32 Communication in Somatoform Disorders

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> Now they [the doctors] act as if I didn't have anything. And I don't think that's okay, because I have something. I have something organic. I don't have nothing.
>
> Patient

Abstract: This article begins by describing how somatoform complaints present themselves in everyday clinical practice and how they are classified diagnostically according to ICD-10 (§ 32.1). In connection with somatoform and physically unclear complaints, however, there is an inconsistent situation with regard to terminology and classification (§ 32.2). This is followed by brief information on the frequency, course and causes of the complaints (§ 32.3). An important aspect in connection with somatoform complaints is the relationship and communication between the practitioner and patient. This is illustrated using a fictitious example of a conversation and with reference to the description and recommendations in the guidelines (§ 32.4).

The following are results from our own conversation-analytically investigated practitioner-patient conversations that took place in an acute hospital as part of the diagnostic clarification of the unclear complaints. It was possible to trace how the psychotherapeutically trained practitioners exerted interactive pressure in their attempt to sensitize patients to alternative explanatory models for their complaints (§ 32.5.1). In this context, the phenomenon of "beating around the bush" is also described (§ 32.5.2). Patients often react evasively and justify themselves using various strategies in the face of these attempts by practitioners to sensitize them to psychosomatics (§ 32.5.3).

Finally, it is discussed how the reconstructed dangers and pitfalls in managing conversations with such patients could be countered with a careful and at the same time clear, appreciative approach (§ 32.6).

32.1 Appearance and classification of somatoform disorders

"Your test results are now available: The laboratory values and ECG results show no abnormalities whatsoever. You are completely healthy." Patients are usually relieved when they receive such a statement from their physician. However, patients who suffer from physical complaints that cannot be explained medically or adequately often feel helpless in the face of such statements.

Just a few years ago, Mrs. A would not have believed it if she was told that she would one day wish she was physically ill. However, after more than 20 visits to physicians and three sick notes lasting several weeks, this thought is very familiar to Mrs. A.

Despite her "medical career", which suggests a serious physical illness, Ms. A has "nothing wrong" with her. From an organic medical perspective, Ms. A's complaints cannot be classified as pathological and therefore cannot be treated with conventional medicine. And yet Mrs. A. suffers from serious physical complaints ranging from joint, muscle, head and abdominal pain to sleep disorders, fatigue and an increased susceptibility to infections, which greatly impair her quality of life.

In psychosomatic medicine and psychiatry, Ms. A. would be suspected of having a somatoform disorder. According to ICD-10 (Dilling, Freyberger 2006), the following characteristics are typical of a somatoform disorder:

1. Patients repeatedly present physical symptoms in conjunction with persistent demands for medical examinations...
2. ...despite repeated negative results and assurances from the physicians that the symptoms cannot be explained physically.
3. If somatic disorders are present, they do not explain the nature and extent of the patient's symptoms, suffering and emotional involvement.

Patients' symptoms are varied and can affect any organ system: For example, those affected complain of a wide variety of pains, cardiovascular complaints, gastrointestinal problems, dizziness or fatigue. Several symptoms often occur at the same time. The most common manifestations are shown in Table 32.1.

Organ system	Common symptoms
Heart	Chest pain, Palpitations, heart stumbling
Blood pressure	Hypertonic and hypotonic regulatory disorder
Upper gastrointestinal tract	Nausea, globus sensation, meteorism
Lower gastrointestinal tract	Pain, diarrhea, constipation
Breathing	Hyperventilation with paresthesia
Musculoskeletal system	Back pain
Urogenital system	Frequent urge to urinate, menstrual disorders
General symptoms	Tiredness, reduced performance, sleep disorders

Table 32.1: Manifestations of somatoform symptoms
(based on Fritzsche and Wirsching 2006)

Somatoform disorders are currently classified in the ICD-10 (Dilling et al. 1993) under the category F45.

- Somatoform autonomic dysfunctions of the vegetatively supplied organ systems such as the heart, gastrointestinal tract, respiratory and urogenital systems (ICD-10: F45.3).
- Persistent somatoform pain disorder (ICD-10: F45.4).
- The most severe form is called somatization disorder (ICD-10: F45.0) and comprises a wide range of frequently changing physical symptoms that have existed for years and affect several organ systems.
- In hypochondriacal disorder (ICD-10: F 45.2), patients worry excessively and for a long time about the possibility of suffering from one or more serious and progressive physical illnesses. Eve-

ryday bodily sensations are misinterpreted as threatening and stressful. In body dysmorphic disorder, the body is interpreted as supposedly misshapen. This is usually accompanied by a desire for cosmetic surgery.

32.2 Terminology, parallel classifications and differential diagnoses

In connection with somatoform disorders, there are numerous, sometimes controversial terms and parallel classifications that reflect the difficulty of conceptualizing the often unclear complaints (Creed et al. 2010, Hausteiner-Wiehle, Henningsen 2015: 5ff). Other medical disciplines often refer to functional or non-specific complaints and have their own codes. The term "functional symptom or syndrome" (e.g. irritable bowel syndrome, functional heart complaints, etc.) expresses the fact that physical functions are disturbed but there is no tissue damage. In addition, somatoform complaints are sometimes referred to as psychosomatic disorders, medically unexplained (physical) symptoms (MUS) or physical complaints without sufficient organ findings. The concept of "physical complaints without sufficient organ findings" is on the one hand more descriptive than the term somatoform disorders, but on the other hand promotes the dualism between body and soul. The patient's complaints are either considered to be organically caused or organically inexplicable. The latter often implicitly leads to the assumption of a psychological cause. This concept contradicts the *biopsychosocial model* (§ 4) in which somatic, psychological and social factors contribute to the disease process in different weightings.

Experts are increasingly discussing which diagnostic description for these complaints could be clinically meaningful and at the same time acceptable and non-stigmatizing for patients. The new edition of the American diagnostic classification system for psychiatric disorders DSM-5 (Dimsdale et al. 2013) attempts to overcome this dualism. In a new diagnostic category called "Somatic Symptom Disorder" (SSD), physical complaints are diagnosed that are experienced as stressful and limiting (regardless of whether they can be explained medically or not) and cognitive-emotional and behavioral characteristics in dealing with the physical symptoms are described in diagnostic criterion B (such as

a dysfunctional perception of illness, conspicuous illness behavior and pronounced health anxiety).

In terms of differential diagnosis, somatoform symptoms can also be part of an anxiety disorder or depression. Feelings of anxiety or depressive symptoms are not experienced consciously, but are only expressed on a physical level. Somatoform disorders must be distinguished from the conscious simulation or aggravation of symptoms. As patients with somatoform disorders often feel that their complaints are not taken seriously, it is important to understand that they actually have the complaints and are not faking them, consciously dramatizing them or imagining them. It is undisputed among experts that the symptoms are just as real for those affected as symptoms that can be clearly explained medically.

32.3 Frequency, course and causes

The 12-month prevalence of somatoform disorders in the adult population is 3.5% (Jacobi et al. 2014). Women are diagnosed with a somatoform disorder significantly more often than men. The disorder occurs regardless of the patient's age and origin. Around 30% of patients who consult a general practitioner have physical complaints without sufficient organ findings. A distinction is made between milder courses (approx. 50-75%), in which there is an improvement in quality of life and functional ability, and more severe courses (10-30%) (olde Hartman et al. 2009). For clinical orientation, it is important to know the characteristics of severe and milder courses and to recognize warning signals ("red flags") and prognostically favorable factors ("green flags") (see Hausteiner-Wiehle et al. 2013: 113-6).

Medically unexplained symptoms are not based on a single disease process, but rather on an interplay of various factors and processes (Rief, Broadbent 2007). The disorder often arises in times of crisis against the background of an early relationship disorder, communication problems or experiences of violence in childhood and learning from the parental model. An experience of illness in the family often plays a role. Genetic and neurobiological causes are also suspected. In many cases, vicious circles develop after a short time: The perception of a physical discrepancy, coupled with the fear of a serious illness, leads to anxiety, which increases the physical and mental tension, so that the

symptoms worsen - and the anxiety increases further. Rest and sick leave can exacerbate these processes. The common background of different therapeutic approaches is a biopsychosocial model in which biological, psychological and social aspects play a role in the development and maintenance of symptoms (see e.g. Kleinstäuber et al. 2012, Arbeitskreis PISO 2012).

Unfortunately, it often takes many years before affected patients are diagnosed with a somatoform disorder and appropriate treatment is initiated. After years of chronicity, however, in more severe cases, improvement can "only" consist of an increase in quality of life and better management of the symptoms. In this respect, patients with somatoform disorders represent an economically relevant group in the healthcare system: Even after a physical illness has been reliably ruled out, non-indicated treatments (e.g. medication) and further diagnostic examinations as well as surgical interventions are repeatedly carried out. For this reason, iatrogenic damage - i.e. damage caused by physicians - is also discussed in connection with MUS.

32.4 Relationship building and conversation management for somatoform disorders

Somatoform disorders are also referred to as "relationship disorders" in the healthcare system (Rudolf, Henningsen 2003). As has been shown in a large number of studies, unsuccessful physician-patient communication can contribute to the maintenance of symptoms and mean the start of a real "sick career". The following dynamic can develop between patients with somatoform disorders and their physicians (cf. Salmon 2007): Patients with medically unexplained symptoms want more emotional support from their physician than patients whose symptoms can be explained medically (Salmon et al. 2005). On the other hand, it has been observed that physicians are less patient-centered in their consultations when patients present with medically unexplained symptoms than when patients present with a classic medical symptom picture (Epstein et al. 2006). At the same time, it has been shown that the majority of patients with medically unexplained symptoms make references to psychosocial problems in the physician-patient consultation. Physicians react to the patient's presentation of symptoms with normalizations and usually ignore psychosocial indications. The appeasing reac-

tion of the physicians provokes the patients to intensify the presentation of their complaints in order to demand involvement and understanding from their physicians. In response to this intensified presentation and possibly to end the consultation, physicians tend to make (medically unindicated) somatic interventions.

These measures often remain ineffective, can lead to side effects or contribute to chronification and somatic fixation in patients. This is how the spiral known as *doctor shopping* or *doctor hopping* often begins, which is characterized by hope for help, renewed disappointment and further referrals. If, on the other hand, patients are given the opportunity to address psychosocial problems in the consultation with the general practitioner, the likelihood of somatic intervention is reduced (Salmon et al. 2007).

32.4.1 Example „Rumbling in my gut“

In the following fictitious conversation with the patient Mrs. A., aspects of this dynamic could be illustrated as follows: Mrs. A's (P) now third general practitioner (GP) has referred her to a practicing gastroenterologist for a colonoscopy. During the discussion of the findings, the following dialog takes place (E 32.1):

E 32.1		„This rumbling in my gut“
01	GP	Hello, Mrs. A. Come in. How are you feeling today?
02	P	Oh, if it weren't for the pain, it would be fine. I'm actually on vacation, but we didn't go travelling after all. This rumbling in my gut, especially when I eat something fatty late in the afternoon, just can't be normal. And my wrists were so bad again the other day ...
03	GP	Yes, I have the results of last week's colonoscopy here, which we did just to make sure there was nothing wrong. And I can happily tell you that everything really is fine. You have nothing!
04	P	(remains silent, looks at GP unbelievingly)
05	GP	(looks at her records) The endoscopy was unremarkable. The colleague was able to see the entire colon. No tumors, no signs of inflammation, no diverticula. Only minor changes to the mucous membrane, which we should examine again in five to ten years. So this feeling of pressure and rumbling must be coming from somewhere else. But we had already checked for food intoleranc-

		es, hadn't we? (looks at documents). Yes ... that was also largely unremarkable. Sometimes stress is the trigger for such complaints.
06	P	But I'm on vacation right now...
07	GP	Well, what do we do now? I'll write you another herbal remedy that can calm the gastrointestinal tract a little. And if that doesn't help, then we'll have to think again. So, enjoy the rest of your vacation, your intestines are really fine.

After this conversation, both Ms. A and her general practitioner are frustrated: Ms. A. feels dismissed, the general practitioner feels helpless and dissatisfied. A closer look at the interaction[1] reveals the following aspects: The patient mentions the stress caused by the complaints, makes a reference to having canceled her vacation due to the complaints and expresses the fear that something might not be normal. The practitioner does not address the references to the patient's psychosocial state. Nor does she address the newly mentioned wrist complaints. Instead, she presents the "encouraging" news that the examination results are unremarkable. The general practitioner also ignores the patient's obvious irritation and non-reaction and continues unperturbed. She does not involve the patient in her ideas about causes and objectives in any way and does not ask about the patient's fears. The reference to the minor mucosal changes can have a rather unsettling effect. The repeated checking of the findings and the patient file (e.g. whether food intolerances have already been checked) appears careless and does not demonstrate a comprehensive review of the findings and an overall therapeutic concept. There is no adequate explanation of the complaints. Stress as a possible triggering/maintaining factor of the complaints is thrown into the room as a last resort and questioned by the patient by pointing out that the complaints also occur during the current vacation (logic: vacation is per se a stress-free time). This explanation follows a simple everyday logic, re-establishes the plausibility of a physical illness and shows that the patient is unaware of complex interaction models of chronic complaints. The general practitioner drops the subject and ends the consultation by prescribing a further medication, a seemingly cynical advice to enjoy the rest of the vacation (which once

1 A conversation analysis of fictitious conversations is unusual and only makes limited sense. Since in this case the example was constructed on the basis of various studies and our own conversation analysis research, it can be used to illustrate some typical interactive pitfalls.

again makes it clear that she has not noticed the patient's condition or is ignoring it) and a final reassurance that everything is fine. The patient doesn't react to any of the three aspects. In an exercise section (§ 32.6.2), the alternative ways of conducting the conversation are to be further differentiated.

32.4.2 Guidelines and recommendations

In the S3 guideline "Non-specific, functional and somatoform physical complaints, dealing with patients" (AWMF 2012) and the S3 guideline "Functional physical complaints" (AWMF 2018), recommendations are formulated on relationship management and specific conversations management between physicians that address various points in the described dynamic between physician and patient and are intended to provide a way out (Hausteiner-Wiehle et al. 2013, Schaefert et al. 2012) (Box 32.1).

Box 32.1	Recommendations for managing relationships and conversations

A symptom and coping-oriented, active-supportive, biopsychosocial attitude characterized by situational "coherence", i.e. the right balance of restraint and authenticity ("I don't want to say everything that is real, but what I say should be real") is recommended. (...)
First, the practitioner should allow the complaints to be described spontaneously and in detail ("accepting the complaint") and verbally and nonverbally signal attention, interest and acceptance ("active listening"). Psychosocial issues should initially be dealt with casually and indirectly rather than confrontationally, for example by alternating between alluding to psychosocial stress and returning to the complaint ("tangential conversation"). References to psychosocial problems and needs should be taken up empathetically and named as significant. Figures of speech can help to establish the contextual reference. The patient should be offered the opportunity to make decisions together after receiving adequate information ("participatory decision-making").

Schaefert et al. 2012: 806ff. (Abridged version of the guideline "Non-specific, functional and somatoform physical complaints, dealing with patients")

In the detailed guidelines, specific examples of formulations are proposed for the various recommendations, which can only be referred to here (Hausteiner-Wiehle et al. 2013). Regular, time-limited, non-complaint-driven appointments are recommended, especially for more severe courses. Certain body-oriented or non-verbal therapy elements and relaxation methods can be recommended as additional measures within an overall treatment plan, but not as monotherapies. Referrals, especially to psychosocial medicine, should be well organized and carefully discussed before and after.

32.5 Conversation analysis: Psychosomatic explanations in conversations about somatoform complaints

There is often a large gap between what is recommended in guidelines and treatment manuals and what is actually said in a specific medical or therapeutic consultation. At the same time, a guideline-oriented or manualized approach to the conversation can lead to the practitioner orienting themselves towards a model and losing sight of the actual patient with their complex complaints and the interaction in the here and now. Linguistic conversation analyses can trace at the micro level what actually happens in the conversation and where, for example, misunderstandings or unfavorable formulations by practitioners lead to interactive problems or resistance. In the following, we would like to present in more detail problematic aspects of the conversation between practitioners and patients with somatoform disorders that can occur when raising awareness of and discussing psychosomatic explanations for the complaints.

If the presence of a somatoform disorder is suspected, physicians in the practice or clinic initiate a referral to psychotherapeutic treatment, as psychotherapy is the indicated treatment for the majority of complaints, alongside physiotherapeutic and pharmacological approaches (Henningsen 2007). This transition represents a challenge for all those involved, as referral to psychosomatic and psychotherapeutic treatment is often still experienced as stigmatizing. Patients regard terms such as "vegetative dystonia", "psychosomatic", "medically unexplained" or "functional exhaustion" as insulting. They interpret these terms as an insinuation that they are mentally disturbed or that they are imagining

or faking the symptoms (Stone et al. 2002). Most explanations given by physicians make patients with medically unclear symptoms question the reality of their complaints (Salmon et al. 1999). In this referral phase from purely somatic treatment to psychosomatic or psychotherapeutic treatment, it is possible in some clinics that psychotherapists are called in during an inpatient diagnostic clarification of the symptoms in order to assess the patients diagnostically in a conversation, to inform them about psychotherapeutic treatment options and to motivate them to undergo such treatment.

A few years ago, we examined such conversations with an interdisciplinary working group. These interviews were conducted as part of a study at the University Hospital with patients who were hospitalized to clarify unclear complaints and who were suspected of having a somatoform disorder. The data originate from the DFG project "The psychotherapeutic treatment of somatoform disorders in the context of the psychosomatic consultation and liaison service" at the Freiburg University Medical Center Department of Psychosomatics (cf. Fritzsche et al. 2005, Schweickhardt et al. 2007). Within this framework, specially trained psychological and medical psychotherapists conducted up to 5 interviews (each lasting 45-60 minutes) with 49 patients with MUS. The interviews are available as audio recordings. The interviews took place between 6/2002 and 10/2004. During the inpatient stay of the patients in the acute hospital, extensive diagnostics were carried out to clarify the physical complaints. The therapy discussions were based on a manualized procedure. The design of the intervention is primarily based on the modified reattribution model according to Goldberg et al. (1989) and integrates various psychotherapeutic approaches (Fritzsche et al. 2005, Schweickhardt et al. 2007). The aim of the study was to motivate patients for subsequent psychotherapy. We examined these recorded conversations using linguistic methods in order to reconstruct frequent and potentially problematic conversation patterns.

The analyses of the explanatory models in the interviews show that the therapists involved in the study often use one-sided psychological explanations for the patients' complaints (Birkner, Burbaum 2013, Stresing 2011). In the conversations and the explanatory models discussed, dichotomous explanatory models can be found - both in the conceptualizations of the patients and in those of the therapists: body vs. soul, organic vs. non-organic/head, conscious vs. subconscious/unconscious or also "having something" vs. "having nothing". Patients are sometimes offered a (simple) cause-and-effect correlation,

which they often reject as not plausible. We would like to take a closer look at this aspect below.

In the analytical analysis of the conversations (Stresing 2011, Burbaum et al. 2010), a very frequently used procedure was reconstructed in the analysis of the therapists' conversational activities, with which therapists attempt to increase the awareness of the patients to alternative disease models. We call this procedure "psychosomatic merging". In relation to the reattribution model on which the study is based, merging corresponds to the point of "making the link", i.e. an open connection between psychological and physiological factors (cf. Goldberg et al. 1989: 693). It is a rather *confrontational* procedure with which the therapists offer the patients a psychosomatic explanation of their physical complaints. While merging, the therapists establish a connection between a current or previous event, the psychosocial stressors experienced, the patient's feelings and their physical complaints. In the sense of external positioning, the patient's experiences, feelings and complaints are viewed against the background of a psychosomatic model and the patient is positioned as a potentially psychosomatic patient.

There are different types and realizations of merging (more abstract and general models vs. concrete and personalized attributions). The following - initially seemingly contradictory - phenomena can be found in most merging procedures:

1. The therapists argue a psychosomatic explanatory model and work on consent by building up interactive pressure on their counterpart in various ways.
2. The therapists often choose vague, cautious and sometimes impractical formulations. Sometimes this approach is combined with an explicit avoidance of the categorization "psychosomatic", which can lead to confused and helpless interventions that take on an explosive quality precisely because of this.

32.5.1 Interactive pressure

On an interactional level, therapists often use psychosomatic merging to build up a high degree of pressure in order to persuade the patient to agree to the model. This can be seen in various techniques that are repeatedly used: Therapists use questions (or question particles) that suggest an affirmative answer such as "can you imagine that...?" or use

tripartite enumerations, which are a (strong) rhetorical strategy to persuade the conversation partner to agree with their own point of view (Hutchby 2006, Jefferson 1991). The therapists repeatedly refer back to what has been said in previous conversations. For example, therapists integrate previously mentioned biographical events into the models or refer to patients' self-statements ("I am a rather reserved person"), which they cannot deny because they had previously characterized themselves in this way during an interview. It is not uncommon for well-known proverbs to be used, which as platitudes also suggest agreement. With these formulations, the therapists pick up on typical models - sometimes in a proverbial way, as recommended in the guidelines - from the patients' everyday lives (see Box 32.1). The disadvantage lies in the simplification of psychosomatic causal relationships, which does not do justice to current psychosomatic models of complex interactions (Rief, Broadbent 2007). With the at times diffuse symptoms, which have often become chronic over a long period of time in combination with other physical illnesses, simple models such as "stress can make you sick" can simply reach their limits.

E 32.2		Interactive pressure: "That you simply see ..."
		Third interview: 48-year-old female patient with diffuse symptoms (acute mainly weakness in the legs) and therapist
01	T	Well, but what is important to me is that you simply see ... [swallows] what you are carrying on your shoulders.
02	P	[hmhm
03	T	or on your back? [inhales] um ... what is piling up? ... what can . also change the experience of pain that you (.) mentioned earlier, yes . that it simply then leads to . stronger pain? ... it can lead to stronger fears, it can also lead to stronger let’s say ... depressive moods, yes? ... if this overall level of tension ... is high, yes?
04	P	hm=hm
05	T	... or it can lead to more physical symptoms, yes?
06	P	yes,
07	T	and as you have just realized yourself, So there's actually a very direct connection for you between this ... work-related stress?

		... and a physical ... reac[tion, yes?
08	P	[hm=hm,
09	T	now this . Stomach pressure or . bile or not eating
10	P	[hmhm
11	T	anything,

The therapist emphasizes the relevance of her following statement with the introductory phrase "what is important to me" and then goes on to establish a connection between psychosocial stress and physical symptoms. She first uses the saying "what you carry on your shoulders", corrects this to "on your back" and then explains "what" in more detail as "what is piling up". Although the statement is realized in a question intonation and the patient is also given an opportunity to answer, there is no listener feedback from the patient, so the therapist continues with her speech and mentions a change in the experience of pain as a result of the mentioned stresses. She refers back to the fact that the patient herself has already drawn attention to such a change.

The therapist then produces a `three-part list' and names three possible consequences of the burdens that the patient "carries on her back", with the consequences she names going further up a `stigmatization scale' in each case: First she names more severe pain, then more severe anxiety and as a final point she names more severe depressive moods. Lists of three are often used to demand an answer from the other person (cf. Jefferson 1991) or to convince the other person of one's own point of view (cf. Hutchby 2006). Despite a 'tag question' ("yes?") demanding an answer, the patient does not respond to her statement. The therapist then 'rounds off' her statement by pointing out that these are reactions that occur when the "overall level of tension" is high, which the patient ratifies with a minimal "hmhm".

The merging is relatively implicit on the verbal surface: The therapist does not name any specific stresses of the patient, but describes them with "what" or just with the relatively vague term "overall level of tension". As the therapist only receives very minimal feedback signals in this case, she continues her summarization and becomes more concrete and direct. She first shifts the focus from psychological problems such as anxiety and depressive moods back to "physical symptoms". She then refers back and points out that the patient herself felt a "very direct connection" between her work-related stress and a physical reaction to it. Shortly before, the patient had pointed out in the conversation that she already feels sick just thinking about her work. With this refer-

ence, the therapist can therefore refer not only to a statement, but also to a physical symptom of the patient, which she herself experienced in the here and now of the conversation. The therapist then specifies the "physical reaction" as "stomach pressure, bile, not eating anything", which the patient accompanies with approving auditory signals.

32.5.2 Vague and careful formulation to the point of "beating around the bush"

In contrast to the rhetorical techniques used in merging, which are often systematically geared towards the patient's agreement, many of the merging methods are also relatively cautious, implicit and sometimes downright impractical at the content level. For example, there are numerous modulizations in merging, e.g. with modal particles such as "somehow", "actually" or "maybe", which downgrade the absolute claim of the attribution and with which the therapists reduce the scope and the claim to validity of their statement. In addition, the therapists often frame their statements as their subjective view and frequently end the merging with concluding questions to the patients as to whether they can accept the psychosomatic merging.

E 32.3	Vagueness I: "not quite sure"
Second consultation with 40-year-old female patient with back pain, abdominal cramps, diarrhea with therapist.	
01 T	um, but I have ... the . fear, and it will . maybe not: be possible to one hundred percent: ... um: to clarify that perhaps ...that you might also be disappointed after such an operation , that just ... the state of your condition ... that um, do you understand, I have . um . a bit of a feeling ... um that your ... clinical picture is very very ... complex and I'm not quite sure whether it is possible with such a um such a single finding to really sufficiently explain it, ... what [do you think

In connection with this vagueness, but also independently of it, therapists choose, for example, descriptive and suggestive terms such as "tension" or "restlessness" in the context of merging, which allow an in-

terpretation in both a physical and psychological direction. In this way, they avoid explicit terms such as "psychosomatic".

E 32.4	Vagueness II: „That would be, so to speak…maybe"

Second consultation with 40-year-old female patient with back pain, abdominal cramps, diarrhea with therapist (at a later date)

01	T	... I think it's more that... what I might also have to consider: that there is a . a core problem that can be ... solved or perhaps that can not always be solved,
02	P	Hm
03	T	or can not be solved as perfectly as you would like, which is of course quite understandable, ... and that it is . about this . core problem which is of course the most important and . completely in the foreground, ... so that would be your physical ... complaints and your illness . p ... perhaps also ... smaller ... problems group around it . hm where a certain assistance is possible, that would be, so to speak . maybe um what . um I could perhaps offer you in a conversation, um so I . um I don't think it's about hm assuming um:: a psychological . causation of this disease, or even ... uh it being imagination which yes um: so . which should be quite a: ... um let's say um humiliating um horrible um ... hm um hm accusation if you . if you got told that, you must ... probably... um . yes: yes . think that is very bad, At least that's how I imagine it,
04	P	so if you were to accuse me of that, that would

The therapist refers to the patient's "core problem", which, however, is only specifically named after several repairs and parentheticals ("that would be your physical complaints and your illness"). First, she explains that this core problem can be solved, but then she repairs this statement twice, so that her original statement is almost reversed. In

her following statement, she identifies the patient's physical complaints as the central problem. In doing so, she explicitly acknowledges the legitimacy of the patient's complaints and emphasizes the patient's credibility.

However, she then refers to other possible psychological or psychosocial stresses that she can work on with the patient in the interviews. However, the stresses are not explicitly named, but are paraphrased as "smaller problems" that are "grouped around" the core problem. The therapist is clearly trying to avoid even remotely categorizing the patient as psychosomatic. She then rejects the patient's accusation that she is imagining her complaints. The therapist mentions psychological causes and an imagination of the complaints virtually 'in the same breath'. Although "psychological causation" is distinguished from "imagination" on a syntactic level by "or", the direct succession of both symptom triggers alone suggests that they belong to the same category.

Even if this example is an extreme example: Impractical and difficult to understand formulations are repeatedly found in the conversations. They can be seen as an attempt to explicitly avoid categorizing the patient as a "psychosomatic patient", which is assumed to be offensive. On a verbal level, however, this leads to a form of expression that could be described in everyday language as "beating around the bush" and which has a rather unsettling, irritating effect on patients. This may be the first time that patients are made aware of the (potentially) delicate nature of the statement (cf. Bergmann 1992). The vagueness and caution of the therapist - as in the previous example - sometimes take on such an extent that they become counterproductive and turn into the opposite.

32.5.3 Patients' reactions to the psychosomatic merging

With regard to the patients' reactions to the merging, two aspects should be emphasized: Many patients simply let the therapists' attempts at psychosomatic explanations using various strategies come to nothing: for example, they pick up on one aspect of the explanation and take it further - but without actually addressing the psychosomatic connection addressed by the therapist. For many patients, it seems perfectly plausible that psychological stress can have an effect on the body. In conversation, however, they make it clear to their counterpart - sometimes subtly, sometimes quite explicitly - that the specific explana-

tions based on childhood or other life stresses only make limited sense to them or simply do not fit their specific, often massive physical complaints. Here they often perform a kind of diagnosis of exclusion, with which they argue why a psychogenesis of the complaints is out of the question in their case.

What is also striking in the analyses is the phenomenon that patients often give the impression that they have to justify themselves in discussions with the therapists. They make it clear that they do not always feel that their complaints are taken seriously and "prove" and defend these complaints, as if they have to fight for their "right to stay" in hospital and in the conventional medical system. Occasionally, they even defend their entire lifestyle ("But I've always done well with this strategy, otherwise I wouldn't be where I am now professionally") - as if they had to fend off an attack on their entire person. A psychosomatic explanation, but sometimes even just talking to a therapist in itself, seems to be a threat to their self-image for quite a few patients. In this context, the dichotomy of "physically ill vs. imaginary", which patients sometimes open up in conversations, is also striking: As an alternative to a physical illness underlying the complaints, patients construct "nothing" or imaginary complaints as a contrast. This conceptualization has a highly appealing character and may be used by patients as a provocation. At the same time, however, it can express the helplessness and irritation that no other explanation is conceivable.

32.6 Conclusion and suggestions for practice

The conversation analyses revealed possible pitfalls and dangers when speaking with patients with somatoform disorders. Both the interactive pressure with which the therapists offer a psychosomatic reading of the complaints and the vague, impractical formulations show the difficulties that even therapists with communication training have to contend with when talking about somatoform complaints. [2]

The analyses presented here focused on the question of how the therapists attempt to explain psychosomatic issues to the patients and how the patients take up these explanations. The question of which ex-

2 See Burbaum et al. 2011 and Stresing 2011 on the extent to which the results of the analyses apply specifically only to the setting studied (study in the context of the psychosomatic consultation service in an acute clinic).

planatory models were discussed in detail in the interviews and how joint search activities for explanations unfold over longer periods of time has been examined in more detail elsewhere (Birkner, Burbaum 2013, Stresing 2011). We have not discussed here which explanatory models were found or should be found for the respective complaints. There are two reasons for this: On the one hand, the question of explanatory models should be developed in a very individualized process with the patients and should take up the patients' own explanations for their complaints. Secondly, the explanatory models of the somatic and possibly psycho-physiological correlations should be based on the state of knowledge of the respective specialist discipline. In view of the wide variety of symptoms, these cannot be addressed here.

What can be taken away from the analyses for practical use?

32.6.1 From the reattribution model to "tangential" conversation management

The study, from which the underlying data corpus originates, and the treatment manual, which was available to the therapists involved, are based on the modified reattribution model (Goldberg et al. 1989), which has been the basis of most communication training courses for doctors on somatoform disorders for over 20 years. This model focuses on the reattribution of the cause of the complaint towards a psychosomatic explanatory model. A few years ago, the leading British working group in research on doctor-patient conversations in somatoform disorders reviewed the study situation on the reattribution model in MUS (Gask et al. 2011) and, on this basis, critically discussed the model and questioned it in its original form as being too simplistic. For example, follow-up studies have shown that the proportion of complaints that were initially considered medically unexplainable but later became medically explainable was higher than previously assumed (in a study by Morriss et al. 2007 it was just under 10%). Therefore, mutual vigilance as to the extent to which organic pathologies are present is definitely appropriate and consultations should take this possibility more into account. A one-sided pursuit of the reattribution model runs the risk of closing off communication for this option. The interactive resistance of patients to one-sided psychosomatic interpretations (Burbaum et al. 2010, cf. also Stresing 2011) and the patients' demands for an open-minded search for medical causes reconstructed in our analyses (Birkner, Burbaum

2013) appear very justified against this background. Overly insistent questioning of possible psychosocial problems as an explanatory cause/trigger of the complaints by the therapists also appears both one-sided and questionable.

In addition, a randomized controlled trial showed that the interview technique in which a general practitioner offered a physical explanation of the complaints (e.g. "stress-related release of hormones causes complaint XY") and approached the patient's sensitive issues indirectly led to a significant improvement in quality of life compared to the reattribution approach (Aiarzaguena et al. 2007). In this context, we speak of a "tangential" conversation (Rudolf, Henningsen 2003, Schäfert et al. 2008) (§ 3.2, 17.3). Our analyses emphasize that psychosocial issues should be addressed in a non-confrontational and non-insistent manner in initial diagnostic discussions and also in the further process. The alternation suggested in the guidelines between addressing psychosocial issues and returning to the complaint may seem unsatisfactory at first glance, but it is better for the patient and the physician-patient relationship than forcing the patient to work towards an - overly simplistic, one-sided and premature - psychosomatic explanation of the complaints.

32.6.2 From vague "beating around the bush" to clear, appreciative and recognizing guidance

However, one conclusion from the analyses is that a *tangential* conversation should not be confused with an overly cautious, overly vague and "convoluted" conversation. An overly modalizing and attenuating approach has an unsettling and irritating effect and can be interpreted by patients as a warning signal that the practitioner is addressing something sensitive and difficult. Instead, a clear, sincere, patient-centered approach should be the way to go. Since patients obviously feel personally questioned by the lack of a "correct" diagnosis, practitioners could address the concern, distress and uncertainty caused by the lack of diagnosis and normalize this situation for the patient. Against the background of the interview analyses, it seems all the more important to recognize the strain of being confronted with the complaints, the associated impairments and uncertainty and the accomplishment of living with them. This can be expressed by simply listening to and taking up the description of the symptoms.

The inclusion of other life achievements and resources can also help the patient to cope with the unsettling situation, as well as following a treatment path in which a wait-and-see openness is maintained (instead of escalating overdiagnosis, which is not medically indicated on the basis of the findings to date). Strengthening the relationship with the patient by taking the symptoms and the possible powerlessness and anger over the unsuccessful examinations seriously, is as important for all parties involved as the further search for a plausible explanation for the complaints. In this "relationship-strengthening" approach, the patient can then also more easily follow the path to accompanying psychotherapeutic support (whilst still going to the general practitioner!). This can be suggested, for example, to "find strategies that help to cope better with the symptoms".

Box 32.2 Exercise and suggested solutions (case of Mrs. A)

Based on the guideline recommendations (§ 32.4), please consider how you could conduct the conversation (E 32.1) with Ms. A. to discuss the findings.

GP: Hello, Mrs. A. Come in. How are you feeling today?
P: Oh, if it weren't for the pain, it would be fine. I'm actually on vacation, but we didn't go travelling after all. This rumbling in my gut, especially when I eat something fatty late in the afternoon, just can't be normal. And my wrists were so bad again the other day ...
What could you answer? How could you discuss the findings?
– Write down possible answers here:

The following small selection of *formulations* and *ideas* are *suggestions* for different ways in which you may be able to understand and reach Ms. A. Of course, they are by no means to be transferred to other conversa-

tions in a template-like manner, but are intended to show different starting points here (see also Hausteiner-Wiehle et al. 2013: 57ff).

- Providing information, ensuring transparency, acknowledging complaints and showing confidence: *"Mrs. A, the findings are all here and I can tell you that they are normal. On the one hand, this means that there are currently no indications that the rumbling in your gut is due to a serious illness. On the other hand, I can't yet say how we can get the symptoms under control."*
- Ask about the burden of symptoms and psychosocial aspects of the complaints: *"Would you like to tell me again exactly what complaints you have at the moment?" - "To what extent are you affected by your symptoms at the moment?"*
- Address emotions throughout (fear and anger in the case of "unclear" complaints/findings) (§ 20); accompany narratives empathically (§ 19, 20); a tangential conversation is often sufficient here (§ 3, 17): *"What a shame you had to cancel your vacation because of the complaints."*
- Ask about subjective theories of illness (§ 21): *"I can see that you are really unwell with this rumbling and I know that you have been suffering for a long time now. You have probably often wondered where your complaints actually come from. What are your assumptions?"*
- Acknowledge subjective explanations and comment professionally if necessary: *"I can now better understand that you are worried that you might also have a tumor after you experienced the illness of your brother up close. And that you now want to be particularly careful, as it was detected too late in his case. We already have a lot of lab results for you and you can be really reassured ..."*
- Make a diagnostic classification and offer to explain the symptoms as stress-related: *"In medical terms, we describe such complaints as functional. This means that the course of physical processes is impaired, but not the organs themselves. This can indicate a stress reaction."*
- Although many patients are open to such explanations, a rejection should be accepted (and no further insistence should be made for the time being): *"But that is inconceivable for you."*
- Use questions to focus on resources, exceptions and coping strategies. Movement, relaxation techniques, body-oriented relaxation techniques, self-care behavior and, if necessary, relief through conversations can be discussed as therapeutic methods: "Is there *something that you notice helps you when your gut is rumbling again?" - "Are there times when the symptoms are better?"*

- Encourage patients to keep a symptom diary. Offer and arrange appointments independent of symptoms: *"If we don't find any causes, it doesn't mean that we can't influence the symptoms at all. The human body is very complex and many external and internal stimuli have an influence on our well-being. If we want to know how you can improve your symptoms, we need to work together to understand them better. I would like to suggest that you keep a symptom diary for the next two weeks. I will give you a form and explain it to you in more detail. We will then meet again in two weeks and take a close look at your diary."*
- Bridge the time until the next consultation (§ 23): *"Do you think you will be able to cope with the symptoms until then* (if necessary, name the patient's own successful strategies)?*"*
- If the symptom diary shows a connection between stress and the symptoms, destigmatizing normalization and pointing out simple explanatory psychophysiological mechanisms can help: *"Many of my patients react to moments of overload with digestive complaints" - "Our intestines are controlled by the autonomic nervous system. If something stresses us, causes us anxiety or stress, the autonomic nervous system reacts and this can lead to digestive complaints, for example."*

32.7 Further information

On the internet, the S3 guidelines "Non-specific, functional and somatoform body complaints, dealing with patients" from 2012 (AWMF 2012) and the S3 guideline Functional body complaints (AWMF 2018) offer an easily accessible and comprehensive insight into the topic in varying degrees of detail and also patient guidelines.

The practice book (Hausteiner-Wiehle, Henningsen 2015) also provides a wealth of suggestions and examples on communication. Introductions for patients (e.g. Rauh, Rief 2006, Lieb, v. Pein 2009) also offer an easy-to-understand introduction that provides suggestions for explanatory models and procedures.

In our experience, however, there is often a break in the application and use of such models in real conversations, and a model can succeed or fail with the respective concrete linguistic implementation in the very specific context of the conversation. We therefore recommend that you occasionally record such a conversation with patients with somatoform

or unclear physical complaints (with the patient's consent, of course) in order to critically reflect on and constructively expand your own conversations. When listening to it again and even more so when writing it down, your own strategies (e.g. interactive pressure or "beating around the bush") become clearly visible. The way in which patients respond to your interventions gives you clear feedback (in terms of intonation, content, detail, etc.) as to whether he/she feels that you are taking him/her seriously or whether he/she has fallen into a defensive position.

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Citation note

Burbaum C, Fritzsche K, Stresing AM (2025): Communication in Somatoform Disorders. In: Koerfer A, Albus C (eds.): Medical Communication Competence. Göttingen (Germany): Verlag für Gesprächsforschung.