CHAPTER 14
THE PSYCHOSOMATIC PATIENT

Everyone has psychosomatic aspects of their emotional lives. Reactions such as rage, guilt, fear, and love have physiological components mediated through the neuroendocrine system, and that same system can directly affect subjective aspects of emotion and cognition. These relationships among brain, mind, muscles, immune system, mood, cognition, and perception are dauntingly complex even before adding in variables such as age, licit and illicit drugs, motivation, and patterns of psychological conflict and defense.

Evaluating psychological components of a physical symptom is, therefore, complicated. Traditional questions to be answered in making this determination include the following:

1. Does the patient's symptomatology not fit into a known pattern of organic disease?
2. Can the physical symptoms be explained in terms of the patient's emotional conflicts?
3. Were emotional or interpersonal stresses prominent in the patient's life at the onset of the condition or clearly related to remissions and exacerbations?
4. Does the patient attach unusual psychological meaning to his symptoms?
5. Can a psychiatric condition be diagnosed, and are the physical symptoms consistent with this diagnosis?
6. Does the patient obtain secondary gain from his illness?

The exact degree to which such psychological factors contribute to physical complaint often remains uncertain. This uncertainty can frus-
trate everyone involved, including the psychiatrist, other physicians, and the patient. This chapter outlines an approach to the psychosomatic patient that emphasizes alliance building as well as techniques that can help determine the degree to which psychological factors are contributing to the physical complaints.

PSYCHOPATHOLOGY AND PSYCHODYNAMICS

Range of Psychopathology

There are multiple categories of psychosomatic illness. First, patients can have a psychological reaction to medical illness. The news of a serious illness may cause a previously healthy person, for example, to become sad or to have a catastrophic psychological response with prominent denial and distortion. Included in this category would be exacerbations of long-standing personality or Axis I disorders. Second, patients can have a medical illness that physiologically induces a psychiatric syndrome. For example, certain cancers evoke a cytokine cascade that can cause depression and irritability, which may in fact be the first sign of the malignant process. A third group of psychosomatic patients have definable medical illnesses that are worsened by psychological distress. Examples include irritable bowel syndrome, psoriasis, and asthma. This would also include a cluster of incompletely characterized disorders such as fibromyalgia, chronic fatigue syndrome, and multiple chemical sensitivities.

Two additional groups of psychosomatic patients tend to arouse particular physician concern. Somatoform patients have physical complaints that lack organic explanation and are presumed to have a psychological etiology. An example is conversion disorder, in which the complaints are neurological. A patient may present with seizures, but the movements do not appear typical and the electroencephalogram is negative. As with all somatoform disorders, the medical problem is not the result of intention but reflects unconscious conflict and anxiety. A final group of patients consciously fakes symptoms. The patient might be faking for obvious gain, as in malingering, or the patient might have factitious disorder in which he consciously feigns illness for reasons that are not clear to the patient but relate to being in the sick role. A severe variant of factitious disorder is Munchausen's syndrome, in which the pursuit of the sick role may lead patients to long hospitalizations, repeated surgeries, and even death.

In practice it is difficult to make these clinical distinctions. There are
no definitive diagnostic tests for any psychosomatic illness. Some of the
diagnostic distinctions rely on assumptions about unconscious pro-
cesses, and it is unusual for the physician and patient to agree on a diag-
nosis of somatoform disorder, factitious disorder, or malingering.
Finally, individual patients tend to straddle diagnostic boundaries. In
any one patient, cancer might lead to a psychological response of sad-
ness as well as a cytokine-mediated depressive response. The same
patient's anxiety might lower his pain threshold and cause a dormant
case of fibromyalgia to flare up, leading to multiple ill-defined pains
that do not conform to the oncologist's expectations. That same patient
might then seek pain medications by consciously dramatizing his pain
symptoms while also seeking the sick role by exaggerating his level of
disability. It is not surprising, then, that primary care physicians tend to
view psychosomatic patents with trepidation.

Psychodynamic Issues

There are a broad range of psychodynamic issues that apply to the psy-
chosomatic patient. For example, physical illness tends to induce re-
gression. Depending on basic character structure, one patient may lapse
into a helpless and dependent state, another may become sad and anx-
ious, and yet another may appear to obtain significant gratification
from his dependency. Disease can induce particular suffering in pa-
tients who unconsciously experience the illness as a punishment for
prior misdeeds. Other patients use projection to convert this suffering
into a punishment of loved ones while they appear to feel normal.

Denial is a common mechanism of defense in the psychosomatic
patient. Even when the acknowledgment of emotional conflict is ines-
capable, the patient may deny any relationship of the conflict to his
symptoms. For example, physical symptoms frequently have an over-
lay of neurotic complaints built upon a minimal degree of organic pa-
thology. Physicians sometimes feel that these symptoms will disappear
as soon as the minor physical ailment is clarified and treated. Instead,
many of these patients end up feeling misunderstood by their physi-
cians and cling even more tightly to their complaints.

Specific psychodynamic constellations have been proposed to ex-
plain the etiology of such medical disorders as asthma, peptic ulcers,
hypertension, and inflammatory bowel disease. These attempts to pre-
dict symptoms from dynamic formulations have been largely unsuccess-
ful. Not only are the psychological conflicts nonspecific, but their
importance in the etiology of each condition is unknown and probably
varies considerably.
Many people use their bodies as defenses. In somatization, painful emotional feelings are transferred to concern about body parts. This can make psychotherapy frustrating because such patients are unable to use words to describe feeling states. Conversion is characterized by the representation of intrapsychic conflict in physical and often symbolic terms. This can be seen in a young man whose urge to hit someone led to the psychogenic paralysis of his arm. In so doing, he converted his conflict over an unacceptable wish into motor symbolization and developed a conversion disorder.

Unconscious processes affect everyone, however, and they do so in ways that have more to do with the individual than with the particular medical complaint. The interview of the psychosomatic patient should, therefore, be aimed at understanding the person rather than applying preformed psychodynamic theories to a symptom cluster.

Differential Diagnosis

Many patients have physical complaints that are secondary to a primary Axis I disorder, and these, although "psychosomatic," are not discussed in this chapter. For example, many patients with major depression present with solely somatic complaints. Similarly, anxiety can increase the tendency to focus on physical sensations, and panic disorder often mimics a heart attack. Alcohol and substance abuse lead to insomnia, aches and pains, and a variety of withdrawal effects that can be misinterpreted or misreported by the patient. Some psychotic disorders present with somatic delusions. For example, parasitosis refers to belief of infestation. It is a delusion that can be neatly circumscribed, leaving the patient otherwise rational and functional. This is in contrast to the patient with schizophrenia who may have somatic delusions that are part of a more obviously bizarre cluster of symptoms. When interviewing patients with prominent somatic complaints, it is important to screen for these primary psychiatric diagnoses, because the interview and the treatment will be quite different.

MANAGEMENT OF THE INTERVIEW

The Opening Phase

The patient with a psychosomatic problem may be particularly uncomfortable coming to see a psychiatrist. Rather than perceiving the psychiatrist as a source of help, the patient fears that the referral means that his primary physician considers his complaints imaginary or that he
may be crazy. Therefore, it is helpful if the interviewer spends time at the beginning of the interview putting the patient at ease. For example, ask the patient, “What did Dr. X tell you about the reasons for this referral?” This development of a therapeutic alliance is critical and is promoted by beginning with a series of medical-model questions. The particular questions should be individualized based not only on the patient’s presentation but also on the information earlier gleaned from the referring physician and a careful consideration of available medical records. The nature of the physical complaint should be addressed early in the initial meeting, and premature psychologizing should be avoided. Instead, find out from the patient how he views the consultation and clarify misunderstandings.

Many of these patients will hesitate to begin the interview without some notion of how it might help. A typical response might be, “I’m not certain that it will help, and that’s what you and I will determine. It sounds like your medical problems are difficult for you. Many people with similar difficulties have found talking about it helpful.”

Patients with puzzling physical complaints are often leery of a psychiatric consultant, fearing that their physical problems will be ignored. This concern can be addressed in several ways, including by demonstrating an interest in the problems and an intention to help with those problems. For example, the following interchange took place with a woman with unusual neurological problems.

**Patient** (angrily): My doctors haven’t done anything to help me. They don’t understand or care how I do.

**Interviewer:** You feel that they have been uncaring, but you have also emphasized that they have been active in ordering tests and prescribing medications.

**Patient:** They had been active. They are getting tired of me. I think I was an interesting diagnostic dilemma, but now even the medical students find me boring.

**Interviewer:** Do you think that may be why they called me?

**Patient:** Yes, because they don’t care anymore.

**Interviewer:** Maybe they see me as another type of test or treatment. Something that will give them some clue about how to help you.

**Patient** (pausing, and with a significant change in mood): Do you think you can actually help?

**Exploration of the Presenting Symptoms**

The medical model is particularly helpful with a wary interviewee. Ask about the symptoms that are most bothersome: “What do they feel like? When did they start? Is there a pattern? How serious are they? How dis-
abling? What helps and hurts?” Develop a medical history that focuses on both present concerns and previous treatments and hospitalizations. A brief family and personal history and a description of the patient’s life situation are often obtained in the early phase of the interview. Most patients are accepting of such structural questions as long as they conform to their expectations of a medical interview. Long silences can increase patient discomfort and erode the budding alliance, so the interviewer should remain interpersonally active and supportive of the patient’s characteristic defenses. It is ineffective to ask such a patient to “say what comes to mind.”

In addition to a longitudinal medical history, it is useful to obtain a detailed parallel history of the patient’s life at the onset of the illness. It is seldom effective to ask questions such as “What was going on in your life when the pains began?” Many of these patients do not spontaneously link conflict with symptoms. Furthermore, such an approach may inform the patient that the interviewer is relatively unconcerned about his patient’s somatic concerns and intends, instead, to focus on a presumed psychological etiology.

It is often more useful to take parallel histories. The first covers the physical complaints using a medical model. The second is a survey of the patient’s life, with particular attention paid to clues concerning psychosocial stresses that might be related to the patient’s complaints. The interviewer may quickly detect links that have remained out of the patient’s awareness. It is often reasonable to suggest that certain emotional responses may have been temporally related to the onset of the physical symptoms and then evaluate the patient’s response. As in other interviews, if the patient becomes mistrustful and withholding, it is often useful to back up and discuss the patient’s mistrust, along with the concerns that motivate it. The interviewer can explain (or reexplain) that a goal of the interview is to get to know the patient as a person, that such an effort has been useful in cases similar to his, and that it is important to understand how the disease affects the patient’s life as well as the physiology of the symptoms.

Frequently, it is useful to ask the patient if he has known anyone with an illness similar to his own. The answer may reveal unconscious attitudes about his illness and clues concerning its origin. Although psychosomatic patients frequently resist attempts to correlate symptoms with specific psychological situations, they will often indicate that their symptoms occur when they are nervous. At this point the interviewer inquires, “What kind of situation makes you nervous?” Other questions include “What did you notice first?”; “How did it all begin?”; or “When do you last recall feeling well?” On some occasions, asking
the patient to describe a typical day in detail, or to describe all of the events of the past week, will successfully circumvent the patient’s defenses.

As the interview progresses, the physician may develop the sense that psychological factors play a significant role in the patient’s complaints. Even so, many patients will remain reluctant to link somatic symptoms and emotion. Certain techniques can help the patient develop a greater awareness and heightened sensitivity to his feelings. The patient may deny the role of anxiety, fear, or anger in the production of his physical symptoms, for example, but may readily acknowledge psychological symptoms such as tension, depression, insomnia, anorexia, fatigue, nightmares, or sexual disturbances. He will often explain that his physical illness is making him nervous or upset. The interviewer is advised not to challenge this patient, nor the one who totally denies nervousness, too early in the interview. The goal is not to push the patient into agreeing to a connection but rather to intrigue the patient into a curiosity about himself. The interviewer might wait until the patient has displayed anxiety, blushing, or sweating during the interview, for example, and then inquire whether the patient links this behavior with nervousness.

A common psychosomatic consultation is for pain, a complex subjective phenomenon. All pain is “real.” It is almost always ineffective and inaccurate to suggest that pain is being consciously faked or exaggerated. Instead, the interviewer can begin by obtaining a careful description of the pain, when it began, what seems to bring it on, and what seems to help it, as well as the patient’s understanding of its cause and significance. Patients whose complaint of pain or preoccupation with physical symptoms is a manifestation of depression may initially deny awareness of depressed feelings. However, if the interviewer refers to the pain and other symptoms by saying to the patient, “It must be terribly depressing to suffer like this,” the patient may readily acknowledge that depression is a reaction to his pain. It may be more difficult for the patient to accept that pain is intensified by depression. As with many psychodynamic possibilities, it is more useful to suggest the link and await the patient’s response. Further insight may not even be necessary. If the pain can be treated with some combination of medication, supportive psychotherapy, yoga, and acupuncture, for example, then the patient’s depressive complaints may diminish without regard to his level of insight. The management of these problems is further discussed in Chapter 7, “The Depressed Patient.” The management of the patient with acute anxiety symptoms is discussed in Chapter 8, “The Anxiety Disorder Patient.”
To better understand the psychodynamic significance and possible secondary gain of the symptoms, the psychiatrist might ask, "What does your illness keep you from doing?" or "What would you do if you were well that you are not able to do now?" It is also useful to ask how family members and doctors view the patient’s complaints as well as how the patient views the doctors. This can open a window onto the patient’s object relationships and his level of psychological sophistication and capacity for trust. It can also promote an alliance by allowing the interviewer to point out the patient’s disappointment and unfulfilled expectations.

In exploring both the central meaning and the secondary gain of the symptoms, it is important to explore who within the family is affected by them. Disabling symptoms may have led to a family dynamic in which the patient has become gratifyingly central. That patient’s unconscious reward may make treatment difficult. A different patient may say, "My husband doesn’t realize how much I suffer with these terrible backaches." The interviewer could reply, "What does he think about them?" As the patient proceeds to discuss her husband’s feelings about illness and his lack of sympathetic understanding, the connections between the meaning of her symptoms and his disapproving, rejecting attitude will gradually emerge.

The interviewer is often unable to discover any specific precipitating stress in the patient’s life, but instead the illness seems to arise as a result of the cumulative effects of life stress. This is particularly true of the individual who lives under the constant pressure of an obsessive-compulsive personality. The interviewer should refrain from offering well-meaning advice such as "Stop worrying" or "Try to relax." Instead, he might explain that chronic stress seems to be worsening the physical symptoms. This can lead to discussions of chronic worries and tensions and ways in which such problems can be reduced or addressed.

**Exploration of the Psychological Problems**

Many psychosomatic patients are concretely literal. Repeated questions that begin with “why” may frustrate them and undermine the early alliance. The interviewer should allow the patient to describe his emotional reaction to the symptoms without suggesting a cause-and-effect relationship. Some patients with unexplained medical complaints are introspective and psychologically minded and may relish the opportunity to share their theories. At times, these theories may appear to be a psychoanalytic caricature, as in the patient who believed that her abdominal pain was secondary to unconscious identification with her
pregnant mother when she had been in labor with the patient. The psychiatrist could ask, "Was your mother's delivery of you quite painful?" If the patient replies affirmatively, the interviewer could continue, "And has she ever implied that you continue to cause her pain?"

Regardless of the levels of apparent insight or pseudo-insight, it is useful to explore the patient's understanding and feelings about his illness. It is also helpful to assess the limitations the symptoms impose and the patient's theories about the cause of the symptoms and the prognosis. Patients may freely admit that their symptoms worsen under stress. This admission creates a natural segue to a discussion of situations that cause stress and anxiety.

The patient should be asked how he has helped himself; for instance, has he tried diet, meditation, exercise, or massage? By mentioning these types of treatments, the interviewer has not only stamped them with legitimacy but also demonstrated a belief that nonverbal efforts can be helpful. Similarly, it is useful to demonstrate knowledge of subsyndromal constellations. For example, the interviewer might ask a hypochondriacal patient if his concern is predominately focused on his body, a fear of disease, or a conviction of having a disease. Such spontaneous discussion of details helps not only with treatment strategies but also with development of the therapeutic alliance. Similarly, the interviewer might comment on the patient's strengths, such as the ability of the person with hypochondriasis to focus intently on small details or the ability of the severely abused woman with somatization disorder to maintain her household in the midst of much stress. The interviewer should try to avoid exacerbating the shame that regularly overwhelms psychosomatic patients.

Some of these people have suffered with various illnesses for many years, and their medical complaints and physical disabilities have gradually structured their self-concept, their social situation, and their interpersonal relationships. Few of these patients will want or be able to recognize their unconscious compromises. Although the interviewer may want to link such a patient's symptoms and life situation, the patient will likely respond defensively. Reassurance and supportive treatment based on the interviewer's psychodynamic understanding of the problems are more effective. If tactfully inducted into therapy, such a patient may eventually become curious about himself and develop a more psychological approach to conflict. Early confrontation is unlikely to accomplish anything other than undermining the alliance and reducing the likelihood that such a patient will become curious about his condition. If reassurance had worked, the patient would presumably not have been sent for a consultation.
Each of these patients warrants a biopsychosocial evaluation. In particular, efforts at defining intrapsychic etiology and psychological ramifications should be intermingled with an awareness of the patient's social milieu as well as an understanding of biological disease models and the patient's particular medical situation. In other words, attempts to use psychodynamic paradigms to fully explain somatic symptoms have been as unsuccessful as attempts to rely on physical examinations, laboratory tests, and computed tomography scans or to rely fully on an investigation into the accompanying secondary gain of the illness.

The Patient's Expectations of the Consultant

The psychosomatic patient expects to ask questions and to receive answers from the psychiatric consultant. Frequently the patient will ask the doctor, “How is talking going to help me?” The physician might explain that emotions have an important effect on the body and offer a brief explanation of how emotional factors can produce or intensify symptoms. Long and complicated explanations give the interview the quality of a lecture and are best avoided.

On some occasions the patient will ask, “Do you think I’m crazy, Doctor?” or “Is it all in my mind?” The physician could reassure the patient that his symptoms are real and that he is not going crazy. The psychiatrist may want to follow up such concerns by discussing the possibility that psychological issues could be intensifying the patient's medical complaints but that this does not mean the patient is insane.

In another situation the patient may surprise the interviewer by asking, “What’s my diagnosis, Doctor?” or “What is really wrong with me?” This can be an excellent opportunity to explore the patient’s fears and fantasies about his illness. Reassurance is more effective when it is specific to the patient’s situation. For example, the patient may have vague abdominal pains that have yielded no diagnosis but that the patient believes are caused by AIDS. He may have, for example, developed vague fantasies of retribution for sexual behavior that he finds shameful. In the patient’s mind, the abdominal pain indicates AIDS, which indicates painful death. This equation binds his free-form anxiety and allows him to focus on only one big problem: dying from AIDS. After noting his recurrently negative HIV tests and his shameful feelings about his sexual activity, the psychiatrist can tactfully point out this link. The doctor can then indicate to the patient that the anxiety will persist and that longer-term therapy can be useful to work on the bigger issues of free-floating anxiety and shame.

A different patient with vague abdominal pain may have developed
intense anxiety after being diagnosed with colon cancer. After prolonged hesitation, he might ask the psychiatrist how long until he dies the same painful death that was suffered by his own mother, who had the same disease. Reassurance in this case could include clarifying the reality that treatments for cancer and pain have both significantly improved since his mother died. Tactful honesty remains the goal, but it is important to appreciate the specific situation. The patient who asks, “Doctor, do I have cancer?” and then adds, “If I do, I will kill myself” will likely need the truth deferred while his psychological state is explored.

**Countertransference**

As in other clinical situations, the psychiatrist’s interview of the psychosomatic patient should combine tact, timing, honesty, and curiosity. Diagnosis and treatment can occur simultaneously. Awareness of both transference and countertransference helps to guide the interview. There are, however, important differences from the typical interview, not least because the nature of the presenting complaint can lead the interviewer to a disregard of each of the above principles. The disregard often stems from unanalyzed countertransference toward a difficult patient, but it can also stem from the interviewer’s anxiety about stepping into medical waters that are unknown or long forgotten.

The interviewer may collude with the patient in avoiding painful feelings by conducting a dryly insensitive fact-finding mission. Alternatively, the interviewer may pursue affect-laden personal and psychodynamic information in an effort to uncover the hidden origins of the medical complaint while avoiding physical reality. The interviewer may think it unobjectionable to link symptoms to their psychological meaning, but this patient will likely recognize that such a perspective is not his own. This patient tends not to believe that psychology plays a role in his symptoms, and an initial interview that is focused only on feelings and intrapsychic conflicts will be experienced as intrusive, unempathic, and adversarial.

Psychosomatic symptoms have eluded complete characterization, and uncertainty tends to prompt medical skepticism. The patient is often a vague or unreliable historian, and if not, he tends to be scrupulously and obsessively focused on symptoms that appear exaggerated. As the clinician becomes frustrated, a somatoform disorder is often considered, which tends to lead to disinterest in the patient’s actual experience and a focus on behavior management. As the patient feels increasingly misunderstood and criticized, he may become increasingly angry or hurt, which tends to confirm the doctor’s diagnosis of psychological
causation. When the patient abandons treatment for another round of “doctor shopping,” the physician is both convinced of the diagnosis and relieved.

The psychiatrist may feel that both the patient and the referring physician possess expectations of magical relief. This pressure can lead to various types of errors, including the attempt to quickly wrap up the patient’s psychological issues during the first session. It may be useful to recall that symptoms may have been developing over a lifetime and that useful biopsychosocial interventions may require a considerable effort by the consultant and the referring doctor as well as family and social services.

When confronting a situation in which the patient and the primary physician are at odds, it is useful to explore the situation rather than take sides in the battle. Early interpretations tend to be ineffective, whether addressed to the patient (e.g., “Your anger at your doctor is actually a projection of your own primitive rage”) or to the referring physician (e.g., “Your premature diagnostic closure is a defense against anxiety”). Such comments are unlikely to have an impact except to focus hostility toward the psychiatric consultant.

The interviewer’s underlying attitude should be of respectful, tactful skepticism toward all information. While maintaining an explicit interest in the patient’s experience, for example, the interviewer should look for obvious secondary gain and precipitating psychological stressors. Similarly, the interviewer should be attentive to the fact that the difficult patient can lead to an uncharacteristically incomplete medical evaluation and that the interview is another opportunity to detect a treatable organic illness. If the psychiatrist concludes that psychological issues play an important role in the development of the medical complaint, he should help the medical treatment team develop a reliable safety net of good care while minimizing invasive procedures.

The Closing Phase

The murkiness of many psychosomatic complaints should not necessarily lead to parallel uncertainty in the interviewer. When possible, the psychiatrist should make diagnoses that fulfill criteria for Axis I disorders such as major depression and panic disorder. The interviewer may be able to develop conviction about the possibility of a somatoform disorder, factitious disorder, or malingering. Most other psychosomatic illnesses inspire a formulation rather than a diagnosis, but as much as possible, the interviewer should clarify the extent to which he believes that psychological factors are contributing to the somatic complaint.
As the interview draws to a close, it may be helpful for the physician to explain to the patient what he has learned. This should initially stick closely to the patient’s report. It may be useful to reorder the information in such a way that implies a psychological formulation. In this way, the physician not only has an opportunity to clarify misunderstandings but also can obtain some measure of the patient’s receptivity to psychological insights concerning his illness. For example, after interviewing a young adult with recurrent stomach pain without physical findings, the psychiatrist might say, “It seems that you get pain every morning during the week, and this pain keeps you from going to work, but you don’t get the pain on weekends and holidays.” The interviewer can then wait and see how the patient reacts before explicitly theorizing a more specific link between work and the stomachache.

In reviewing the situation, it can sometimes be useful to frame the patient’s concerns in terms of being especially sensitive to physical sensations. The interviewer might say that the patient seems to have a particular ability to appreciate subtle physical sensations and then remind the patient that most people have physical pains every week without any demonstrable organic pathology. The patient’s sensitivity may be making the patient unduly worried. By normalizing aches and pains and creating a framework to experience bodily sensations, the interviewer can help reduce the patient’s tendency to “catastrophize.”

Before ending the interview, the therapist should allow the patient sufficient time to ask questions. If the patient’s questions and comments remain stuck on physical symptoms, the patient is unlikely to be amenable to suggestions of insight-oriented psychotherapy. If, on the other hand, the patient proceeds to inquire about matters related to his emotional life, he may be more responsive to an uncovering psychotherapy.

People who are especially sensitive to discomfort are often quite sensitive to the side effects of all medications, including, for example, antidepressants. Adequate time should be allowed to explain the rationale for the medication, the dosage regimen, the expected benefits, and the expected side effects. Similarly, many of these patients are sensitive to the suggestion of psychotherapeutic treatments. Explanation and reassurance are often needed before a psychosomatic patient is likely to be intrigued by the possibility of therapy.

CONCLUSION

The psychosomatic patient is often difficult to interview, and it is useful to recall that most difficult patients are making an unconscious effort to
hold themselves together. The misuse of others, the denial and projection of harsh emotions, and the rapid fluctuations between idealization and denigration may be uncomfortable for the interviewer but have become an important coping strategy for the patient. For many of these patients, symptoms have a useful purpose. Part of the responsibility of the interviewer is to model a sense of curiosity and compassionate interest. The interviewer should try to understand the patient individually rather than create a unified theory of either causation or response. The patient with psychosomatic complaints has intrigued and frustrated the greatest clinicians for centuries, offering an opportunity to balance the traditional medical effort to understand each patient with the central Hippocratic adage to do no harm.