequently than did those who presented openly mental difficulties. After adjusting for age and sex, however, the difference with reference to pregnancy disappeared [32].

Psychopathology of Somatizers and Psychologizers

Two measures of the extent to which somatizing patients, patients with mental complaints and average patients differ from each other in psychopathology are available. Table 3 indicates the number of psychosocial areas in which the two groups of patients indicated they were experiencing problems and which percentage of the patients from the two groups had GHQ scores indicating the significant likelihood of a severe mental problem.

This comparison shows that the patients who made explicitly psychosocial complaints have experienced more psychosocial problems and are more likely to be suffering from a serious mental disorder. At first sight, one would say that they are in a "more serious" psychosocial state. On average, both groups had a higher

Table 3. Number of Psychosocial Problem Areas and GHQ-Scores for Somatizers and Psychologizers

	Somatizers	Psychologizers	Average Consulters
<i>N</i>	411	397	4775
Number of Problem Areas			
No problems	23%	17%	45%
1-5	49%	46%	45%
6-8	20%	19%	7%
> 8	8%	18%	3%
Mean	3.0 ^{b,c}	4.0 ^{a,c}	1.6 ^{a,b}
GHQ			
Mean score	4.6 ^{b,c}	7.3 ^{a,c}	2.7 ^{a,b}
Percent > 4	32%	45%	16%

^aStatistically significant difference with somatizers ($p < 0.05$).

^bStatistically significant difference with psychologizers ($p < 0.05$).

^cStatistically significant difference with average consultants ($p < 0.05$).

Effect sizes:

	Somatizers- Psychologizers	Somatizers- Average	Psychologizers- Average
Mean η of problem areas	.30	.29	.38
Mean GHQ	.34	.18	.34

contact frequency, experienced more problems and had higher GHQ scores than the average visitor to the doctor's office. These differences are all somewhat larger than earlier reported differences: as is reproduced in the note at Table 3, effect-sizes mostly vary between .30 and .40.

To allow a comparison of the characteristics and the course of the complaints of somatizing and psychologizing patients, the severity of the mental problems as assessed by the GHQ must be taken into account. The following analyses sub-divides each group of patients into those who, according to the GHQ, have a considerable chance of a serious mental disorder, and those who do not.

The Course of Complaints among Somatizing and Non-Somatizing Patients

To investigate the extent to which somatizing patients continued to voice psychosomatic complaints, a comparison is made between the complaints voiced in the first (selection) quarter and the last quarter of the study.

Figure 1 shows the number of contacts per 100 patients in the first and last quarters. Because patients were selected on the basis of having made at least one contact during the first quarter, *T1* is artificially high and a drop is to be expected. At *T1*, psychologists had a higher contact frequency than somatizers, and among the former, those with elevated GHQ scores had the highest number of contacts. (Cohen's $d = .41$).

By *T2*, the contact rate for psychologists with low GHQs had dropped to the level of the average patient (80 contacts per 100 registered patients). The contact rate of somatizers with a low GHQ is considerably higher (Cohen's $d = .25$). Among the patients with a high GHQ there is no significant difference anymore between somatizers and psychologists on *T2*.

Reasons for visiting the GP have been categorized as "psychosocial" (ICPC P or Z), "psychosomatic" (ICPC other than P or Z and judged by the GP not to be entirely somatic) and "somatic" (ICPC other than P or Z and judged by the GP to be entirely somatic). Figures 2 and 3 show the total number of complaints presented to the GP in the first and last quarters of the study period. Patients who scored below the GHQ threshold value (Figure 2) and patients who scored above it (Figure 3) have been considered separately.

It would be meaningless to compare the complaints presented by somatizers and psychologists at *T1*, because they have been designated as such according to the presence or absence of explicitly stated psychosocial complaints. As might be expected given the larger number of contacts, psychologists also had a larger number of complaints and symptoms at *T1* than did either low-GHQ somatizers or high-GHQ somatizers. The effect sizes are .26 respectively .52.

At *T2*, however, psychologists with low GHQs (like average patients) presented fewer symptoms and complaints than did somatizers with low GHQs ($d = .25$). The difference can be entirely accounted for by the larger number of entirely physical complaints and symptoms presented by the latter. Patients with high GHQs at *T1* present more complaints at *T2* than the average patient, with psychologists presenting more complaints than somatizers. Patients with high GHQs presented both more entirely physical complaints and more explicitly stated psychosocial complaints. (This was especially true of psychologists.)

In brief, although the psychosomatic complaints of the majority of the "somatizers" had vanished by the fourth quarter, explicitly mental complaints and above all purely somatic complaints had taken their place; as a result, the average number of complaints remains above the level of an average population.

At both *T1* and *T2* (Figure 4) GHQ scores show more remitting cases and more continuing cases among psychologists than among somatizers. The net result is a larger proportion of psychologists being a GHQ-case in both periods.

Figure 1. Number of contacts for somatizers and psychologists on T1 and T2.

Figure 2. Somatizers and psychologizers: T1 and T2 GHQ-.

Figure 3. Somatizers and psychologizers: T1 and T2 GHQ+.

Treatment of the Psychosocial and Psychosomatic Complaints of Somatizers and Psychologizers

Over the course of the year, individuals in both the somatizing and the psychologizing groups presented explicitly mental complaints and psychosomatic complaints. Table 4 identifies the types of treatment the GPs provided: by group, by GHQ category and by complaint category over the course of the registration year.

Treatment of explicitly mental complaints is notably different from that provided for psychosomatic complaints, regardless of the original classification of the patients as somatizing or psychologizing. Consistent with the evidence in the literature noted in the introduction to this article, patients with psychosomatic complaints received less discussion therapy and were less frequently referred to specialists. Fewer mental health consultations are carried on about them, and with the GPs consultations are shorter. A *t*-test of these differences comparing all psychosomatic complaints to all mental complaints is statistically significant at a 0.05 level.

On the other hand, neither the likelihood of having psychiatric problems (according to the GHQ) nor the initial categorization of patients as somatizers or psychologizers correlated with the type of treatment received. In other words, "somatizers" who later presented explicitly mental complaints received the same treatment as "psychologizing" patients who presented explicitly mental complaints in the first quarter.

Table 4. Treatment of Mental and Psychosomatic Complaints of Somatizers and Psychologizers, Divided according to GHQ-Score

Type of Problem	Somatizers			Psychologizers		
	GHQ+ Ment.	GHQ- Psom.	Ment.	GHQ+ Ment.	GHQ- Psom.	Ment.
N	41	130	46	279	175	93
						216
						84
Treatment: Percent of patients with at least one:						
Counseling	76%	61% ^a	76%	53% ^a	85%	68% ^a
Referral	5%	5%	13%	3% ^a	16%	3% ^a
Mental health consultation	0%	0%	2%	0%	10%	0% ^a
						76%
						55% ^a
						2%
						1%
Average length of consultation (min.)	12	10 ^a	12	10 ^a	13	11 ^a
						10 ^a

^aStatistically significant difference between treatment of mental and psychosomatic complaints.

Figure 4. GHQ-caseness on T1 and T2: somatizers and psychologizers.

DISCUSSION

One group of patients was selected over a three-month period according to whether they visited their GP in order to present, at least once, physical complaints which the GP diagnosed as being primarily psychosocial. During the selection quarter, the individuals selected for this group did not explicitly mention mental or psychosocial problems. This group was compared to a second group which, during the selection period, explicitly raised mental problems as such to the GP; the groups were then compared to national survey data (the average patient).

The finding that "somatizers" are younger, less often divorced or widowed, and less dependent on the GP than "psychologizers" is inconsistent with the usual characterization of somatizing patients presented in the literature. Patients who express their emotional problems by means of physical complaints are commonly described as older, less educated [13] and more dependent on their physicians than the present study suggests [14]. In fact, the psychologizing group was older, less well educated and more dependent than the somatizing group, although the effect sizes in these respects were only small.

According to the GHQ, somatizers are less likely to have a serious mental disturbance, and according to the BIOPRO they experience fewer psychosocial problems than do patients who present their problems as explicitly mental. They also visited their GPs less frequently during the selection period. These effect sizes are somewhat larger than the former. However, the severity of their complaints is approximately the same as that of the patients who described explicitly mental problems. Wright reports the same results: patients with "clinically significant psychiatric disturbance, who restricted themselves to somatic symptoms without physical explanation" were better off than those who complained explicitly about psychiatric disturbance [31]. Bridges et al. report higher consultation rates for "somatizers" than for "psychologizers" and lower scores on depression scales and on the GHQ [33].

Psychosomatic complaints are less often treated by discussion, and more specialized mental health care workers are almost never involved irrespective of the group within which the patient was originally classified. Nevertheless, the frequency with which patients from the two groups bring these psychosomatic complaints forward declines strongly. Again, Wright reported the same results [31]. The frequency with which patients in the psychologizing group visit the doctor remains higher than expected, although most of their complaints are assessed by their GPs as purely somatic.

Therefore, somatizing in primary care is in many cases not a matter of somatization disturbance in a psychiatric sense (many symptoms without physical explanation over an extended period) but of "(sub)acute somatization," which can be expected in primary care settings. As others have noted, while chronic somatization disorders (including DSM-III diagnoses of somatization disorders) are rare in primary care settings, one-time incidents of somatization are not [31, 34].

However, a patient who presents a single psychosomatic complaint is unlikely to continue to do so. On the contrary, the patients in our cohort of "somatizers," while frequent visitors to their doctors' offices, presented complaints that were diagnosed as entirely physical. In our opinion it is necessary to distinguish between patients with DSM-III disorders and patients who are (perhaps too) eager to visit their GPs.

Thus somatization need not be an expression of underlying emotional distress. Firstly, the initial GHQ described only one third of the group of "somatizers" as likely to have "serious mental disturbance." Secondly, by far the majority of "somatizing" patients voiced no mental complaints to their GPs in the course of the follow-up year. Thirdly, over the course of the study period the frequency with which psychosomatic complaints were presented fell to the average rate for the general population. And finally, the minority of patients who, according to the GHQ, were more likely to have a serious mental disturbance did not differ in these respects from the majority. While they tended to visit their GPs more frequently at the end of the study than did the psychologizing group, they generally presented purely somatic complaints.

The same patterns observed among the physicians as a group were observed in the case of most of the physicians individually; thus although the behavior studied is partly determined by the treating physicians, the results cannot be ascribed to anomalies of a few individuals.

The gap between the initial presentation of symptoms and the administration of the GHQ ranged from one week to three months, and it is possible that delaying the initial GHQ test until the first month of the second quarter of the study may (partially) account for the fact that most somatizers could not be classified as "psychologically disturbed." However, the same delay occurred in the administering of GHQ tests to the cohort of psychologizers, of whom a significantly larger number were identified as likely to suffer from psychological disturbance. In addition, the GHQ proved to be a rather stable measurement. About 60 percent of the original high-GHQ cases in each group remained high-GHQ cases at 72, approximately a year after the original assessment. Moreover, the apparently more "severe" condition of the psychologizers might derive from their higher consultation frequency in the first three months (Table 2) and the larger number of problems they experienced. Theoretically it is possible that, at the time they presented symptoms, all of the somatizers had elevated GHQ scores. However, as other studies have pointed out in general their psychosocial distress is less severe than that of people who explicitly mentioned such distress [31, 32].

It is also possible that the GPs have underreported or misclassified psychosomatic complaints. If the GPs fail to recognize and classify cases of somatization disorder and instead tend to classify the majority of complaints as purely physical, this would affect the accuracy of the regression analysis of psychosomatic complaints. The discrepancy between symptom presentation as assessed by the GP (mostly "entirely physical") and the persistence of elevated GHQ scores would

then indicate a need to reassess the findings. Recent research in The Netherlands indicates that many instances of mental illness that are unrecognized by GPs are borderline cases; such individuals are not severely handicapped and do not demand help [35].

Given our results, we would go one step further and take the position that somatizing need not always refer to underlying unsolved psychosocial problems, but may in itself be an undesirable behavioral pattern. Such a pattern could, in a psychiatric sense, be characterized as "hypocondria," "hysterically cognitive style" or "obsessive behavior" [36]. However, like Portegijs et al. [15] we suggest viewing somatizing less as a disturbance than as a personality trait. Somatizing is then interpreted as a problem-solving mechanism at a cognitive and behavioral level, which should be handled as such.

In other words, it is not the symptom in itself which is relevant but the help-seeking behavior of the patient. As argued above, such patients are unlikely to be more mentally distressed than average patients. They distinguish themselves by help-seeking behavior which might be seen in psychosocial terms but also can be understood as a form of consumerism.

Moreover, this behavioral pattern is not explained by the literature's characterization of the older, submissive patient who, vis-à-vis the physician, resorts to medical language to express discomfort or distress. The patients in our study whose physical complaints were judged to be psychosocial in no way adopted dependent attitudes toward their physicians. It seems more appropriate to characterize them as self-aware consumers. The majority of the "somatizers" are characterized neither by an oversupply of mental problems nor by a dependent attitude, but by frequent visits to the physician and an independent attitude.

Further, although physicians rarely discussed their assessment that particular physical complaints had psychosocial bases with their patients, and although these patients were rarely referred to mental health care workers, such complaints largely disappeared over the course of the year. Somatizing patients continued to be frequent visitors, but possibly the patient, rather than the complaint, calls for attention. If this is the case there seems to be little point in raising the potentially psychosocial basis of a complaint with the patient. Ford emphasizes the importance of a physician-patient relationship in which the physician, by mutual participation (as opposed to a physician-oriented attitude), must make the patient aware of the patient's own responsibilities (cf. the concept "room for the patient") [37-39]. This implies that the general way in which the patient deals with sickness and health should be treated.

Our interpretation of somatizing offers on the other hand a hopeful prospect: the "somatizer" is well-equipped as an equal negotiating partner to make the desired contribution to personal health. On the other hand, he or she may be typified as a modern consumer who might not accept a doctor's authority but who will argue that one has paid for and deserves the maximum amount of care. In this respect,

emphasis should be laid on the doctor-patient relationship, while serious attention should be paid to the complaints as well.

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Direct reprint requests to:

P. F. M. Verhaak
 Netherlands Institute for Primary Health Care (NIVEL)
 P.O. Box 1568
 3500 BN Utrecht
 The Netherlands